

Antenatal and postnatal mental health

Quality standard

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This standard is based on CG192.

This standard should be read in conjunction with QS105, QS95, QS88, QS80, QS53, QS46, QS37, QS34, QS32, QS22, QS14, QS11, QS8, QS128, QS129, QS179, QS48, QS69 and QS189.

Introduction

This quality standard covers the recognition, assessment, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth). It also includes providing pre-conception support and advice for women with an existing mental health problem who might become pregnant, and the organisation of mental health services needed in pregnancy and the postnatal period. For more information see the [antenatal and postnatal mental health topic overview](#).

Why this quality standard is needed

In pregnancy and the postnatal period, women are vulnerable to having or developing the same range of mental health problems as at other times, such as depression, anxiety disorders, eating disorders, drug and alcohol use disorders, post-traumatic stress disorder and severe mental illness (including psychosis, bipolar disorder, schizophrenia and severe depression). Some changes in mental health state and functioning (such as appetite) may represent normal pregnancy changes, but they may be symptoms of a mental health problem.

Depression and anxiety are the most common mental health problems occurring during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point, and many women experiencing both. Depression and anxiety also affect 15–20% of women in the first year after childbirth. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth. Women with pre-existing bipolar type 1 disorder are at particular risk, but postpartum psychosis can occur in women with no previous history of mental health problems.

Mental health problems occurring in pregnancy and the postnatal period are often similar to those occurring at other times in their nature, course and potential for relapse, but there can be differences. For example, women have an increased risk of relapse or developing a first episode of bipolar disorder during the early postnatal period than at other times.

The majority of mental health problems during pregnancy and the postnatal period are mild to

moderate, and are treated in primary care. Other settings where women with mental health problems during pregnancy and the postnatal period may be treated include obstetric and gynaecological services, health psychology services, general mental health services and specialist secondary care mental health services.

Mental health problems in pregnancy and the postnatal period may often need more urgent intervention than they would at other times because of their potential effect on the baby and on the woman's physical health and care, and her ability to function and care for her family. However, problems frequently go unrecognised and untreated in pregnancy and the postnatal period. Some women do not seek help because of fear of stigma, or fear of intervention by social services. The perinatal period can also present practical barriers to treatment; for example, the demands associated with the care of an infant may interfere with a woman's ability to attend treatment regularly. If mental health problems are left untreated, women can continue to have symptoms detrimental to their wellbeing, sometimes for many years, which can also affect their children and other family members.

There are risks associated with taking psychotropic medication in pregnancy and during breastfeeding, and with stopping medication taken for an existing mental health problem without professional advice, because of the potential to trigger or worsen an episode.

Between 2009 and 2012 there were 0.67 maternal deaths per 100,000 maternal deliveries in the UK that were as a result of psychiatric causes; this is an increase from 0.55 per 100,000 maternal deliveries in the UK between 2009 and 2011 ([MBRRACE-UK 2014 Saving Lives, Improving Mothers' Care](#)).

The quality standard is expected to contribute to improvements in the following outcomes:

- maternal wellbeing
- service user experience of mental health services
- quality of life for women with severe mental illness
- neonatal and infant health and wellbeing
- suicide rate.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable

improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2015–16](#)
- [The Adult Social Care Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–16.](#)

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2015–16](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p><i>Overarching indicator</i></p> <p>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults</p> <p><i>Improvement areas</i></p> <p>Reducing premature mortality in people with mental illness</p> <p>1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)</p>

<p>2 Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicator</p> <p>2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition</p> <p>Enhancing quality of life for people with mental illness</p> <p>2.5 Employment of people with mental illness** (ASCOF 1F and PHOF 1.8)</p>
<p>3 Helping people to recover from episodes of ill health or following injury</p>	<p>Overarching indicators</p> <p>3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)</p> <p>Improvement areas</p> <p>Improving outcomes from planned treatments</p> <p>3.1 Total health gain as assessed by patients for elective procedures</p> <p>ii Psychological therapies</p>

