



*National Institute for  
Health and Clinical Excellence*

## **Quick reference guide**

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# **Antenatal and postnatal mental health**

Clinical management and service guidance

### About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Antenatal and postnatal mental health: clinical management and service guidance' (NICE clinical guideline 45).

### Who should read this booklet?

This quick reference guide is for GPs, obstetricians, midwives, health visitors, mental healthcare professionals and other staff who care for women who are planning a pregnancy or are pregnant, or during the postnatal period (the first year after birth).

### Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Mental Health, which is a partnership between the Royal College of Psychiatrists and the British Psychological Society. The Collaborating Centre worked with a group of healthcare professionals (including professionals in psychiatry, clinical psychology, mental health nursing, midwifery, health visiting, social work and general practice), former patients and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation. For more information on how NICE clinical guidelines are developed, go to [www.nice.org.uk](http://www.nice.org.uk)

### Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for patients and carers, and tools to support implementation (see page 20 for more details).

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### This guidance is written in the following context

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

## Contents

|   |           |
|---|-----------|
| <b>Key priorities for implementation</b>  | <b>4</b>  |
|  <b>Principles of care</b>  | <b>6</b>  |
|  <b>Prediction, detection and initial management</b>                                    | <b>7</b>  |
|  <b>Preventing mental disorders</b>   | <b>9</b>  |
|  <b>The treatment of pregnant and breastfeeding women: balancing risks and benefits</b> | <b>10</b> |
|  <b>Psychotropic medication</b>   | <b>12</b> |
|  <b>Guidance for specific disorders</b>   | <b>14</b> |
|  <b>Service organisation</b>   | <b>18</b> |
| <b>Implementation</b>   | <b>19</b> |
| <b>Further information</b>  | <b>20</b> |

### Introduction

Mental disorders during pregnancy and the postnatal period can have serious consequences for the mother, her infant and other family members. This guideline covers all mental disorders, including anxiety disorders, depression, bipolar disorder, schizophrenia and postnatal psychotic disorders (often termed puerperal psychoses). It aims to help clinicians balance the risks of treating a mental disorder (in particular with psychotropic medication) with the risks of not treating it.

When treating any psychotic disorder, clinicians should refer to the sections on bipolar disorder and schizophrenia. The guideline avoids the term 'postnatal depression' because this is often used inappropriately as a term for any perinatal mental disorder.

No psychotropic drug has marketing authorisation specifically for pregnant or breastfeeding women.

### Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Carers and relatives should have the chance to be involved in discussions unless the patient thinks it inappropriate.

## Key priorities for implementation

### Prediction and detection

- At a woman's first contact with services in both the antenatal and the postnatal periods, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask questions about:
  - past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression
  - previous treatment by a psychiatrist/specialist mental health team including inpatient care
  - a family history of perinatal mental illness.

Other specific predictors, such as poor relationships with her partner, should not be used for the routine prediction of the development of a mental disorder.

- At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.
  - 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?

A third question should be considered if the woman answers 'yes' to either of the initial questions<sup>1</sup>.

- Is this something you feel you need or want help with?

### Psychological treatments

- Women requiring psychological treatment should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological therapies during pregnancy and the postnatal period arising from the changing risk–benefit ratio for psychotropic medication at this time.

### Explaining risks

- Before treatment decisions are made, healthcare professionals should discuss with the woman the absolute and relative risks associated with treating and not treating the mental disorder during pregnancy and the postnatal period. They should:
  - acknowledge the uncertainty surrounding the risks
  - explain the background risk of fetal malformations for pregnant women without a mental disorder
  - describe risks using natural frequencies rather than percentages (for example, 1 in 10 rather than 10%) and common denominators (for example, 1 in 100 and 25 in 100, rather than 1 in 100 and 1 in 4)
  - if possible use decision aids in a variety of verbal and visual formats that focus on an individualised view of the risks
  - provide written material to explain the risks (preferably individualised) and, if possible, audio-taped records of the consultation.

<sup>1</sup> In this reissued guideline, this recommendation has been corrected by changing 'both of the initial questions' to 'either of the initial questions'.

