National Institute for Health and Clinical Excellence

Antenatal and Postnatal Mental Health
Guideline Consultation Comments Table
10 October 2012- 7 November 2012

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
109	SH	4Children	1		4.3.1 d	8	In our report "Suffering in Silence", attached, we found that a significant number of women experiencing postnatal depression were being prescribed anti-depressants with very little offered in additional support. Indeed, we found that 70% of those we surveyed who had sought help for their postnatal depression were given anti-depressants, almost twice as many as were offered counselling (41%). Further, of the women we spoke to who were not happy about the support they received for their postnatal depression, more than half wanted more access to counselling (52%). As a result, we believe it is absolutely vital that the NICE guidelines around perinatal depression make it clear that counselling can be just as effective as anti-depressants in the short run, and more effective in the long run – and that access to counselling and talking therapies should be offered in all cases of perinatal depression.	Thank you for your comment. This will be looked into and if evidence is identified then it will be included.
114	SH	4Children	2		4.3.1 g		We welcome the recognition of the role of families, carers, and wider support networks in helping women experiencing perinatal depression back to health. Families are often an under-recognised or under-used resource in supporting people back to health, so formal acknowledgement of the support they offer is welcomed. Where possible, the NICE guidelines should make reference to any documents which would support healthcare professionals to involve families in the healing	Thank you for your comment

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							process. Any advice which healthcare professionals can direct family members to would be particularly welcomed.	
123	SH	4Children	3		4.3.2 a		Our research indicated that adopting a 'whole family' approach to support often results in better rates of recovery, and the creation of a more supportive and nurturing environment for women experiencing perinatal depression to recover in. This is particularly pertinent in cases where depression or mental ill-health in other family members appears to have occurred partly as a result of perinatal depression in a mother. NICE should consider exploring routes to include 'whole family' approaches to treatment in its guidance, and in particular treating family members with linked cases of mental ill-health together.	Thank you for your comment. We will look at the evidence which will determine whether this will feature in the guideline.
151	SH	4Children	4		4.5.1 a, b		In Suffering in Silence, we recommend that a more proactive approach be taken to identifying key risk factors including relationship conflict, social isolation, financial or housing worries or employment issues during the perinatal period, and that this approach should be backed up by an offer of practical support when it is needed. Too often health professionals, particularly GPs, work in isolation from wider community support – and when women experiencing perinatal ill-health discuss problems they are experiencing, opportunities for sign-posting and cross-referring are lost. In order to address this issue, health professionals should be directed to have appropriate hand off points for patients in need of support – including to local services such as Sure Start centres, local authority housing support, and domestic violence and substance abuse services.	Thank you for your comments.
168	SH	4Children	5		4.5.2 a, b		We also recommended the re-introduction of an antenatal role for health visitors in order to build relationships with parents earlier and co-ordinate the	Thank you for your comment.

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							earlier, practical support needed by some families. Including this recommendation in the NICE guidance would ensure that this vital addition to screening and treatment of perinatal mental ill-health received the prominence it deserves.	
169	S H	4Children	6		4.5.2 a, b		Further, parents told us extensively of the positive benefits they received from peer-to-peer networks, and the central role these networks played in their recovery. Wherever possible, referring women experiencing peri-natal depression to support networks in their area – in addition to more formal medical treatment – should be encouraged within the NICE guidelines.	Thank you for your comment.
128	S H	All Wales Birth Centre Group			4.3.2 b	8	Disappointment that this is a clinical area that will not be covered as this is a great clinical concern in many areas of the country.	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand.
144	S H	All Wales Birth Centre Group			4.5.1 a	9	There appears to be continuing reluctance, of some Primary Trusts/ Health Boards, to use the EPDS in preference to the Whooley Questions. Anecdotal evidence suggests the extra training in the use, rather than misuse of the EPDS makes it unviable, particularly when austerity measures are in place. However, again anecdotally, some Practitioners feel the Whooley Questions do not tackle the whole picture and may be used superficially. There was original concern about the dismissal of the EPDS in	Thank you for your comment, this has been noted and will be taken into consideration.

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							preference to the (closed) 3 questioning approach of Whooley et al. There was minimal evidence for the reduction in the number of questions and whether the study had been validated for use with childbearing women was unclear. The worldwide use of the EPDS suggests it is reliable and has ease of use. It has been accepted by Practitioners as an opportunity to introduce mothers to an awareness of their emotional health and has an important function helping clinicians and practitioners who may be uncomfortable asking mothers about their mental health. It is not used in practice as a predictive measure.	
145	S H	All Wales Birth Centre Group			4.5.1 a	9	When the wider picture is taken into account then the EPDS is better placed for detecting anxiety. A fuller 'mood assessment' might help to clarify the presence of eating disorders and substance misuse. A continuing difficulty is cultural sensitivity and accessing minority groups, particularly from Eastern Europe and South Asia where language is a significant barrier. The problem with using the EPDS in a specific language is that the Practitioner will have the added obstacle of interpreting the complexity of the mother's distress. The use of the 'How are you feeling' pictorial leaflets from the CPHVA are currently unavailable, with no likelihood of them being produced in the near future. These were helpful to identify the	Thank you for your comment. Will be including self-identification methods in the guideline.

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							mother's current mood.	
146	S H	All Wales Birth Centre Group			4.5.1 a	9	The Marce Society is currently putting forward a position statement on psychosocial screening and assessment in the postnatal period which has significant worldwide support. The argument is that it is better to screen than not!	Thank you for your comment.
162	S H	All Wales Birth Centre Group			4.5.2 a	10	Work with mothers and infants have been enhanced by projects like the Solihull approach…. Sorry I don't know enough about this …but it may help!? There is growing evidence of the efficacy of web-based services and mothers appear to be seeking advice from these sources	Thank you, we have taken note of your comment.
174	S H	All Wales Birth Centre Group			4.5.2 d	11	Mark Williams www.fathersreachingout.com has highlighted the plight of fathers and his work has substantially indicated the need for a more inclusive approach to the needs of fathers, by providing individual telephone support and establishing support groups. Mark's organisation is now being supported by Children in Wales and the Marcé Society Doulas in Wales are also expressing the need to be trained in the awareness of perinatal mental health disorders to be more supportive to mothers, both ante and postnatally. Anecdotal evidence has suggested that they are increasingly encountering	Thank you for your comment, this has been noted.