<p>4 Ensuring that people have a positive experience of care</p>	<p>Overarching indicators</p> <p>4a Patient experience of primary care</p> <p>4b Patient experience of hospital care</p> <p>4c Friends and family test</p> <p>Improvement areas</p> <p>Improving hospitals' responsiveness to personal needs</p> <p>4.2 Responsiveness to in-patients' personal needs</p> <p>Improving women and their families' experience of maternity services</p> <p>4.5 Women's experiences of maternity services</p> <p>Improving experience of healthcare for people with a mental illness</p> <p>4.7 Patient experience of community mental health services</p> <p>Improving people's experience of integrated care</p> <p>4.9 People's experience of integrated care** (ASCOF 3E)</p>
<p>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</p>	<p>Overarching indicator</p> <p>5c Deaths attributable to problems in healthcare</p> <p>Improvement area</p> <p>Improving the safety of maternity services</p> <p>5.5 Admission of full-term babies to neonatal care</p>
<p>Alignment across the health and social care system</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p>	

Table 2 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	<p><i>Overarching measure</i></p> <p>1A Social care-related quality of life* (NHSOF2)</p> <p><i>Outcome measures</i></p> <p>People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation</p> <p>1F Proportion of adults in contact with secondary mental health services in paid employment* (PHOF 1.8 and NHSOF 2.5)</p> <p>1H Proportion of adults in contact with secondary mental health services living independently, with or without support** (PHOF 1.6)</p> <p>1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like** (PHOF 1.18)</p>
3 Ensuring that people have a positive experience of care and support	<p><i>Overarching measure</i></p> <p>People who use social care and their carers are satisfied with their experience of care and support services</p> <p>3A Overall satisfaction of people who use services with their care and support</p> <p>Placeholder 3E The effectiveness of integrated care* (NHSOF 4.9)</p>

<p>4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm</p>	<p>Overarching measure</p> <p>4A The proportion of people who use services who feel safe* (PHOF 1.19)</p> <p>Outcome measures</p> <p>Everyone enjoys physical safety and feels secure</p> <p>People are free from physical and emotional abuse, harassment, neglect and self-harm</p> <p>People are protected as far as possible from avoidable harm, disease and injuries</p> <p>People are supported to plan ahead and have the freedom to manage risks the way that they wish</p> <p>4B The proportion of people who use services who say that those services have made them feel safe and secure</p>
<p>Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p>	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
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<p>1 Improving the wider determinants of health</p>	<p>Objective Improvements against wider factors that affect health and wellbeing and health inequalities</p> <p>Indicators</p> <p>1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation* (ASCOF 1G and 1H)</p> <p>1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services* (NHSOF 2.2) ** (ASCOF 1E, NHSOF 2.5 and ASCOF 1F)</p> <p>1.9 Sickness absence rate</p> <p>1.18 Social isolation* (ASCOF 1I)</p>
<p>2 Health improvement</p>	<p>Objective People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.1 Low birth weight of term babies</p> <p>2.5 Child development at 2-2½ years</p> <p>2.10 Self-harm</p> <p>2.23 Self-reported well-being</p>
<p>4 Healthcare public health and preventing premature mortality</p>	<p>Objective Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Indicators</p> <p>4.3 Mortality rate from causes considered preventable** (NHSOF 1.1)</p> <p>4.9 Excess under 75 mortality rate in adults with serious mental illness* (NHSOF 1.5)</p> <p>4.10 Suicide rate</p> <p>4.11 Emergency readmissions within 30 days of discharge from hospital* (NHSOF 3b)</p>

Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework

* Indicator is shared

** Indicator is complementary

Service user experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to antenatal and postnatal mental health.

NICE has developed guidance and associated quality standards on patient experience in adult NHS services and service user experience in adult mental health services (see the NICE Pathways on [patient experience in adult NHS services](#) and [service user experience in adult mental health services](#)), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects people's experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that impact on people's experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for antenatal and postnatal mental health specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole antenatal and postnatal mental health care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to women with a mental health problem in pregnancy and the postnatal period.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing high-quality services for antenatal and postnatal mental health are listed in [related quality standards](#).

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in antenatal and postnatal mental health should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting women with a mental health problem in pregnancy and the postnatal period. If appropriate, healthcare professionals, public health professionals and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1 Women of childbearing potential are not prescribed valproate to treat a mental health problem.