### Management of depression

- When choosing an antidepressant for pregnant or breastfeeding women, prescribers should, while bearing in mind that the safety of these drugs is not well understood, take into account that:
  - tricyclic antidepressants, such as amitriptyline, imipramine and nortriptyline, have lower known risks during pregnancy than other antidepressants
  - most tricyclic antidepressants have a higher fatal toxicity index than selective serotonin reuptake inhibitors (SSRIs)
  - fluoxetine is the SSRI with the lowest known risk during pregnancy
  - imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels
  - citalopram and fluoxetine are present in breast milk at relatively high levels
  - SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate
  - paroxetine taken in the first trimester may be associated with fetal heart defects
  - venlafaxine may be associated with increased risk of high blood pressure at high doses, higher toxicity in overdose than SSRIs and some tricyclic antidepressants, and increased difficulty in withdrawal
  - all antidepressants carry the risk of withdrawal or toxicity in neonates; in most cases the effects are mild and self-limiting.
- For a woman who develops mild or moderate depression during pregnancy or the postnatal period, the following should be considered:
  - self-help strategies (guided self-help, computerised cognitive behavioural therapy or exercise)
  - non-directive counselling delivered at home (listening visits)
  - brief cognitive behavioural therapy or interpersonal psychotherapy.

### Organisation of care

- 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 disorders, 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.

## Principles of care

### Providing and using information effectively

- Give culturally sensitive information to women with an existing mental disorder who are planning a pregnancy or are pregnant, and to those who develop a mental disorder during pregnancy or the postnatal period.
  - This should include the impact of the disorder and its treatment on the health of the woman and the fetus or child (including the proper use and likely side effects of medication).
- Develop a trusting relationship with the woman and, where appropriate and acceptable to her, her partner, family members and carers.
  - Explore the woman's ideas, concerns and expectations and regularly check her understanding of the issues.
  - Discuss the level of involvement of her partner, family members and carers and their supportive role.
  - Be sensitive to issues of stigma and shame in relation to mental illness.
- Make sure that adequate systems are in place to ensure continuity of care and effective transfer of information to reduce the need for multiple assessments.

### Discussing the risks of pregnancy and the use of contraception

- Discuss contraception and the risks of pregnancy (including relapse, risks associated with stopping or changing medication, and risk to the fetus) with all women of child-bearing potential who have a mental disorder and/or who are taking psychotropic medication. Encourage them to discuss pregnancy plans.

### Supporting families and carers

- Assess and address the needs of the woman's partner, family members and carers, including:
  - the welfare of the infant and other dependent children and adults
  - the impact of any mental disorder on relationships with her partner, family members and carers.

### Considerations for adolescents

- When working with adolescents with a mental disorder during pregnancy or the postnatal period:
  - be familiar with local and national guidelines on confidentiality and the rights of the child
  - obtain appropriate consent, bearing in mind the adolescent's understanding (including Gillick competence<sup>2</sup>), parental consent and responsibilities, child protection issues, and the use of the Mental Health Act and Children Act (1989).

<sup>2</sup> Also known as the Fraser Competence Rule

## Prediction, detection and initial management

### Prediction and detection

#### Prediction

- In all communications (including initial referral) with maternity services, include information on any relevant history of mental disorder.
- At the woman's first contact with services during pregnancy and the postnatal period, healthcare professionals (including midwives, obstetricians, health visitors and GPs), should ask about:
  - past or present severe mental illness, including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression
  - previous treatment by a psychiatrist/specialist mental health team, including inpatient care
  - family history of perinatal mental illness.
- Do not use other specific predictors, such as poor relationships with her partner, routinely to predict development of a mental disorder.

#### Detection

- At the woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.
  - 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?

If the woman answers 'yes' to either of the initial questions, also ask<sup>3</sup>:

- Is this something you feel you need or want help with?
- As part of a subsequent assessment or for routine monitoring of outcomes, consider using self-report measures such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire 9 (PHQ9).

<sup>3</sup> In this reissued guideline, this recommendation has been corrected by changing 'both of the initial questions' to 'either of the initial questions'.