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							distressed mothers	
1	SH	Birth Trauma Association			General		We would like to see PTSD specifically mentioned rather than as part of a general diagnosis of 'anxiety disorders'. PTSD and PTSD spectrum disorders following childbirth are extremely common - with up to a third of women affected to some degree.	Thank you for your comment. We have specified PTSD in the review questions included in 4.5.
46	SH	Birth Trauma Association			3.1.c	2	We welcome recognition that the diagnosis of perinatal mental illness is sometimes inaccurate.	Thank you for your comment.
103	SH	Birth Trauma Association			4.3.1. a	7	It is good to see that prevention of mental health disorders is being considered.	Thank you for your comment
132	SH	Birth Trauma Association			4.4	9	We would like to see some form of patient rated outcome	Thank you for your comment, we will be including patient-rated outcomes.
71	SH	BLISS	1		3.1 l		Bliss would like to see mention made in this section of the potential effect on a mother's mental health of having a baby admitted to neonatal care immediately after birth. Evidence suggests that mothers of preterm infants are at higher risk of depression than mothers of term infants in the immediate postpartum period, with continued risk throughout the first post-partum year for mothers of very low birthweight infants (BJOG 2010 Apr:117(5):540-50. Epub 2010 Jan 29).	Thank you for your comment. We have added a separate bullet point to section 3.1 (l) to include neonatal care.
80	H	BLISS	2		3.1 n	6	It is worth noting that admission to neonatal care in itself can have an effect on the mother-infant relationship. And as noted above, mothers of preterm infants are at higher risk of postnatal depression.	Thank you for your comment. We have added a separate bullet point to section 3.1 (l) to include neonatal care.
90	SH	BLISS	3		4.1.1 c	7	Bliss would recommend that mothers of babies admitted to neonatal care immediately after birth are also given special consideration.	We have added a separate bullet point to section 3.1 (l) to include neonatal care

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2	SH	British Psychological Society	1		General		Given the rapidly developing evidence concerning the implications of mental health of the mother on foetal wellbeing outcomes, the Society believes it is important that this should be included within the scope this guideline update	Thank you for your comment. We will be including all relevant foetal outcomes (please see section 4.4 bullet (i)).
3	SH	British Psychological Society	2		General		Throughout the document, there are specific references to depression, anxiety disorders, eating disorders etc. We are concerned that this minimises the significance of specific anxiety disorders such as OCD, Trauma, Generalised Anxiety Disorder during this period compared to depression. Given the recognised salience of anxiety, the Society believes that there needs to be greater equivalence of focus, to include reference to these specific disorders.	Thank you for your comment. We agree and believe this has been set out in section 3.1 bullet (g).
4	SSH	British Psychological Society	4		General		The Society believes that post traumatic stress symptoms in relation to childbirth are a key adverse mental health outcome and given their chronicity and health implications they receive inadequate focus.	Thank you for your comment. We agree that this is a key outcome and believe this has been set out in section 3.1 bullet (g). However we have also specified PTSD in the review questions included in 4.5.
5	SH	British Psychological Society	5		General		In relation to Case identification and diagnosis. The Society supports the use of a definition of post-natal depression (PND) which differentiates between de novo cases where there is no obvious explanation, in line with the original definition by Pitt (1968), and what might be referred to as secondary PND, which is a continuation or exacerbation of pre-existing depression, or where there are identifiable reasons for the mood disorder, e.g. lack of support from	Thank you for your comment. We have already included de novo cases but have made this more explicit in paragraph section 3.1(f) of the scope.

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							partner, family and friends, abuse, poverty, loneliness, unfamiliarity with the available resources, etc. In these women, variables other than the birth may have played a more significant role compared to the de novo cases and need to be addressed. The distinction between the PND and the exacerbation of existing conditions is in line with the review of the definition of premenstrual syndrome (O'Brien, 2011). Increased diagnostic precision is essential if we are to provide optimal treatment. The review of terminology also applies to antenatal depression and anxiety. 'Antenatal' depression is only meaningful as a diagnostic term if it excludes women who were depressed before their pregnancy, and where the illness represents a continuation of a pre-existing clinical disorder. Emphasis on the pregnancy may also be unhelpful if there is an explanation, e.g. parent died,	
6	SH	British Psychological Society	6		General		In relation to case identification and research. We recommend a clear differentiation between studies which used self-report or screening questionnaires to identify women with depressive symptoms, and research on women who were diagnosed by an appropriate health professional after a thorough assessment.	Thank you for your comment. We agree and will be looking at, and differentiating between, self-report methods or screening questionnaires to identify women with depressive symptoms, and clinician assessed diagnoses.
7	SH	British Psychological Society	8		General		Finally in relation to case identification. The fear of disclosure is well recognised (NICE Guideline 45, 2007, 4.2.2). A mother's unwillingness to report her feelings may not just reflect the stigma which	Thank you for your comment. We agree and this will be looked at in the guideline.

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							surrounds mental illness but also the fear that doing so may result in the involvement of social services and the removal of the child.	
8	SH	British Psychological Society	11		General		The title of the scope focuses on antenatal and postnatal mental health – not illness - and has a strong preventative slant. We think this is an important approach considering maternity care policy is based on optimising women's experience of birth and as there is an emphasis on primary care delivery. However this is not well represented in the scope (for example, there is only one mention of quality of life and that is in the section of topics that will not be updated). We are concerned that this review should not be limited to the prevention and treatment of illness.	Thank you for raising this issue, however it is outside the limits of the scope of this guideline to look beyond prevention and treatment of illness.
38	SH	British Psychological Society	7		3.1 b	2	We recommend that the final point should be amended to read 'the impact of illness on the developing foetus and baby'	Thank you for your comment. We have amended the final bullet point.
39	SH	British Psychological Society	8		3.1 b	2	We believe that as pregnancy is a period of psychological physiological and social adjustment and therefore provides a window of psychological flexibility as well as high contact with health service professionals- it provides a unique opportunity for prevention of mental illness and enhancement of wellbeing.	Thank you for your comment.
47	SH	British Psychological Society			3.1 c	2	We agree that the current terminology may have resulted in a failure to identify other mental disorders. However, we are aware of a tendency not to differentiate between de novo depression within 6-12 weeks of birth and depression in women with pre-existing mood disorders (e.g. Kumar, 1982). Studies from different countries estimate that	Thank you for your comment. We have added 'de novo cases' to section 3.1 of the scope.

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							the percentage of new onset depression is around 8-10% and lower than in more vulnerable women, e.g. those with a history of mood disorder, refugees etc. This lack of precision has implications for treatment.	
52	S H	British Psychological Society			3.1 e	2	We believe that care is required in relation to the incidence of antenatal depression. Some studies have shown that rates are higher in the first and third trimester than in the second. This may reflect the influence of different factors. Verkerk et al (2003 doi: 10.1016/S0165-0327(02)00146-5) suggest that depression mid-pregnancy is a risk factor for PND.	Thank you for your comment.
72	S H	British Psychological Society	6		3.1 l		We recommend that after the first bullet point "traumatic delivery and preterm birth" should be added.	Thank you for your comment. We have added a separate bullet point to section 3.1 (l) to include neonatal care.
73	S H	British Psychological Society	9		3.1 l		We recommend that more attention be given to the influence of social and cultural factors. One risk factor which is not included in the draft scope is that of unplanned pregnancy (cf. Yanikkerem et al., 2012, doi: 10.1111/j.1447-0756.2012.01958.x.). A review of PND in subgroups such as refugees and asylum seekers may also be of value (cf Collins et al., 2011. doi: 10.1007/s00737-010-0198-7 and Glasser et al. 2000. doi: 10.3109/01674820009075615	Thank you for your comment. We will consider the issues pertaining to increased risk in the guideline under identification and assessment.
78	S H	British Psychological Society			3.1 m	5	We would welcome clarification in relation to the '1.27 per 100,000 maternal deaths' stated in the document- Should this state that 1.27 maternal deaths from psychiatric causes occur in every 100,000 births	Thank you for highlighting this typo, it has been corrected.
79	S	British	10		3.1.n	6	Women with depression during pregnancy are at	Thank you for your comment.