Statement 2 Women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Statement 3 Pregnant women with a previous severe mental health problem or any current mental health problem are given information at their booking appointment about how their mental health problem and its treatment might affect them or their baby.

Statement 4 Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.

Statement 5 Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive mental health assessment.

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

Statement 7 (developmental) Specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units are available to support women with a mental health problem in pregnancy or the postnatal period.

Quality statement 1: Valproate

Quality statement

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

Rationale

Valproate is commonly used to treat epilepsy and some mental health problems. However, it can harm unborn babies when taken during pregnancy. Babies exposed to valproate in the womb are at a high risk of serious developmental disorders (approximately 30–40% of babies) and congenital malformations (approximately 10% of babies).

Valproate treatment must not be used in girls and women, including in young girls below the age of puberty, unless alternative treatments are not suitable and unless the conditions of the [pregnancy prevention programme](#) are met. Valproate must not be used in pregnant women. See also the Medicines and Healthcare products Regulatory Agency (MHRA) [toolkit to ensure female patients are better informed about the risks of taking valproate during pregnancy](#). In March 2019, we produced a [summary of NICE guidance and safety advice on valproate](#) to support the safe use of valproate.

Quality measures

Structure

Evidence of practice arrangements and written clinical protocols to ensure that women of childbearing potential are not prescribed valproate to treat a mental health problem.

Data source: Local data collection.

Process

Proportion of women of childbearing potential prescribed valproate to treat a mental health problem.

Numerator – the number in the denominator prescribed valproate to treat a mental health problem.

Denominator – the number of women who are of childbearing potential.

Data source: Local data collection.

Outcome

Children with serious developmental disorders or congenital malformations born to mothers who took valproate in pregnancy for treatment of a mental health problem.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (primary care, community health services, general mental health services and specialist secondary care mental health services) have practice arrangements and written clinical protocols in place to ensure that women of childbearing potential are not prescribed valproate to treat a mental health problem.

Healthcare professionals (GPs and mental health professionals) do not prescribe valproate to women of childbearing potential to treat a mental health problem.

Commissioners of primary care and specialist and general mental health services (NHS England regional teams and clinical commissioning groups) specify within contracts that providers should not prescribe valproate to women of childbearing potential to treat a mental health problem.

Women who may become pregnant or who are pregnant should not be prescribed a medication called valproate to treat a mental health problem as it can harm unborn babies.

Source guidance

[Antenatal and postnatal mental health](#) (2014) NICE guideline CG192, recommendations 1.2.3 and 1.4.27

Definitions of terms used in this quality statement

Valproate

At the time of publication 3 formulations of valproate were available in the UK: sodium valproate and valproic acid (licensed for the treatment of epilepsy) and semi-sodium valproate (licensed for the treatment of acute mania and continuation treatment in people whose mania responds to treatment). Both semi-sodium and sodium valproate are metabolised to valproic acid (also known

as valproate), which is the pharmacologically active component.

Women of childbearing potential

Childbearing potential should be determined for women on an individual basis. It should not be determined solely by age because childbearing potential can be dependent on factors other than age. It includes girls and young women under 18 and pregnant women.

[Adapted from NICE's guideline on [antenatal and postnatal mental health](#)]

Equality and diversity considerations

When information is provided, there must be equal access to information for all women, including those with additional needs, such as physical or learning disabilities, and those who do not speak or read English. Women receiving information should have access to an interpreter or independent advocate if needed.

Quality statement 2: Pre-conception information

Quality statement

Women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Rationale

Women with a severe mental health problem can make informed decisions about safe treatments and managing their condition if they understand how their mental health problem, or its treatment, could affect them or their baby if they become pregnant.

Quality measures

Structure

Evidence of local arrangements to ensure that women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Data source: Local data collection.

Process

Proportion of women of childbearing potential with a severe mental health problem given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Numerator – the number in the denominator who have received information as part of their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Denominator – the number of women of childbearing potential with a severe mental health problem having an annual review.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (general mental health services and specialist secondary care mental health services) have systems in place to ensure that the annual review for women of childbearing potential with a severe mental health problem includes information about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Mental health professionals provide information at the annual review for women of childbearing potential with a severe mental health problem about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Commissioners (commissioners of general and specialist and mental health services, clinical commissioning groups) specify and check that annual reviews for women of childbearing potential with a severe mental health problem include giving women information about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

Women with a severe mental health problem who might become pregnant are given information at their annual review about how their mental health problem might affect them or their baby if they become pregnant. It should include the possible benefits and harms of any treatment they are having for their mental health problem. This will help them to make decisions about pregnancy and treatment for their mental health problem.