## Referral and initial care

- After identifying a possible mental disorder, consider further assessment, in consultation with colleagues if necessary.
- If there are significant concerns, the woman should normally be referred to her GP for assessment.
  - If she has, or is suspected to have, severe mental illness (for example, schizophrenia or bipolar disorder), she should be referred to a specialist mental health service, including, if appropriate, a specialist perinatal mental health service. This should be discussed with the woman and preferably with her GP.
  - In all cases the GP should be informed, even if no further assessment or referral is made.
- If the woman has a mental disorder or history of severe mental illness, ask about her mental health at all subsequent contacts.
- If the woman has a current or past history of severe mental illness, develop a written care plan, usually in the first trimester, covering pregnancy, delivery and the postnatal period. It should:
  - be developed with the woman, her partner, family members and carers, and relevant healthcare professionals
  - include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services)
  - be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes) and communicated to the woman and all relevant healthcare professionals.
- 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 know how to access assessment and treatment
  - staff have training and supervision, including appropriate knowledge of mental disorders, assessment methods and referral routes, to enable them to follow care pathways.

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

## Preventing mental disorders

### Treating subthreshold symptoms in pregnant women

- For symptoms of depression and/or anxiety that do not meet diagnostic criteria but significantly interfere with personal and social functioning, consider:
  - brief psychological treatment (four to six sessions), such as interpersonal psychotherapy (IPT) or cognitive behavioural therapy (CBT), for women who have had a previous episode of depression or anxiety
  - social support (regular informal individual sessions or group-based) for those who have not had a previous episode of depression or anxiety.

### Routine antenatal and postnatal care

- Psychosocial interventions (for example, group psychoeducation) designed specifically to reduce the likelihood of the woman developing a mental disorder during pregnancy and the postnatal period should not be part of routine antenatal and postnatal care.

### Traumatic birth and stillbirth

- Do not routinely offer single-session formal debriefing focused on the birth to women who have experienced a traumatic birth.
  - Maternity staff and other healthcare professionals should support women who wish to talk about their experience, encourage them to make use of support from family and friends, and consider the effect of the birth on the partner.
- Do not routinely encourage mothers of infants who are stillborn or die soon after birth to see and hold the dead infant. Offer an appropriate follow-up appointment in primary or secondary care.

## The treatment of pregnant and breastfeeding women: balancing risks and benefits

All pregnancies carry a background risk, although this may be increased by the presence of a mental disorder. Treatment can reduce the risk, but the use of some psychotropic drugs may increase it.

### Psychological treatments

- Women requiring psychological treatment should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological therapies during pregnancy and the postnatal period arising from the changing risk–benefit ratio for psychotropic medication at this time.

### Discussing and balancing risks

- When discussing treatment options with a woman with a mental disorder who is planning a pregnancy, pregnant or breastfeeding, cover:
  - the risk of relapse or deterioration in current symptoms and the woman's ability to cope with untreated or subthreshold symptoms
  - severity of previous episodes, response to treatment and the woman's preference
  - the possibility that stopping a drug with teratogenic risk after pregnancy is confirmed may not remove the risk of malformations
  - the risks from stopping medication abruptly
  - the need for prompt treatment because of the potential impact of an untreated mental disorder on the fetus or infant
  - the increased risk associated with drug treatments during pregnancy and the postnatal period, including the risk in overdose
  - treatment options that would enable the woman to breastfeed if she wishes, rather than recommending that she does not breastfeed.
- When prescribing a drug:
  - choose drugs with lower risk profiles for the mother and fetus or infant
  - start at the lowest effective dose and slowly increase it; this is particularly important where the risks may be dose related
  - use monotherapy in preference to combination treatment
  - consider additional precautions for preterm, low birthweight or sick infants.
- When stopping a drug, take into account:
  - NICE guidance on the specific disorder (see 'Related NICE guidance' on page 20)
  - the risk to the fetus or infant during the withdrawal period
  - the risk from not treating the disorder.

- Discuss with the woman the absolute and relative risks associated with treating and not treating the mental disorder before making treatment decisions.
- Acknowledge the uncertainty surrounding the risks.
- Explain the background risk of fetal malformations for pregnant women without a mental disorder (between 2 and 4 in 100 in the general population).
- Describe risks using natural frequencies rather than percentages (for example, 1 in 10 rather than 10%) and common denominators (1 in 100 and 25 in 100, rather than 1 in 100 and 1 in 4).
- If possible, use decision aids in a variety of verbal and visual formats that focus on an individualised view of the risks.
- Provide written material to explain the risks (preferably individualised) and, if possible, audio-taped records of the consultation.