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	H	Psychological Society					increased risk for preterm birth and low birth weight (Grote et al., 2010) so the implications are for the infant themselves and not just in terms of the mother infant relationship	We will be including all relevant foetal outcomes (please see section 4.4 bullet (i)).
81	S H	British Psychological Society	11		3.2	6	We are concerned that whilst some care for postnatal depressive symptoms is now provided by the Voluntary sector, there is no mention of this within this section.	Thank you for your comment. NHS provided and funded services is within the remit of this scope and we have amended the scope to reflect this more clearly.
82	S H	British Psychological Society	12		3.2	6	We are concerned that whilst there is mention where women are treated but there is no mention that there are other sectors of the NHS where PND presents and where mothers'/parents' needs should be assessed. Compared to controls mothers and fathers in NICU-particularly in association with premature birth, present increased rates of clinically relevant anxiety depression and stress including trauma responses particularly where they have infants with more difficulties (Carter et al., 2005) Maternal depression is also a factor affecting infant hospitalisation in the first two years of life and might be a trigger for assessment. (Guttman, Dick & To, 2003)	Thank you for your comment. We will include settings in the guideline (please see section 4.2 of the scope).
87	S H	British Psychological Society	16		4.1.1	7	We suggest that consideration be given as to whether it would it be relevant to have a section on the sequelae of medical and obstetric and neonatal problems? This could inform other professionals about what to look for in terms of risk rather than their starting from a position of the identification of mental health problems.	Thank you for your comment. We have added a separate bullet point to section 3.1 (l) to include neonatal care and will include all risk factors pertinent to identification of mental health problems.

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88	S H	British Psychological Society	17		4.1.1 a	7	While we understand the focus on those at risk, a significant number of women develop PND with no apparent risk factors (e.g. Verkerk et al., 2003). It may be worth addressing this to provide balance.	Thank you for your comment. This issue will be considered in the guideline under risk and assessment.
91	S H	British Psychological Society	14		4.1.1 c	7	We believe that this specific consideration should also be given to women with a history of trauma responses and women who experience childbirth as traumatic	Thank you for your comment. We will be looking at the mental health sequelae of birth which will include traumatic birth.
92	S H	British Psychological Society	15		4.1.1 c	7	The review of the needs of women with disabilities is welcomed by The Society. We believe that there may be variation across the country in the needs of women with physical disabilities	Thank you for your comment.
97	S H	British Psychological Society	17		4.2	7	We are concerned that whilst there is mention where women are treated, there is no mention that there are other sectors of the NHS where PND presents and where mothers'/parents' needs should be assessed. Compared to controls mothers and fathers in NICU-particularly in association with premature birth present increased rates of clinically relevant anxiety depression and stress including trauma responses particularly where they have infants with more difficulties (Carter et al., 2005). Maternal depression is also a factor affecting infant hospitalisation in the first two years of life and might be a trigger for assessment. (Guttman, Dick& To, 2003) (repeated from 3.2)	Commented repeated. Please see response to comment 82.
99	S H	British Psychological Society			4.3	7	Under clinical management, interventions for women with Mental Health and Psychological difficulties may need both individual and systemic interventions including case – management within	Thank you for your comment. The literature search will seek to identify the evidence in the area.

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							the MDT. There appears to be an assumption that all women in antenatal/postnatal services have delivered a live baby but in antenatal and postnatal services consideration needs to be made of the mental health and psychological distress of women who experience loss such as stillbirth.	
100	SH	British Psychological Society	18		4.3.1	7	We recommend the inclusion of the role of the mother's mental health on foetal development. Prospective studies from around the world have shown that if the mother is stressed, anxious or depressed while pregnant her child is more likely to have symptoms of childhood psychopathology or likely precursors indexing stress reactivity or early negative temperament. These findings are reviewed in Van den Bergh, Mulder, Mennes and Glover (2005), Talge, Neal, and Glover (2007), Glover (2011), Glover and Hill (2012). Studies have specifically identified associations between prenatal stress and altered Hypothalamic Pituitary Adrenal axis (HPA) reactivity (de Bruijn, van Bakel, Wijnen, Pop and van Baar, 2009), cardiovascular regulation (Cotrell and Seckl, 2009; Barker, 2008) and negative emotionality in infants (Davis, Glynn, Schetter, Hobel, Chicz-Demet et al., 2007) , and ADHD and conduct disorders (O'Connor, Heron, Golding & Glover, 2003; Rodriguez & Bolen, 2005), and emotional problems in children (Glover, 2011; O'Connor, Heron, Golding & Glover, 2003, Seckl, 2008, Van den Bergh, Van Calster, Smits, Van Huffel & Lagae, 2008). Foetal programming of the HPA axis in utero is thought to account for these effects.	Thank you for your comment. We will be including all relevant foetal outcomes (please see section 4.4 bullet (i))

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106	SH	British Psychological Society			4.3.1 c	7	With respect to the use of the term "Psycho-social interventions", this terminology reflects a reductionist approach. In most clinical settings, practitioners tend to refer to cognitive-behavioural interventions, psychotherapy, counselling etc. 'Psycho-social' tends to refer to issues between a person and his/her environment but modern interventions are often more individualized and holistic. We would recommend the use of the term "Psychological interventions".	Thank you for your comment. All psychological interventions will be included in psychosocial interventions.
115	SH	British Psychological Society	19		4.3.1 g	8	We believe that this section needs to cover the potential role of peers as well.	Thank you for your comment, we agree and peers will be added to section 4.3.1 g) of the NICE scope.
136	SH	British Psychological Society			4.5	9	We are concerned that the list of mental health problems does not include women with ongoing history of psychosis such as diagnosis of schizophrenia, schizo affective disorder or bipolar affective disorder. These diagnoses should be included in the update as the needs of the women in the perinatal period are extremely complex and the questions about identification and treatment are just as relevant as other mental health issues.	Thank you for your comment. These diagnosis are included (see section 3.1 bullet (i) and now also in the review questions 4.5).
142	SH	British Psychological Society	20		4.5.1	9	We believe that as an aim is prevention (4.3.1), a question needs to be for ALL pregnant and postnatal women what approaches can a) prevent significant increases in symptomatology b) enhance wellbeing in pregnancy and/or the postnatal period.	Thank you for your comment. We will be focussing on women who have/are at risk of mental health disorders during pregnancy and the postnatal period, including subthreshold symptoms and mild, moderate and severe disorders. However, the wellbeing of all

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								pregnant and postnatal women is beyond the scope of this guideline.
143	S H	British Psychological Society	23		4.5.1	9	Consideration of the appropriateness of measures is welcomed by the Society as it was noted some services currently require the use of specific instruments of questionable suitability for the antenatal and postnatal population.	Thank you for your comment, we will be reviewing instruments.
147	S H	British Psychological Society	21		4.5.1 a	9	We believe that methods in this sentence should specifically include self identification methods- providing the opportunity for women to self identify to clearly signposted routes into services on either a direct or referral basis	Thank you for your comment. Will be including self-identification methods in the guideline.
148	S H	British Psychological Society	22		4.5.1 a	9	We would welcome clarification in relation to how is harm to be defined in terms of benefits outweighing harm	Thank you for your comment. The clinical and cost-effectiveness of the harms and benefits of treatments will be assessed as set out in the NICE technical manual.
153	S H	British Psychological Society			4.5.1 b	10	We believe that the assessment of the reliability of the various screening measures should also take into account data at follow-up and relationship with outcome, (Yawn et al., In Press. doi:10.1155/2012/363964)	Thank you for your comment. These issues will be considered in the guideline.
154	S H	British Psychological Society	24		4.5.1 b	10	We would welcome clarification in relation to what does "assess" mean? If assess refers to level of severity, we would recommend that this be clearly stated.	Thank you for your comment but assessment clearly includes the assessment of severity.
160	S H	British Psychological Society	26		4.5.2	10	We recommend that this section should include a review of those interventions aimed at preventing the onset of mental health problems in high risk women such as those with bipolar disorder or	Thank you for your comment. The GDG will refine the review questions at the beginning of the guideline development