Source guidance

[Antenatal and postnatal mental health](#) (2014) NICE guideline CG192, recommendations 1.2.1 (key priority for implementation), 1.4.4 and 1.4.6 (key priority for implementation)

Definitions of terms used in this quality statement

Annual review

The Care Programme Approach sets out support that women with a severe mental health problem should receive from secondary mental health services. It includes a formal review at least once a year.

[NHS Choices [Care Programme Approach](#)]

Information

The following information should be discussed with women of childbearing potential who have a 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.

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.2.1]

Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period should include discussion of the following, depending on individual circumstances:

- the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- the likely benefits of each treatment, taking into account the severity of the mental health problem
- 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 to mental health and parenting associated with no treatment
- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- 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.

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.4.6]

Healthcare professionals discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. This should include an explanation of the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed. Healthcare professionals should discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed.

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.4.4]

Postnatal period

Up to 1 year after childbirth.

[NICE's guideline on [antenatal and postnatal mental health](#)]

Severe mental health problem

A severe mental health problem includes severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder or postpartum psychosis.

[NICE's guideline on [antenatal and postnatal mental health](#)]

Equality and diversity considerations

When information is provided, there must be equal access to information for all women, including those with additional needs, such as physical or learning disabilities, and those who do not speak or read English. Women receiving information should have access to an interpreter or independent advocate if needed.

Quality statement 3: Information for pregnant women

Quality statement

Pregnant women with a previous severe mental health problem or any current mental health problem are given information at their booking appointment about how their mental health problem and its treatment might affect them or their baby.

Rationale

It is important that pregnant women with a previous severe mental health problem, or any current mental health problem, understand how their mental health problem might affect them during and after pregnancy, and how pregnancy and childbirth might affect their condition, including the risk of relapse. In particular, it is important that the risks of using some medications to treat mental health problems during pregnancy and while breastfeeding are discussed, and alternatives considered to help women make informed decisions about managing their condition. This discussion might happen earlier for some women if they have a discussion with a specialist before their booking appointment.

Quality measures

Structure

Evidence of local arrangements to ensure that women with a previous severe mental health problem or any current mental health problem are given information at their booking appointment about how their mental health problem and its treatment might affect them or their baby.

Data source: Local data collection.

Process

Proportion of pregnant women with a previous severe mental health problem or any current mental health problem who are given information at their booking appointment about how their mental health problem and its treatment might affect them or their baby.

Numerator – the number in the denominator who have received information about how their mental health problem and its treatment might affect them or their baby.

Denominator – the number of pregnant women with a previous severe mental health problem or

any current mental health problem attending their booking appointment.

What the quality statement means for different audiences

Service providers (antenatal care providers) have systems in place to ensure that women with a previous severe mental health problem or any current mental health problem are given information at the booking appointment about how their mental health problem and its treatment might affect them or their baby.

Healthcare professionals (midwives) provide information at the booking appointment to women with a previous severe mental health problem or any current mental health problem about how their mental health problem and its treatment might affect them or their baby.

Commissioners (clinical commissioning groups) specify and check that booking appointments for women with a previous severe mental health problem or any current mental health problem include midwives giving information to women about how their mental health problem and its treatment might affect them or their baby.

Women who are pregnant and who have had a severe mental health problem in the past or have any current mental health problem are given information at their booking appointment about how their mental health problem might affect them or their baby during pregnancy and after their baby is born. They are also given information about the possible benefits and harms of any treatment they might have for their mental health problem during this time and while breastfeeding, if they choose to breastfeed. This will help them to make decisions about pregnancy and their treatment.

Source guidance

Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendations 1.4.3 and 1.4.4 and expert opinion

Definitions of terms used in this quality statement

Information

Discuss treatment and prevention options and any particular concerns the woman has about the pregnancy or the fetus or baby. Provide information to the woman and, if she agrees, her partner, family or carer, about:

- the potential benefits of psychological interventions and psychotropic medication
- the possible consequences of no treatment
- the possible harms associated with treatment
- what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly.