### Special considerations for women taking psychotropic drugs during early pregnancy or while breastfeeding

- In pregnant women who, at the time of conception and/or in the first trimester, were taking drugs with known teratogenic risk (lithium, valproate, carbamazepine, lamotrigine or paroxetine):
  - confirm the pregnancy as quickly as possible
  - offer screening and counselling about the continuation of the pregnancy, the need for additional monitoring and the risks to the fetus if the woman continues to take medication
  - carry out a full paediatric assessment of the newborn infant
  - monitor the infant in the first few weeks after delivery for adverse drug effects, drug toxicity or withdrawal (for example, floppy baby syndrome, irritability, constant crying, shivering, tremor, restlessness, increased tone, feeding and sleeping difficulties and, rarely, seizures); if the mother took antidepressants in the last trimester, these may result from serotonergic toxicity syndrome rather than withdrawal.
- Monitor infants of mothers who are breastfeeding while taking psychotropic medication for adverse drug reactions.

### Specific risks of psychotropic medication

The risks of fetal malformations, problems for the neonate and obstetric complications may be increased by the use of psychotropic drugs. For most drugs the risks are uncertain because there is limited data. If the level of risk is known, or it is known to be substantial, the table on pages 12 and 13 gives this information and recommends alternative treatment options to consider.

For recommendations on treating specific disorders, see pages 14 to 16.

## Psychotropic medication

### Antipsychotics

#### Risks to consider

- Raised prolactin levels with some antipsychotics (amisulpride, risperidone, sulpiride).
- Gestational diabetes and weight gain with olanzapine.
- Agranulocytosis in the fetus (theoretical) and breastfed infant with clozapine.
- Extrapyramidal symptoms in the neonate especially with depot medication (these are usually self-limiting).

#### Actions to take

- Advise women taking antipsychotics who are planning a pregnancy that raised prolactin levels reduce the chances of conception. If levels are raised, consider an alternative drug.
- If prescribing olanzapine to a pregnant woman, consider risk factors for gestational diabetes and weight gain, including family history, existing weight and ethnicity.
- Do not routinely prescribe:
  - clozapine to women who are pregnant or breastfeeding; for those taking it, consider switching to another drug and monitor carefully
  - depot antipsychotics to pregnant women
  - anticholinergic drugs for extrapyramidal side effects of antipsychotics, except for short-term use; instead, adjust dose and timing of the antipsychotic or switch to another drug to avoid side effects.

### Lithium

#### Risks to consider

- Fetal heart defects (risk raised from 8 in 1000 to around 60 in 1000).
- Ebstein's anomaly (risk raised from 1 in 20,000 to 10 in 20,000).
- High levels in breast milk.

#### Actions to take

- Do not routinely prescribe, particularly in the first trimester of pregnancy or during breastfeeding.
- Advise a woman who is taking lithium and is planning a pregnancy, and who is well and not at high risk of relapse, to stop the drug.
- If a woman taking lithium becomes pregnant:
  - if the pregnancy is confirmed in the first trimester, and the woman is well and not at high risk of relapse, stop the drug gradually over 4 weeks; explain that this may not remove the risk of cardiac defects in the fetus
  - if she is not well or is at high risk of relapse, consider:
    - ◆ switching gradually to an antipsychotic, or
    - ◆ stopping lithium and restarting it in the second trimester if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past, or
    - ◆ continuing with lithium if she is at high risk of relapse.
- If a woman continues taking lithium during pregnancy:
  - check serum levels every 4 weeks, then weekly from the 36th week, and less than 24 hours after childbirth
  - adjust the dose to keep serum levels towards the lower end of the therapeutic range
  - make sure she maintains adequate fluid intake.
- Women taking lithium should deliver in hospital and be monitored during labour by the obstetric team. Monitoring should include fluid balance, because of the risk of dehydration and lithium toxicity (in prolonged labour, it may be appropriate to check serum lithium levels).