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							previous post partum psychosis as an additional question.	process.
163	S H	British Psychological Society	25		4.5.2 a	10	B of this section considers harm to mother foetus or baby. To be consistent a) should consider benefit to foetus or baby. We suggest it should also consider benefit in terms of improved experience of childbirth given that adverse experiences can be triggers for subsequent symptomatology.	Thank you for your comment. We will be including all relevant foetal and infant outcomes (please see section 4.4 bullet (i))
171	S H	British Psychological Society	27		4.5.2 c	11	We recommend that this should include interventions that do not target maternal mental health specifically but may serve to benefit the mental health such as interventions with the infant, couples' communication (and not just the quality of mother infant interaction)	Thank you for your comment, these will be included.
179	S H	British Psychological Society	References		Section 4		Alcorn, K.L., O' Donovan, A., Patrick, J.C., Creedy, D., Devilly, G.J. (2011). A prospective longitudinal study of the prevalence of post traumatic stress disorder resulting from childbirth events. Psychological Medicine 40 1849-1859 White, T., Matthey, S., Boyd, K. et al. (2006) Postnatal depression and Posttraumatic stress after childbirth- prevalence and cooccurrence. Journal of Reproductive and Infant Psychology, 24 107-120 Olatunji, B.O., Cisler J.M. and Tolin, D.F. (2007). Quality of life in the anxiety disorders - A Meta analytic review. Clinical Psychology Review, 27, 572-581	Thank you for the references you have provided us with.
180	S H	British Psychological Society			Section 5		Pitt. (1968). "Atypical" depression following childbirth. British Journal of Psychiatry, 114, 1325-1335 O'Brien, S., Rapkin, A., Dennerstein, L., Nevatee, T. (2011) Diagnosis and management of premenstrual	Thank you for the references you have provided us with.

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							disorders. British Medical Journal, 342, d2994	
181	SH	British Psychological Society	Section 5		Section 10		Grote, N.K., Bridge, J.A., Gavin, A.R., Melville, J.L., Iyengar, S. and Katon, W.J. (2010). A metanalysis of depression during pregnancy and risk of preterm birth , low birth weight and intra uterine growth restriction Archive of General Psychiatry 67 1012-1024	Thank you for the reference you have provided us with.
182	SH	British Psychological Society			Section 12		Carter, J.D., Mulder, R.T., Bartram, A.F. (2005) Infants in a neonatal intensive care unit – parental responses. Arch Dis Fetal Neonatal Ed, 90 F109-F113) Guttman, A., Dick, P. and To, T. (2004). Infant hospitalization and maternal depression, poverty and single parenthood - a population-based study. Child Care health and Development 30 67	Thank you for the references you have provided us with.
183	SH	British Psychological Society			Section 18		Barker, D.J. (2008). Human growth and cardiovascular disease. Nestle Nutr Workshop Ser Pediatr Program 61: 21-38. Cottrell, E.C. and Seckl, J.R. (2009). Prenatal stress, glucocorticoids and the programming of adult disease. Front Behav Neurosci 3: 19. Davis, E.P., Glynn, L.M., Schetter, C.D., Hobel, C., Chicz-Demet, A. et al. (2007). Prenatal exposure to maternal depression and cortisol influences infant temperament. J Am Acad Child Adolesc Psychiatry 46: 737-46. de Bruijn, A.T., van Bakel, H.J., Wijnen, H., Pop, V.J., van Baar, A.L. (2009) Prenatal maternal emotional complaints are associated with cortisol responses in toddler and preschool aged girls. Dev Psychobiol 51: 553-63. Glover, V. (2011) Annual Research Review:	Thank you for the references you have provided us with.

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							Prenatal stress and the origins of psychopathology: an evolutionary perspective. J Child Psychol Psychiatry 52: 356-67. Glover, V. (2011). Prenatal stress and the origins of psychopathology – an evolutionary perspective. Journal of Child Psychology and Psychiatry 52 356-367 Glover, V. and Hill, J. (2012). Sex differences in the programming effects of prenatal stress on psychopathology and stress responsiveness- an evolutionary perspective. Physiology and Behaviour 106 736-740 O'Connor, T.G., Heron, J., Golding, J., Glover, V. (2003). Maternal antenatal	
185	SH	British Psychological Society					Anxiety and behavioural/emotional problems in children: a test of a programming hypothesis. J Child Psychol Psychiatry 44:1025-36. Seckl, J.R. (2008) Glucocorticoids, developmental 'programming' and the risk of affective dysfunction. Prog Brain Res 167: 17-34. Talge, N. M., Neal, C., & Glover, V. (2007). Antenatal maternal stress and long-term effects on child neurodevelopment: how and why? Journal of Child Psychology and Psychiatry, 48, 245-261. Van den Bergh, B. R., Mulder, E. J., Mennes, M., & Glover, V. (2005). Antenatal maternal anxiety and stress and the neurobehavioral development of the fetus and child: links and possible mechanisms. A review. Neuroscience and Biobehavioral Reviews, 29, 237-258.	Thank you for the references you have provided us with.
186	SH	British Psychological			Section 18		Van den Bergh, B. R., Van Calster, B., Smits, T., Van Huffel, S., & Lagae, L. (2008). Antenatal	Thank you for the references you have provided us with.

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		Society					maternal anxiety is related to HPA-axis dysregulation and self-reported depressive symptoms in adolescence: a prospective study on the fetal origins of depressed mood. Neuropsychopharmacology, 33, 536-545. Rodriguez, A. & Bohlin, G. (2005). Are maternal smoking and stress during pregnancy related to ADHD symptoms in children? Journal of Child Psychology and Psychiatry, 46, 246-254.	
40	S H	Camden and Islington NHS Trust	1		3.1 b	2	Management also differs because of service organisation: in all other adult mental health services the population is defined by pathology. In perinatal work, as in child mental health care, the population is defined by a physiological state. This means the scope of the work is much broader and does not fit into to service line model currently adopted by most mental health and foundation trusts.	Thank you for you comment, we have taken note of this.
55	S H	C-Sections Org	1		3.1 f bullet 6	3	This point should be broken into two separate bullet points. We feel that anxiety about a child (e.g. their health or their development etc.) and anxiety including thoughts of harming the child are two entirely different things and should not be grouped together.	Thank you for your comment. We have added a separate bullet point to section 3.1 (f) to more clearly differentiate between these two issues.
74	S H	C-Sections Org	2		3.1 l	5	A further factor should be included, namely the mental health of the partner (who may or may not be the father). Research clearly shows that the partner is at increased risk of mental health issues during the pregnancy and this will have a knock on effect on mother's own mental health and her environment.	Thank you for your comments. The mental health of the partner is beyond the scope of the guideline; however we will be considering the issues pertaining to increased risk in the guideline under