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.4.3]

Healthcare professionals discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. This should include an explanation of the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed. Healthcare professionals should discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed.

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.4.4]

Postnatal period

Up to 1 year after childbirth.

[NICE's guideline on [antenatal and postnatal mental health](#)]

Severe mental health problem

A severe mental health problem includes severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder or postpartum psychosis.

[NICE's guideline on [antenatal and postnatal mental health](#)]

Equality and diversity considerations

When information is provided, there must be equal access to information for all women, including those with additional needs, such as physical or learning disabilities, and those who do not speak or read English. Women receiving information should have access to an interpreter or independent advocate if needed.

Quality statement 4: Asking about mental health and wellbeing

Quality statement

Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.

Rationale

Routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems. It also gives women an opportunity to talk about any concerns they might have, such as fears around childbirth, multiple pregnancy, or past experiences, such as loss of a child or traumatic childbirth. This will help health professionals provide appropriate support.

Quality measures

Structure

Evidence of arrangements for healthcare professionals to ask women about their emotional wellbeing at all routine antenatal and postnatal contacts.

Data source: Local data collection.

Process

The proportion of routine antenatal and postnatal contacts at which woman are asked about their emotional wellbeing by a healthcare professional.

Numerator – the number in the denominator at which women were asked about their emotional wellbeing by a healthcare professional.

Denominator – the number of routine antenatal and postnatal contacts.

Data source: Local data collection.

Outcome

a) Women's satisfaction with being able to discuss any concerns or worries at routine appointments.

Data source: Local data collection. The Care Quality Commission's [Maternity services survey](#) asks women whether a midwife or health visitor had asked how they were feeling emotionally at the postnatal stage.

b) Identification of mental health problems.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (antenatal and postnatal care service providers in community, primary and secondary care) have protocols in place to ensure that healthcare professionals ask women about their emotional wellbeing at each routine antenatal and postnatal contact.

Healthcare professionals (GPs, midwives, health visitors and consultant obstetricians) ask women about their emotional wellbeing at each routine antenatal and postnatal contact to support identification and discussion of mental health problems.

Commissioners (NHS England area teams, clinical commissioning groups and local authorities) specify and check that antenatal and postnatal care providers have protocols in place to ensure that healthcare professionals ask women about their emotional wellbeing at each routine antenatal and postnatal contact.

Women who are pregnant or in the first year after giving birth are asked how they are feeling at every routine appointment. This is so that they can talk to their healthcare professional about any concerns they have, and any problems can be identified.

Source guidance

[Antenatal and postnatal mental health](#) (2014) NICE guideline CG192, recommendations 1.5.4 (key priority for implementation) and 1.5.8

Definitions of terms used in this quality statement

Mental health and wellbeing

Healthcare professionals should consider asking the following questions at a woman's booking appointment and at regular contacts in pregnancy, as part of a general discussion about her mental

health and wellbeing:

- The depression identification questions:
 - 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?
- Questions about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):
 - Over the last 2 weeks, have you been feeling nervous, anxious or on edge?
 - Over the last 2 weeks, have you not been able to stop or control worrying?

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.5.4]

Recommendations 1.5.5–1.5.7 in NICE's guideline on [antenatal and postnatal mental health](#) set out additional questions to ask if initial questioning indicates the need for further investigation.

Routine antenatal contacts

Routine antenatal contacts include:

- a pregnant woman's first contact with a midwife or doctor to discuss their pregnancy
- the booking appointment (between 8 and 12 weeks of pregnancy)
- the dating scan (between 8 and 14 weeks of pregnancy)
- the 16-week check
- the anomaly scan (between 18 and 20 weeks of pregnancy)
- further routine scheduled checks (the frequency of these will vary depending on whether it is the woman's first pregnancy).

[NHS Choices [Your antenatal appointments](#)]

Routine postnatal contacts

Women should receive the number of postnatal contacts that are appropriate to their care needs.