See also 'Discussing and balancing risks' (pages 10 and 11) and advice on specific disorders (pages 14 to 16).

**Antidepressants****Risks to consider**

- Lowest known risks during pregnancy: tricyclic antidepressants (TCAs) such as amitriptyline, imipramine, nortriptyline; but most are more likely to cause death if taken in overdose than selective serotonin reuptake inhibitors (SSRIs).
- Lowest known risk with an SSRI during pregnancy: fluoxetine.
- Fetal heart defects with paroxetine taken in the first trimester.
- Persistent pulmonary hypertension in the neonate with SSRIs taken after 20 weeks' gestation.
- High blood pressure with venlafaxine at high doses, together with higher toxicity in overdose than SSRIs and some TCAs and increased difficulty in withdrawal.
- Withdrawal or toxicity in the neonate with all antidepressants (in most cases the effects are mild and self-limiting).
- Lower than other antidepressants in breast milk: imipramine, nortriptyline and sertraline.
- Higher levels in breast milk: citalopram and fluoxetine.

**Actions to take**

- Advise a woman taking paroxetine who is planning pregnancy or has an unplanned pregnancy to stop the drug.

**Benzodiazepines****Risks to consider**

- Cleft palate and other fetal malformations.
- Floppy baby syndrome in the neonate.

**Actions to take**

- Do not routinely prescribe to pregnant women, except for the short-term treatment of extreme anxiety and agitation.
- Consider gradually stopping in pregnant women.

**Carbamazepine and lamotrigine****Risks to consider**

- Carbamazepine: neural tube defects (risk raised from 6 in 10,000 to around 20 to 50 in 10,000) and other major fetal malformations including gastrointestinal tract problems and cardiac abnormalities.
- Lamotrigine: oral cleft (risk estimated at nearly 9 in 1000), and dermatological problems (notably Stevens–Johnson syndrome) in the infant if taken while breastfeeding.

**Actions to take**

- Advise a woman taking these drugs who is planning a pregnancy or has an unplanned pregnancy to stop them. Consider an alternative (such as an antipsychotic) if appropriate.
- Do not routinely prescribe:
  - carbamazepine and lamotrigine for pregnant women
  - lamotrigine for women who are breastfeeding.

**Valproate****Risks to consider**

- Neural tube defects (spina bifida and anencephaly; risk raised from around 6 in 10,000 to 100–200 in 10,000).
- Effects on the child's intellectual development.
- Polycystic ovary syndrome in women younger than 18 years.

**Actions to take**

- Do not routinely prescribe to women of child-bearing potential. If there is no effective alternative, explain risks during pregnancy and importance of using adequate contraception.
- Do not prescribe to women younger than 18 years (increased risk of unplanned pregnancy in this group).
- If a woman taking valproate is planning a pregnancy or pregnant, advise her to stop the drug. In the treatment of bipolar disorder consider, if appropriate, an alternative drug (usually an antipsychotic).
- If there is no alternative to valproate, limit doses to a maximum of 1 gram per day, in divided doses and in the slow-release form, with 5 mg per day folic acid.

## Guidance for specific disorders

This section recommends how NICE clinical guidelines on specific mental disorders may be adapted for women who are planning a pregnancy, pregnant or breastfeeding. Each disorder should be treated according to the relevant NICE guideline (see 'Related NICE guidance' on page 20 for details) except where indicated in these tables. The tables should be read with other advice in this booklet, particularly on balancing the risks and benefits of treatment (pages 10 and 11) and on individual psychotropic drugs (pages 12 and 13).