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
							T. Solantaus, S. Salo, 'Paternal Postnatal Depression: Fathers Emerge from the Wings' Lancet, 365/9478 (2005) 2158-9 Fatherhood Institute, 'Fathers and Postnatal Depression: Research Results from the Project: Men's Psychological Transition to Fatherhood – Mood Disorders in Men Becoming Fathers' Fatherhood Institute, [on-line article] Aug 2010 – accessed Sept. 2010 < http://www.fatherhoodinstitute.org/2010/fatherhood-institute-research-summary-fathers-and-postnatal-depression/>	identification and assessment of maternal mental health.
86	S H	C-Sections Org	3		4.1.1	7	The wording of this 'Population' description does not appear to include those women whose symptoms arise specifically as a result of pregnancy. The wording suggests that it only includes those already "have, or are at risk of, mental health disorders during pregnancy and the postnatal period." In other words those who had signs prior to their pregnancy. We assume it is the intention of the guide to include guidance covering those women whose symptoms arise only as a result of pregnancy (e.g. no prior signs) in which case we would suggest the wording be altered to reflect this more specifically.	Thank you for your comment. We believe the statement 'women who have, or are risk of, mental health disorders during pregnancy' [bullet 4.1.1 (a)] adequately includes women whose onset is during pregnancy and do not agree the wording requires amendment.
124	S H	CSections.org	4		4.3.2 a	8	Is the mental health of partners considered in a separate guideline? The incidence of this form of mental health issue is notable and can have a significant impact upon the mother, particularly those already experiencing mental health issues.	Thank you for your comments. The mental health of the partner is beyond the scope of the guideline, other than its impact on maternal mental

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
							We would hope a guideline of equal weight for this group of people is being considered elsewhere? T. Solantaus, S. Salo, 'Paternal Postnatal Depression: Fathers Emerge from the Wings' Lancet, 365/9478 (2005) 2158-9 Fatherhood Institute, 'Fathers and Postnatal Depression: Research Results from the Project: Men's Psychological Transition to Fatherhood – Mood Disorders in Men Becoming Fathers' Fatherhood Institute, [on-line article] Aug 2010 – accessed Sept. 2010 < http://www.fatherhoodinstitute.org/2010/fatherhood-institute-research-summary-fathers-and-postnatal-depression/> Surviving Depression 'Male Depression' Surviving Depression accessed Aug. 2010 http://www.survivingdepression.net/types/male.html E. Bielawska-Batorowicz, K. Kossakowska-Petrycka 'Depressive Mood in Men after the Birth of their Offspring in Relation to a Partner's Depression, Social Support, Fathers' Personality And Prenatal Expectations' Journal of Reproductive and Infant Psychology, 24/1 (2006) 21-29	health.
164	S	Csections.org	5		4.5.2 a	10	When researching this aspect of intervention it	Thank you for your comment.

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	H						would be worth considering the role of antenatal education in the development of realistic birth expectations. Caesarean birth for example is regularly omitted from antenatal education or included with such negative connotations that trauma associated with this mode of birth is common. Such levels of trauma are reported by organisations such as the Birth Trauma Association as regularly contributing to on-going depression and extended difficulties bonding with a new infant as well as figuring in cases of Postnatal Depression. A requirement for balanced information and realistic birth expectations in antenatal education would go a long way to helping reduce the incidence of birth trauma leading to extended periods of depression in the postnatal period. Such a requirement should specify that caesarean birth be discussed as a positive intervention and women should be taught how to prepare for such an eventuality (natural may be best but is frequently unattainable).	Educational interventions are beyond the scope of the guideline.
175	S H	Csections.org	6		4.5.2 d	11	There are very specific issues identified for partners of pregnant women, whether these women are exhibiting signs of mental health problems or not. Issues which if unaddressed can significantly add to a woman's own mental health difficulties during and post pregnancy. We would suggest the following research be investigated when determining whether or not to include paternal mental health in the scope of this document as indicated may be the intention by the wording "What are the needs of family and	Thank you for your comments. The mental health needs of the partner is beyond the scope of the guideline.

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
							carers in the treatment and support of women with mental health disorders during pregnancy and the postnatal period?" T. Solantaus, S. Salo, 'Paternal Postnatal Depression: Fathers Emerge from the Wings' Lancet, 365/9478 (2005) 2158-9 Fatherhood Institute, 'Fathers and Postnatal Depression: Research Results from the Project: Men's Psychological Transition to Fatherhood – Mood Disorders in Men Becoming Fathers' Fatherhood Institute, [on-line article] Aug 2010 – accessed Sept. 2010 < http://www.fatherhoodinstitute.org/2010/fatherhood-institute-research-summary-fathers-and-postnatal-depression/>	
9	S H	Department of Health	1		General		We are pleased to see that the scope of the partial update appears to be comprehensive in the areas that it will cover.	Thank you for your comment.
137	S H	Department of Health	2		4.5	9	Review questions: the introductory paragraph states that the questions may relate to service delivery, and that the review questions are draft and will be finalised within the GDG. We are particularly concerned that, in looking at the evidence for the tools and methods for diagnosis and treatment of mental health disorders, questions are asked relating to who (i.e. which healthcare professionals), when (i.e. the best timing for the use of the tools and methods) and where (which may be	Thank you for comment, the GDG will refine the review questions at the beginning of the development process of the guideline and the issues raised will be considered.

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
							Primary Care, community or secondary care). Of particular importance is evidence supporting the development of the health visitor role.	
138	S H	Department of Health	3		4.5	9	We would like re-assurance that any available evidence is assessed relating to the detection and treatment or management of perinatal mental health problems concerning issues and influences relating to handover of care and transitions between services (for example, handover of care from midwifery care to health visitor and primary care, and the interface between maternity, primary care and mental health services).	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand. Due consideration regarding setting and transitions in care will be made where pertinent to the guideline
149	S H	Devon Partnership NHS Trust	1		4.5.1 a	9	During pregnancy- The development of a prediction and detection tool and auditing of rigorous process to ensure it is delivered to every pregnant woman. Good practise includes midwives remaining vigilant and open minded throughout pregnancy for changes in mental health or women becoming more comfortable to disclose. Midwifery training and auditing of process necessary. Our prediction and detection tool asks "do you or have you had mental health problems such as depression, bipolar disorder, eating disorder or significant anxiety? By using the words in the question we invite women to share their history.	Thank you for your comment, this has been noted.

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							The benefits of using a standardised proforma which is supportive, inclusive and nonstigmatising outweigh the risks. Occasionally disclosures have necessitated a safeguarding referral which has been traumatic for the mother- additional thought needs to be given to mothers wellbeing and risk needs consideration.	
156	SH	Devon Partnership NHS Trust	2		4.5.1 b	10	Good triaging and a strong multidisciplinary approach. Skilled clinicians with excellent diagnostic and specialist Perinatal mental health training.	Thank you for your comment.
165	SH	Devon Partnership NHS Trust	3		4.5.2 a	10	To ensure women can access the correct treatment it is vital to have adequate information to recommend a way forward. This often involves gathering additional information from the GP, midwife, heath visitor, or the women herself to make an informed recommendation. This can take time, but is time well spent. Evidence based therapies can then be advised accordingly. Newer therapy such as EMDR for specific past trauma need to be thoughtfully considered and package of care put in place in case treatment causes temporary deterioration in mental health. Our team is integrated into the wider health system, and all women with significant prescribed treatment in pregnancy are discussed at a vulnerable babies meeting which is chaired by consultant paediatrician – all the infants are then considered and monitored appropriately.	Thank you for your comment, this has been noted.
170	SH	Devon Partnership	4		4.5.2 b	10	In a location with no local MBU we are mindful that admitting mothers and infants out of area takes	Thank you for your comment.