A routine postnatal contact is a scheduled postnatal appointment that may occur in the woman or baby's home or another setting such as a GP practice, children's centre or a hospital setting if the woman or baby needs extended inpatient care. All women should have a postnatal check about 6 weeks after their baby's birth to make sure that they feel well and are recovering properly.

[Expert consensus]

Postnatal period

Up to 1 year after childbirth.

[NICE's guideline on [antenatal and postnatal mental health](#)]

Equality and diversity considerations

Women with complex social needs may be less likely to access or maintain contact with antenatal and postnatal services. Examples of women with complex social needs include, but are not limited to, women who:

- have a history of substance misuse (alcohol and/or drugs)
- have recently arrived as a migrant, asylum seeker or refugee
- have difficulty speaking or understanding English
- are aged under 20
- have experienced domestic abuse
- are living in poverty
- are homeless.

It is therefore appropriate that localities give special consideration to these groups of women. NICE's guideline on [pregnancy and complex social factors](#) has recommendations about how to make antenatal care accessible to women with complex social needs and how to encourage ongoing contact.

Quality statement 5: Comprehensive mental health assessment

Quality statement

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

Rationale

A comprehensive mental health assessment can support accurate diagnosis of a mental health problem in pregnancy or the postnatal period, and can ensure that women are offered the most appropriate treatment at the earliest opportunity. Factors specific to pregnancy or the postnatal period, such as a previous traumatic birth, loss of a child, and other individual circumstances, can help identify additional support needs.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive mental health assessment.

Data source: Local data collection.

Process

Proportion of women with a suspected mental health problem in pregnancy or within 12 months of giving birth who receive a comprehensive mental health assessment.

Numerator – the number in the denominator who receive a comprehensive mental health assessment.

Denominator – the number of women with a suspected mental health problem who are pregnant or have given birth within the past 12 months.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (primary care and general mental health services) provide resources that support professionals to carry out comprehensive mental health assessments for women with a suspected mental health problem in pregnancy or the postnatal period.

Healthcare professionals (GPs and mental health professionals) carry out comprehensive mental health assessments for women with a suspected mental health problem in pregnancy or the postnatal period to aid diagnosis and identify appropriate support.

Commissioners (NHS England area teams and clinical commissioning groups) specify that comprehensive mental health assessments are carried out for women with a suspected mental health problem in pregnancy or the postnatal period.

Women who may have a mental health problem in pregnancy or within a year after giving birth have a full assessment to find out if they have a mental health problem and whether they need extra support.

Source guidance

Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendation 1.6.1

Definitions of terms used in this quality statement

Comprehensive mental health assessment

Assessment and diagnosis of a suspected mental health problem in pregnancy and the postnatal period should include:

- history of any mental health problem, including in pregnancy or the postnatal period
- physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem
- alcohol and drug misuse
- the woman's attitude towards the pregnancy, including denial of pregnancy
- the woman's experience of pregnancy and any problems experienced by her, the fetus or the baby

- the mother–baby relationship
- any past or present treatment for a mental health problem, and response to any treatment
- social networks and quality of interpersonal relationships
- living conditions and social isolation
- family history (first-degree relative) of mental health problems
- 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.

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.6.1]

Postnatal period

Up to 1 year after childbirth.

[NICE's guideline on [antenatal and postnatal mental health](#)]

Suspected mental health problem

Women might be suspected to have a mental health problem if they have a history of a mental health problem or possible symptoms (such as mood difficulties or detachment from their pregnancy or baby).

[Expert consensus]

Equality and diversity considerations

Healthcare professionals should ensure that, in comprehensive mental health assessments with all women, they understand variations in the presentation of mental health problems, and are sensitive to any potential concerns about disclosing mental health problems. This includes ensuring that they are culturally competent in their discussions with women from black, Asian and minority ethnic groups to support full and meaningful discussion. Women should have access to an interpreter or independent advocate if needed.

When assessing or treating a mental health problem in pregnancy or the postnatal period, healthcare professionals should take account of any learning disabilities or acquired cognitive impairments, and assess the need to consult with a specialist when developing care plans.

Quality statement 6: Psychological interventions

Quality statement

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

Rationale

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

Quality measures

Structure

Evidence of local arrangements to ensure psychological interventions can be started within 6 weeks of referral for women with a mental health problem in pregnancy or who have a mental health problem in the postnatal period.