### Depression

| Disorder                              | Planning a pregnancy   | During pregnancy  | Breastfeeding                  |
|---------------------------------------|--|---|--------------------------------|
| <b>Mild depression</b>                | <ul style="list-style-type: none"> <li>Withdraw antidepressant and consider watchful waiting.</li> <li>If intervention is needed consider:               <ul style="list-style-type: none"> <li>self-help approaches (guided self-help, C-CBT, exercise)</li> <li>brief psychological treatments (counselling, CBT and IPT).</li> </ul> </li> </ul>  | <p><b>Unplanned pregnancy</b><br/>See 'Planning a pregnancy' (left).</p> <p><b>New episode of mild depression</b></p> <ul style="list-style-type: none"> <li>Consider:           <ul style="list-style-type: none"> <li>self-help approaches (see left)</li> <li>non-directive counselling at home (listening visits)</li> <li>brief CBT/IPT.</li> </ul> </li> </ul> <p><b>New episode of mild depression with a history of severe depression</b></p> <ul style="list-style-type: none"> <li>Consider antidepressant if psychological treatments declined or not responded to.</li> </ul> | See 'During pregnancy' (left). |
| <b>Moderate and severe depression</b> | <p><b>Latest presentation was moderate depression</b></p> <ul style="list-style-type: none"> <li>Consider:           <ul style="list-style-type: none"> <li>switching to CBT/IPT if taking an antidepressant</li> <li>switching to an antidepressant with lower risk.</li> </ul> </li> </ul> <p><b>Latest presentation was severe depression</b></p> <ul style="list-style-type: none"> <li>Consider:           <ul style="list-style-type: none"> <li>combining CBT/IPT and antidepressant (switching to one with lower risk)</li> <li>switching to CBT/IPT.</li> </ul> </li> </ul> | <p><b>Unplanned pregnancy</b><br/>See 'Planning a pregnancy' (left).</p> <p><b>New episode of moderate depression</b><br/>See mild depression, above.</p> <p><b>Moderate depressive episode and a history of depression, or a severe depressive episode</b></p> <ul style="list-style-type: none"> <li>Consider:           <ul style="list-style-type: none"> <li>CBT/IPT</li> <li>antidepressant if preferred by the woman</li> <li>combination treatment if there is no, or a limited, response to psychological or drug treatment alone.</li> </ul> </li> </ul>                        | See 'During pregnancy' (left). |
| <b>Treatment-resistant depression</b> | Follow the NICE clinical guideline on depression.  | <ul style="list-style-type: none"> <li>Consider a different single drug or ECT before combination drug treatment. Avoid lithium augmentation.</li> </ul>  | See 'During pregnancy' (left). |

CBT, cognitive behavioural therapy; C-CBT, computerised CBT; IPT, interpersonal psychotherapy.

See also 'Discussing and balancing risks' (pages 10 and 11) and advice on specific drugs (pages 12 and 13).

## Anxiety and eating disorders

| Disorder   | Planning a pregnancy  | During pregnancy  | Breastfeeding  |
|--|---|---|--|
| <b>Generalised anxiety disorder (GAD) and panic disorder</b>                                     | <ul style="list-style-type: none"> <li>Consider:                             <ul style="list-style-type: none"> <li>– withdrawing medication and starting CBT if this has not already been tried</li> <li>– switching to a safer drug.</li> </ul> </li> </ul>   | See 'Planning a pregnancy' (left) and in addition:<br><b>GAD (new episode)</b> <ul style="list-style-type: none"> <li>Offer CBT.</li> </ul> <b>Panic disorder (new episode)</b> <ul style="list-style-type: none"> <li>Consider CBT, self-help or C-CBT before starting drug treatment.</li> <li>If medication is needed do not start paroxetine; consider a safer drug.</li> </ul> | Follow the NICE clinical guideline on anxiety.   |
| <b>Obsessive-compulsive disorder (OCD)</b>   | <ul style="list-style-type: none"> <li>Consider:                             <ul style="list-style-type: none"> <li>– withdrawing medication and starting psychological therapy</li> <li>– starting psychological therapy before medication.</li> </ul> </li> <li>Withdraw paroxetine if the woman is taking it, and switch to a safer drug.</li> </ul>   | See 'Planning a pregnancy' (left).  | <ul style="list-style-type: none"> <li>Avoid the combination of clomipramine and citalopram.</li> </ul>  |
| <b>Post-traumatic stress disorder (PTSD)</b>   | <ul style="list-style-type: none"> <li>Withdraw antidepressant and offer trauma-focused CBT/EMDR.</li> <li>Do not prescribe adjunctive olanzapine.</li> </ul>   | See 'Planning a pregnancy' (left).  | Follow the NICE clinical guideline on post-traumatic stress disorder.  |
| <b>Eating disorders</b><br>(for anorexia follow the NICE clinical guideline on eating disorders) | <b>Binge eating disorder</b> <ul style="list-style-type: none"> <li>If taking an antidepressant, treat according to depression (see page 14).</li> </ul> <b>Bulimia nervosa</b> <ul style="list-style-type: none"> <li>Consider:                             <ul style="list-style-type: none"> <li>– withdrawing medication gradually</li> <li>– referral for specialist treatment if problem persists.</li> </ul> </li> </ul> | See 'Planning a pregnancy' (left).  | <b>Binge eating disorder</b><br>See 'Planning a pregnancy' (far left).<br><b>Bulimia nervosa</b> <ul style="list-style-type: none"> <li>Offer psychological treatment rather than fluoxetine at 60 mg.</li> <li>If the woman is taking fluoxetine at 60 mg, advise her not to breastfeed.</li> </ul> |