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		NHS Trust					them away from their local supports and family. This can have an adverse affect on relationships. Some women elect to be admitted to our local acute psychiatric ward and recovery can be slower. Alternatively plans are made to support treatment at home with support of crisis team, when it may be risky to do so.	
172	S H	Devon Partnership NHS Trust	5		4.5.2 c	11	In working with a mother and her family the skills of the practitioner to form a relationship with her and to develop a shared understanding of the issues important to her with honesty and containment provides the context in which meaningful change can occur. Adherence to a specific treatment modality in the absence of the above will result in less sustainable outcomes. Taking time to complete an initial assessment well is time well spent and can prevent multiple less satisfactory, less productive meetings if shorter slots are spread over a longer time period.	Thank you for your comment, this has been noted.
176	S H	Devon Partnership NHS Trust	6		4.5.2 d	11	Needs of family are considered in every case and need to be discussed as a matter of routine. A comprehensive multiagency birth plan includes the mother and her supports as a matter of routine where the needs of the family for support, information gathering, Information provision and creation of the plan fully include the views of and the needs of the woman and her supports.	Thank you for your comment.
10	S H	Elective Caesarian.com			General		Thank you very much for this opportunity to comment on the Draft Scope.	Thank you for your comment.
58	S H	Elective Caesarian.co			3.1 g	3	While I acknowledge that tokophobia (fear of	Thank you for raising this issue. We will focus on anxiety

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		m					childbirth or pregnancy) needs to be classified in this scope, and that it is certainly characterised by anxiety in women, my organisation would appreciate changes to the wording here to reflect that this particular anxiety is not necessarily "abnormal or inappropriate" in all cases. Risks to both mothers and babies are a reality during pregnancy and childbirth, and even someone categorised as low risk can become high risk at any time – particularly during labour. Indeed it is often the very unpredictability of childbirth that creates high levels of anxiety in tokophobic women. I'd like to suggest that since it is not possible for any midwife or doctor to assure a woman categorically that the things she fears will not happen to her, it is therefore not helpful to classify her fears as inappropriate or abnormal. Especially given that we know there are numerous cases where women's entirely normal and appropriate fears are realised in the event, and they then suffer with subsequent physical and psychological trauma as a result. Also, in terms of preparing for the birth itself, the NICE Clinical Guideline 132 on Caesarean section (published November 2011) recommends that women with tokophobia	that is abnormal as this is within the guideline remit.
70	S H	Elective Caesarian.com			3.1 l l. 12-13	5	Suggestion of additional wording here please (shown in bold below), in order to reflect that the woman's perception of whether a delivery was traumatic is of equal importance to whether the delivery is categorised as traumatic by others.	Thank you for your comment, however we feel that our current wording adequately covers traumatic birth.

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							Suggestion: "in addition to the psychological effects of a traumatic or unwanted mode of delivery" This would cover cases where, for example, a woman who wanted a natural birth has had a caesarean, as well as vice versa. For example, here is a recent story in which a woman describes her very 'normal' vaginal birth as deeply traumatic, whereas the healthcare professionals around her continue to describe it as a very good outcome. The birth occurred in Canada but reflects women's experiences in the UK too. http://www.mothering.com/community/t/1367561/sometimes-birth-satisfaction-is-spelt-c-e-s-a-r-e-a-n Extract: My first birth experience happened in a baby friendly hospital with the lights turned low, a nurse reminding me that "my body was made to do this", and resulted in the vaginal delivery of a 6 pound 4 ounce girl after just five hours of labour and fentanyl and gas for pain relief. There were some tears - 3 second degree tears that were repaired by way of stitches. I was told how good of a job I had done by everybody...One of the nurses quipped to me in the day or so following delivery that if I had wanted an elective caesarean that "I should have gone to Brazil". I'll be blunt: it was the worst experience of my life - it was the most painful and terrifying thing I have ever been through. It left me feeling violated, betrayed	

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							and abandoned and shattered my trust in my care providers and the health care system. At my follow up appointment with my doctor she made a comment to the effect that I had done so well, that I should have more children. I retorted that "I needed to get over this birth first".]	
34	S H	Medway NHS Trust	1		3.1 a	1	This should identify the baby as an INFANT, which categorises children up to 2 years of age. In developing guidelines for discussing risk benefit ratio with pre- conceptual couples and pregnant women it must be taken into consideration the growing evidence (I can supply references, since this format does not allow for electronic formats) that treatment of depression alone by medication does not improve attachment status in both mother and infant. When reviewing with parents the treatment options this should be identified, that documented psychological treatments in combination with other forms of treatment increase reflective function in mothers about their infants. The risk of treatment of mother alone must be outlined to parents. This ameliorates the effect on the infants' cognitive and emotional development. (see Foreman 2007)	Thank you for your comments. In response to your first comment, we are only including infant outcomes up to up to one year post delivery as this is the configuration of perinatal mental health services in general. In response to your second comment, we are grateful to you for raising this issue and agree. Combined treatments and associated outcomes will be included in the guideline (please see section 4.3.1 bullet (e) and section 4.4).
48	S H	Medway NHS Trust	2		3.1 c	2	This should read misunderstanding rather than misuse. Knowledge of the psychology around childbirth is a highly specialised and unique subject	Thank you, but we believe that 'misuse' is the most appropriate word in this

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							and therefore in most health professionals it is not an intentional misuse of terms but a misinterpretation. This should also alert health professionals to the development of PTSD (as a unique anxiety disorder) in the postnatal period either as an acute reaction to childbirth or as a re emergence of symptoms due to a previous related or unrelated trauma.	context.
50	S H	Medway NHS Trust	3		3.1 d	2	This should read that these feelings (emotions) may pass. This must be highlighted in the actual guidelines as a predictor for development of later anxiety and depressive disorders and in the presence of a previous history (ontological deficits) may precipitate a psychotic breakdown. When reviewing case notes of women who developed severe depression or psychosis anxiety and low mood was often minimised by Heath professionals because of this assumption that the majority of mood disorders will resolve with minimal intervention	Thank you for your comment. We will be looking at predictors of later development of mental health disorders in the guideline. We do not believe a change in wording to section 3.1 bullet (d) is warranted.
51	S H	Medway NHS Trust	4		3.1 e	2	There is a step missing in this process, detection can only lead to appropriate treatment if the cause of the anxiety or low mood is identified. This involves at least a basic level of understanding of the normal psychological processes of childbirth. Treatment can only be efficient and efficacious if it is directed towards the presenting problem as indentified in (3.1 (c)). This can be complicated by co- morbid issues. Since the NICE process identifies the guidelines	Thank you for highlighting this issue. We have amended this bullet point to include assessment.