Data source: Local data collection.

Process^[1]

a) Proportion of women referred for psychological interventions in pregnancy or within 12 months of giving birth who are assessed for treatment within 2 weeks of referral.

Numerator – number of women in the denominator who are assessed for treatment within 2 weeks of referral.

Denominator – the number of women referred for psychological interventions in pregnancy or within 12 months of giving birth.

Data source: Local data collection.

b) Proportion of women assessed as appropriate for psychological interventions in pregnancy or within 12 months of giving birth who start psychological interventions within 4 weeks of assessment.

Numerator – number of women in the denominator who start psychological interventions within 4 weeks of assessment.

Denominator – number of women assessed as appropriate for psychological interventions in pregnancy or within 12 months of giving birth.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (general mental health services, primary care psychological therapy services and specialist secondary care mental health services) have service capacity to ensure that women who are referred for psychological interventions in pregnancy or the postnatal period are assessed within 2 weeks of referral and treatment is started within 6 weeks of referral.

Healthcare professionals (mental health professionals) assess women who are referred for psychological interventions in pregnancy or the postnatal period within 2 weeks of referral and start treatment within 6 weeks of referral.

Commissioners (clinical commissioning groups) commission psychological interventions and specify that assessment of women referred for psychological interventions in pregnancy or the postnatal period should take place within 2 weeks of referral and treatment should start within 6 weeks of referral.

Women with a mental health problem who are pregnant or have had a baby in the past year and who have been referred by their healthcare professional for psychological therapy start their therapy within 6 weeks of being referred, so they can receive the treatment they need as soon as possible.

Source guidance

Antenatal and postnatal mental health (2014) NICE guideline CG192, recommendation 1.7.3

Definitions of terms used in this quality statement

Psychological interventions

Psychological interventions should be tailored to the (sometimes highly specialist) needs of women in pregnancy and the postnatal period, and to support the baby's development, attachment and mental health. All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated (for example, maternity services, health visiting and mental health services).

[NICE's guideline on [antenatal and postnatal mental health](#)]

Equality and diversity considerations

When tailoring psychological interventions to women's individual needs, health professionals need to ensure that assessments and interventions are culturally competent and that women are able to understand and communicate effectively. An independent interpreter should be provided if needed.

^[1] Process measures have been included to reflect that the 6 weeks to treatment set out in the quality statement comprises 2 weeks to assessment and 4 weeks to treatment, as recommended in NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.7.3.

Quality statement 7 (developmental): Specialist multidisciplinary perinatal mental health services

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

Developmental quality statement

Specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units are available to support women with a mental health problem in pregnancy or the postnatal period.

Rationale

Access to specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units can help to ensure that the most appropriate assessment, monitoring and treatment is provided. Access currently varies considerably, because services are not available in all localities.

In particular, women with severe mental health problems need specialist perinatal support to ensure that their condition is monitored appropriately, and that they can access the most suitable treatment. This is because severe mental health problems can be associated with significant impairment in social and personal functioning, which might affect the woman's ability to care for herself and her child. Psychiatric causes of maternal death, particularly suicide, continue to be a significant cause of maternal mortality in the UK.

Quality measures

Structure

- a) Evidence of local arrangements to provide specialist multidisciplinary perinatal community services.
- b) Evidence of local arrangements to ensure that women needing inpatient care for a mental health problem within 12 months of childbirth can be admitted to an inpatient psychiatric mother and baby unit.

c) Evidence of referral arrangements for women with a severe mental health problem to be referred to specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (mental health trusts and specialist tertiary services) provide specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units for women with a mental health problem in pregnancy or the postnatal period.

Healthcare professionals (GPs, midwives, health visitors and mental health professionals) support women with a mental health problem in pregnancy or the postnatal period through specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units. They are aware of local referral pathways and use them to refer women with a mental health problem in pregnancy or the postnatal period.

Commissioners (NHS England specialised commissioning teams) commission specialist multidisciplinary perinatal community mental health services and inpatient psychiatric mother and baby units for women with a mental health problem in pregnancy or the postnatal period. NICE has produced a [costing report](#) that can support commissioners to consider the cost impact of commissioning specialist perinatal mental health services.