EMDR, eye movement desensitisation and reprocessing.

See also 'Discussing and balancing risks' (pages 10 and 11) and advice on specific drugs (pages 12 and 13).

## Severe mental illness

| Disorder                | Planning a pregnancy  | During pregnancy  | The perinatal period and breastfeeding  |
|-------------------------|---|---|---|
| <b>Bipolar disorder</b> | <ul style="list-style-type: none"> <li>• If antimanic medication is needed, choose a low-dose typical or atypical antipsychotic.</li> <li>• If depression develops after stopping prophylactic medication, offer CBT.</li> <li>• If an antidepressant is used, it should usually be an SSRI (but not paroxetine); monitor closely.</li> </ul> | <ul style="list-style-type: none"> <li>• Maintain on antipsychotic if stable and likely to relapse without medication.</li> <li>• If a woman has an unplanned pregnancy and is stopping lithium, offer an antipsychotic.</li> </ul> <p><b>Acute mania</b></p> <ul style="list-style-type: none"> <li>• Consider a typical or atypical antipsychotic.</li> <li>• If taking prophylactic medication:             <ul style="list-style-type: none"> <li>– check dose and adherence</li> <li>– increase dose if taking an antipsychotic or consider switching to an antipsychotic if not</li> <li>– if no response and woman has severe mania, consider ECT, lithium and, rarely, valproate.</li> </ul> </li> <li>• If there is no alternative to valproate consider augmenting it with antimanic medication (not carbamazepine).</li> </ul> <p><b>Depressive symptoms</b></p> <ul style="list-style-type: none"> <li>• For mild symptoms, consider in the following order:             <ul style="list-style-type: none"> <li>– self-help approaches (guided self-help and C-CBT)</li> <li>– brief psychological treatments (counselling, CBT and IPT).</li> </ul> </li> <li>• For moderate to severe symptoms, consider:             <ul style="list-style-type: none"> <li>– CBT for moderate depression</li> <li>– combined medication and CBT for severe depression.</li> </ul> </li> <li>• When prescribing, consider quetiapine alone, or SSRIs (but not paroxetine) in combination with prophylactic medication. Monitor closely for signs of switching and stop the SSRI if manic or hypomanic symptoms develop.</li> </ul> | <ul style="list-style-type: none"> <li>• After delivery, consider starting or restarting medication as soon as fluid balance is established if at high risk of an acute episode.</li> <li>• Consider augmenting treatment with an antipsychotic if a woman maintained on lithium is at high risk of a manic relapse in the immediate postnatal period.</li> <li>• If a prophylactic agent is needed when breastfeeding offer an antipsychotic.</li> </ul> |
| <b>Schizophrenia</b>    | <ul style="list-style-type: none"> <li>• Consider switching from an atypical antipsychotic to a low-dose typical such as haloperidol, chlorpromazine or trifluoperazine.</li> </ul>   | See 'Planning a pregnancy' (left).  | <ul style="list-style-type: none"> <li>• If taking depot medication advise that the infant may show extrapyramidal symptoms several months after administration.</li> </ul>   |

See also 'Discussing and balancing risks' (pages 10 and 11) and advice on specific drugs (pages 12 and 13).