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							develop from the scope there must not be a misunderstanding or misuse of terms like anxiety disorder or antenatal depression. Childbirth is a unique experience and brings with it a teleological connection to the transformation of anxiety disorders. In the main guidance examples of these can be identified, though in general terms.	
56	S H	Medway NHS Trust	5		3.1 f	3	There should be consistency here in terms of the INFANT as I have already stated an infant is up to 2 years of age. The mother's mood may affect her interaction with other children. Though the ontological effect on older children over 2 years of age is limited (there is much neurological evidence for this and I can supply details) The degree to which self harming behaviour is acted upon will be dependent on several factors : 1.the mothers own psychological resilience (much evidence of investigative work into this concept) 2. Constitutionally the infant has deficits for example prematurity, early separation from the mother, antenatal substance misuse and domestic violence in the family situation. 3. The family environment isolation and economic and physical and psychological safety.	Thank you for your comments. In response to your first comment, we are only including infant outcomes up to one year post delivery as this is the configuration of perinatal mental health services in general. In response to your second comment, self-harming behaviour will be included in the guideline under assessment.
57	S H	Medway NHS Trust	6		3.1 g	3	It is not helpful to describe a particular fear of childbirth as Tokophobia, though Wikki experts will describe it as this. There is a growing evidence base where work is being done with women who fear giving birth. This is a complex issue and women fear birth for many reasons. Not because they are fearful of uterine contractions. In depth	Thank you for highlighting this issue. The systematic search of the literature will seek to identify this evidence.

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							investigation of womens cognitive and emotional explanations for fear in childbirth (not always fear OF childbirth), reveal previous traumatic episodes. As I have said in reference to 3.1 (c) there is often a re-emergence of PTSD symptoms around childbirth. This statement about prevalence rates is very vague. I hope that the guidance must be rigorous about investigating the evidence for some of the disorders mentioned. Part of the scope of the guideline is to identify this evidence and recommended treatment in accordance.	
60	S H	Medway NHS Trust	7		3.1 h	3	Dealing with this aspect of the scope in the main guidelines will have a major impact on practice since diagnosis of personality disorder is complex and needs a multi- disciplinary approach (see NICE Guideline CG 78 and CG 77). This must cross reference with CG 100 since women with personality disorder often have resultant social issues.	Thank you for your comment. We will be cross referencing the guideline to other, relevant guidelines when necessary and helpful.
61	S H	Medway NHS Trust	10		3.1 h	3	There is a link here to CG 100. Evidence shows that women often use substances to self medicate for anxiety resultant from domestic abuse and previous unresolved psychological distress (see RCPsych guidance CR150 2008)	Thank you for your comment. We will be cross referencing the guideline to other, relevant guidelines when necessary and helpful.
62	S H	Medway NHS Trust	8		3.1 i	4	As mentioned in (h) women can have a diagnosis of Schizoid personality disorder. Schizoid episodes are often triggered by unmanageable stressful situations and childbirth may present such a situation. Psychotic episodes after childbirth may not always be a developmental phase of a	Thank you for your comment. As set out in the scope, the guideline will be looking at personality disorders (please see section 3.1 bullet (h)) and recomemndations pertaining to

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							schizophrenic illness or bipolar disorder. Though these are issues of differentiation and distinction, they will lead to differences in recommendations in the main guideline. This also relates to the statement in this section about safety of the mother and baby. The threshold for implementation of safeguarding procedures for the infant may depend on this differentiation. (see also link to CG 100)	specific personality disorders will be based on the best available evidence.
63	S H	Medway NHS Trust	9		3.1 j	4	It should be part of the scope of this guideline to review the evidence of screening for eating disorders. It should be taken into consideration the evidence that women self report lower levels of disturbance of all types due to fear of involvement of other agencies (See DH guidance on domestic abuse, Problems with EPDS 'false negatives'.) Women manage their eating disorders in different ways during pregnancy. Ed as a specialised form of anxiety disorder can have an impact on exacerbation of other anxiety symptom. Therefore screening for anxiety in pregnancy should involve these considerations (e'g Health child promotion programme DH)	Thank you for your comment. As set out in the scope, the guideline will be looking at eating disorders (please see section 3.1 bullet (j)) and recomemndations pertaining to eating disorders will be based on the best available evidence.
83	S H	Medway NHS Trust	11		3.2 a	6	Treatment also occurs in the voluntary sector (see WWW:annafreudcentre.org). Social enterprises must be recognised and involved in stake holding if the guideline is to have major impact on practice.	Thank you for your comment. We will include settings in the guideline (please see section 4.2 of the scope).
84	S H	Medway NHS Trust	12		3.2 b	6	As mentioned already in the scope the majority of women do not have severe mental health problems but the impact of mild to moderate morbidity has been shown on the cognitive and emotional	Thank you for your comment. We agree and will be including all relevant foetal outcomes (please see section 4.4 bullet

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							development of the infant,. The scope must reflect this major public health issue as equally as that of the minor moderate to severe issues. As a consequence guidance on identification and management will have the greater impact on the population of England and Wales.	(i)).
125	SH	Medway NHS Trust	13		4.3.2 a	8	This does not make sense if this scope identifies the risk to the infants development and identifies resultant problems in the mother infant relationship, yet does not propose to make any review and recommendation for intervention. Where are these problems to be addressed by NICE? Having identified risk of morbidity, ethically there must be a proposal for investigation of a resolution.	Thank you for your comment. We look at the evidence on the interventions addressing the mother infant relationship
129	SH	Medway NHS Trust	14		4.3.2 b	8	Where is there to be a review of management and treatment of the group identified in 3.1 (i). Again this makes no sense to identify a group yet make no investigation. In which guideline will recommendations be found?	Thank you for your comment. The review questions will be refined with the guideline development group members at the beginning of the development process.
11	SH	National Perinatal Epidemiology Unit	1		General		In updating, the guideline developers needs to be mindful of the changing landscape of both service delivery and commissioning which will affect and may even fragment service organisation and delivery. Services for women at the moment cross/involve a number of NHS organisations and this may become even more complicated.	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand. However the changes in service delivery and

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								commissioning will be considered where ever relevant to the update recommendations
12	SH	National Perinatal Epidemiology Unit	2		General		Perinatal mental health networks never developed in the way envisaged and subsequently were never properly evaluated. Evidence on other models would be helpful.	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand.
13	SH	National Perinatal Epidemiology Unit	3		General		Anecdotally many more women are now identified due to increasing use of Whooley questions, EPDS etc. But then nothing seems to happen. We need evidence on how adequate service coordination is and how well midwives and health visitors are in not just identification of mental disorder but also how to refer on and who to.	Thank you for your comment. We will take this issue into consideration in the guideline.
14	SH	National Perinatal Epidemiology Unit	8		General		There is again great policy interest in so-called public mental health and mental health promotion. The scope is very disease focussed although it talks about mental health in the title.	Thank you for raising this issue, however it is outside the limits of the scope of this guideline to look beyond prevention and treatment of illness.
93	SH	National Perinatal Epidemiology Unit	4		4.1.1 c	7	Consider female offenders including those in prison. This group has a high degree of overlap with injecting drug users – another high risk group.	Thank you for your comment. We will link with the new NICE guidance on this issue and draw attention to the NICE

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								public health group.
119	SH	National Perinatal Epidemiology Unit	5		4.3.1 i	8	There is great policy interest in the long term sequelae of perinatal mental illness on child development. Treatment of the underlying disorder may not in itself be sufficient to prevent these sequelae. Evidence on what else needs to be done would be helpful.	Thank you for your comment. We agree and will be including all relevant foetal and infant outcomes (please see section 4.4 bullet (i)) and developing recommendations accordingly.
120	SH	National Perinatal Epidemiology Unit	7		4.3.2	8	The scope states: "The guideline will not update the configuration of services for the provision of effective care for women and their children". Why? At this, of all times, it seems the most critical thing of all! See comment 1 above.	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand.
130	SH	National Perinatal Epidemiology Unit	6		4.3.2 b	8	I would have thought inpatient services were important: I'm not sure why they should be excluded – relevant to comment 2 above.	Thank you for your comment. Please see comment 12.
15	SH	NHS Direct			General		There is no reference to remote telephone assessment. Please could this be considered particularly with regards to the initial assessment of symptoms and onward referral.	Thank you for your comment. We will be including mode of assessment in the guideline.
16	SH	NHS North Somerset			General		Consider women who have high levels of anxiety but sub clinical depression levels as their stress levels can affect them and the infant. High levels of anxiety would not meet the threshold for adult	Thank you for your comment. We believe this is adequately covered in the scope (please see section 4.1.1. bullet (a)).