Commissioners of primary and secondary care services (NHS England and clinical commissioning groups) should check that providers refer women with a mental health problem in pregnancy or the postnatal period to specialist multidisciplinary perinatal community mental health services and inpatient psychiatric mother and baby units when appropriate.

Women who have a mental health problem during pregnancy or in the year after having a baby receive support from services that are specially designed for women with a mental health problem during these times. These services can give them the care and support they need.

Source guidance

[Antenatal and postnatal mental health](#) (2014) NICE guideline CG192, recommendations 1.5.10, 1.10.1 and 1.10.3 (key priority for implementation)

Definitions of terms used in this quality statement

Specialist multidisciplinary perinatal mental health service

A specialist multidisciplinary perinatal mental health service that provides direct services, consultation and advice to maternity services, other mental health services and community services, and is available in all localities.

[NICE's guideline on [antenatal and postnatal mental health](#), recommendation 1.10.3]

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

See NICE's [how to use quality standards](#) for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's [quality standard service improvement template](#) helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health, public health and social care practitioners and women with a mental health problem planning or during pregnancy and in the year after giving birth is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to women with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards [process guide](#).

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Antenatal and postnatal mental health \(2014\) NICE guideline CG192](#)

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- NHS England (2015) [Improving access to perinatal mental health services in England](#)
- Royal College of Midwives (2014) [Maternal mental health: improving emotional wellbeing in postnatal care](#)
- National Audit Office (2013) [Maternity services in England](#)
- NHS England (2013) [NHS standard contract for specialised perinatal mental health services \(in patient mother and baby units and linked outreach teams\) Schedule 2 The Services A Service Specifications](#)
- Department of Health (2012) [Maternal mental health pathway](#)
- Public Health Agency (2012) [Integrated perinatal mental health care pathway](#)
- Centre for Maternal and Childhood Enquiries (2011) [Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–2008](#)

Definitions and data sources for the quality measures

- Care Quality Commission (2013) [Maternity services survey](#)
- NHS Choices (2015) [Your antenatal appointments](#)

- NICE (2014) Quality and outcomes framework (QOF) menu indicator NM78

Related NICE quality standards

Published

- [Medicines optimisation](#) (2016) NICE quality standard 120
- [Intrapartum care](#) (2015) NICE quality standard 105
- [Bipolar disorder in adults](#) (2015) NICE quality standard 95
- [Personality disorders: borderline and antisocial](#) (2015) NICE quality standard 88
- [Psychosis and schizophrenia in adults](#) (2015) NICE quality standard 80
- [Ectopic pregnancy and miscarriage](#) (2014) NICE quality standard 69
- [Anxiety disorders](#) (2014) NICE quality standard 53
- [Depression in children and young people](#) (2013) NICE quality standard 48
- [Multiple pregnancy](#) (2013) NICE quality standard 46
- [Postnatal care](#) (2013) NICE quality standard 37
- [Self-harm](#) (2013) NICE quality standard 34
- [Caesarean section](#) (2013) NICE quality standard 32
- [Antenatal care](#) (2012) NICE quality standard 22
- [Service user experience in adult mental health services](#) (2011) NICE quality standard 14
- [Alcohol-use disorders: diagnosis and management](#) (2011) NICE quality standard 11
- [Depression in adults](#) (2011) NICE quality standard 8

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- [Suicide prevention](#). Publication expected September 2019
- [Maternal health](#)

- [Mental wellbeing: life course, settings and subgroups](#)
- [Parenteral nutrition in neonates](#)
- Termination of pregnancy services
- Premature birth
- Premature labour

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3. Membership of this committee is as follows:

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Update information

Minor changes since publication

July 2019: A link has been added to the rationale for statement 1 to the [summary of NICE guidance and safety advice on valproate](#).

April 2018: Information has been added to statement 1 to update the advice and link to resources from the Medicines and Healthcare products Regulatory Agency (MHRA) on the use of valproate in women and girls.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE Pathway on [antenatal and postnatal mental health](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Royal College of Midwives](#)

- Royal College of Obstetricians and Gynaecologists
- Royal College of General Practitioners (RCGP)