## Managing sleep problems

- For a pregnant woman with a mental disorder who has sleep problems, first provide general advice about sleep hygiene (including bedtime routines, avoiding caffeine and reducing activity before sleep).
- If problems are serious and chronic, consider low-dose chlorpromazine or low-dose amitriptyline.

## Electroconvulsive therapy (ECT)

- Consider ECT for pregnant women who have:
  - severe depression
  - severe mixed affective states or mania in the context of bipolar disorder
  - catatoniaand whose physical health or that of the fetus is at serious risk.

## Rapid tranquillisation

- Treat a pregnant woman requiring rapid tranquillisation according to the NICE clinical guidelines on the short-term management of disturbed/violent behaviour, schizophrenia and bipolar disorder, but:
  - do not seclude the woman following rapid tranquillisation
  - adapt restraint procedures to avoid possible harm to the fetus
  - when choosing an agent for rapid tranquillisation, consider an antipsychotic or a benzodiazepine with a short half-life
  - manage the woman's care during the perinatal period in close collaboration with a paediatrician and an anaesthetist.

## Service organisation

- 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 perinatal service in each locality, able to provide 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 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 disorders 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.
- Each managed perinatal mental health network should have designated specialist inpatient services and cover a population of between 25,000 and 50,000 live births a year depending on the local psychiatric morbidity rates.
- Each specialist perinatal inpatient service should:
  - provide facilities specifically for mothers and infants (typically with 6–12 beds)
  - be staffed by specialist perinatal mental health staff
  - be staffed to provide appropriate care for infants
  - have effective liaison with general medical and mental health services
  - have available the full range of therapeutic services
  - be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.

## Implementation

NICE has developed tools to help organisations implement this guidance (listed below).

These are available on our website ([www.nice.org.uk/CG045](http://www.nice.org.uk/CG045)).

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

## Further information

### Ordering information

You can download the following documents from [www.nice.org.uk/CG045](http://www.nice.org.uk/CG045)

- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- The NICE guideline – the recommendations in full.
- ‘Understanding NICE guidance’ – information for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they are based on.

For printed copies of the quick reference guide or ‘Understanding NICE guidance’, phone the NHS Response Line on 0870 1555 455 and quote:

- N1201 (quick reference guide)
- N1202 (‘Understanding NICE guidance’).

### Related NICE guidance

For information about NICE guidance that has been issued or is in development, see the website ([www.nice.org.uk](http://www.nice.org.uk)).

#### Published

- Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. NICE clinical guideline 38 (2006). Available from [www.nice.org.uk/CG038](http://www.nice.org.uk/CG038)
- Routine postnatal care of women and their babies. NICE clinical guideline 37 (2006). Available from [www.nice.org.uk/CG037](http://www.nice.org.uk/CG037)
- Obsessive–compulsive disorder: core interventions in the treatment of obsessive–compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from [www.nice.org.uk/CG031](http://www.nice.org.uk/CG031)
- Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from [www.nice.org.uk/CG026](http://www.nice.org.uk/CG026)
- Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. NICE clinical guideline 25 (2005). Available from [www.nice.org.uk/CG025](http://www.nice.org.uk/CG025)
- Depression: management of depression in primary and secondary care. NICE clinical guideline 23 (2004). Available from [www.nice.org.uk/CG023](http://www.nice.org.uk/CG023)
- Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2004). Available from [www.nice.org.uk/CG022](http://www.nice.org.uk/CG022)
- Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004). Available from [www.nice.org.uk/CG009](http://www.nice.org.uk/CG009)
- Guidance on the use of electroconvulsive therapy. NICE technology appraisal 59 (2003). Available from [www.nice.org.uk/TA059](http://www.nice.org.uk/TA059)
- Antenatal care: routine care for the healthy pregnant woman. NICE clinical guideline 6 (2003). Available from [www.nice.org.uk/CG006](http://www.nice.org.uk/CG006)

- Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. NICE clinical guideline 1 (2002). Available from [www.nice.org.uk/CG001](http://www.nice.org.uk/CG001)

### Under development

- Antenatal care: routine care for the healthy pregnant woman. Update of CG006. NICE clinical guideline. (Publication expected November 2007.)

### Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be posted on the NICE website ([www.nice.org/CG045](http://www.nice.org/CG045)).

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