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							mental health services in the main	
17	SH	NHS North Somerset			General		More focus is needed on the effects of stress and anxiety on the unborn infant levels of cortisol on brain development	Thank you for your comment. We will be including all relevant foetal outcomes (please see section 4.4 bullet (i)).
18	SH	NHS North Somerset			General		Look at the risk to infant with mothers who have chronic mental distress that is not a clinical levels but that effects the mothers function and social interaction leading to isolation	Thank you for your comment. We will be including all relevant foetal outcomes (please see section 4.4 bullet (i)) and believe subthreshold symptoms have been adequately covered in the scope (please see section 4.1.1. bullet (a)).
22	SH	Public Health Camden	1		General		As public health strategists for both mental health and children and young people, we are pleased to see that a draft guideline has been published, to update part of Clinical Guideline 45. This has not been updated since 2007. An update is timely with the restructuring of commissioning services and the responsibility for maternity services being transferred to Clinical Commissioning Groups.	Thank you for your comment.
23	SH	Public Health Camden	2		General		We would support the continuing of the definition of postnatal care to include the period from delivery up to the first year, as mental illness can arise some time after delivery. It would be helpful to make this explicit in order to provide clarity about the timeframe.	Thank you, in light of your comment "from delivery up to the first year" has been added to 3.1 a), 4.1.1 a) and a footnote has been added in section 4.5.1.
24	SH	Public Health Camden	8		General		Finally we understand that this guidance can only focus on specific issues, but it appears that there is no specific guidance regarding support to parents	Thank you for your comment. This will be covered in the guideline.

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
							who have experienced a stillbirth or neonatal death. Such guidance would be welcomed.	
33	SH	Public Health Camden	3		3.1	1	It would be helpful to stress here that not only are women in the antenatal and postnatal period vulnerable to the same mental disorders as other adults, but are at increased risk if they have adopted health-risk behaviours in adolescence (No Health without Public Mental Health. Royal College of Psychiatrists. 2010) We note that this is mentioned in the original guideline (Guideline 45), but it could be emphasised here. This is true for a range of disorders and not just the severe conditions mentioned here.	Thank you for your comment. We will consider the issues pertaining to increased risk in the guideline under identification and assessment.
53	SH	Public Health Camden	4		3.1e	2	Although early intervention is mentioned, it would be helpful to reference this to the importance of early intervention and assessment, referencing this to the studies undertaken by Graham Allen MP and Dame Clare Tickell (Allen,G Early Intervention: The Next Steps. 2011 HM Government/ Dame Tickel,C Children's Experiences of the Early Years Foundation Stage. D of Education. 2010)	Thank you for your comment, please see response above (51).
76	SH	Public Health Camden	5		3.1 l	5	Research demonstrates that common mental health disorders are also associated with chronic physical illness, for example diabetes and heart disease. These should also be considered as risk factors for mental illness.	Thank you for your comment.
94	SH	Public Health Camden	6		4.1.1 c	7	Specific groups are considered, which is helpful, but we would suggest that other groups should also be listed here, namely teenagers, late bookers, lesbian and bi-sexual women and those with chronic disease as discussed above.	Thank you for your comment, we will be considering specific risk factors in the development of the guideline.
110	S	Public Health	7		4.3.1 d	8	Again, it is really helpful to include a section on key	Thank you we will be covering

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	H	Camden					clinical issues, but we would like to see a more prescriptive approach with regard to pharmacological interventions and the balance of risk to the mother and infant. The recent case of the mother who smothered her children following the discontinuation of her anti-depressants highlights this issue. Support to mothers with postnatal depression needs to be flexible and on a balanced and individual basis. This could be stressed in the guidance. This could also be addressed when considering treatment and interventions (4.5.2. c).	this in the guideline.
25	S H	RCGP			General		No consideration of PTSD. This may be an important consideration in perinatal mental health. I think it should be included in the scope	Thank you for your comment. We agree and believe this has been set out in section 3.1 bullet (g). We have also specified PTSD in the review questions included in 4.5.1 and 4.5.2.
26	S H	Royal College of Midwives	1		General		The Royal College of Midwives considers the main scope of the update of this important guideline to be appropriate.	Thank you for your comment.
101	S H	Royal College of Midwives	2		4.3.1	7	We are very pleased to see the inclusion of psychosocial interventions in the issues that will be covered.	Thank you for your comment.
102	S H	Royal College of Midwives	3		4.3.1	7	We are also pleased to see the inclusion of the role of the family and carers.	Thank you for your comment
121	S H	Royal College of Midwives	4		4.3.2	8	We are disappointed that the 'need for specialised inpatient services eg mother and baby units' is not going to be covered. We understand that where this provision exists, it is recognised as a vital component of care.	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore

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								decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand.
122	S H	Royal College of Midwives	5		4.3.2	8	The RCM disagrees with the decision not to update the guidance on 'the configuration of services' when this could clearly have an impact on effective care for these women.	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand.
141	S H	Royal College of Midwives	6		4.5	9	The review questions are valuable and we look forward to seeing the results of the relevant literature reviews.	Thank you for your comment
27	S H	Royal College of Nursing			General		The Royal College of Nursing welcomes proposals to update this guideline. It is timely. The draft scope seems comprehensive	Thank you for your comment.
28	S H	Sheffield Health and Social Care Trust	10		General		Equality of opportunity is addressed in the scope in terms of groups covered but interventions are now delivered in a broader range of settings than just Healthcare, e.g. Children's Centres, which is particularly relevant to disadvantaged groups who may not attend healthcare settings. Achieving equality of opportunity is an ongoing process throughout the life of the guideline	Thank you for your comment.
29	S	Sheffield	11		General		The review of the guideline stated: Current	Thank you for your comment.

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	H	Health and Social Care Trust					recommendation suggested mothers of stillborn should not be routinely encouraged to view or hold the dead infant. However, the overall management of traumatic birth had not been appropriately addressed in the guideline. We cannot find any reference to the management of traumatic birth in the current draft scope and feel that there is inconsistency in approach across the country and including this issue in relation to mental health would be helpful.	We will be looking at the mental health sequelae of birth which will include traumatic birth.
49	SH	Sheffield Health and Social Care Trust	1		3.1c	2	We fully endorse the need to avoid the use of the generic term postnatal depression when describing mental health disorders	Thank you for your comment. We recognise that it is a problematic term, but it is commonly used and we believe it would be inappropriate not to use it. We will define terms as used in the guideline. We believe section 3.1 bullet (c) covers this issue and other mental health disorders have been adequately described in the scope (specifically section 3.1).
67	SH	Sheffield Health and Social Care Trust	3		3.1 j	4	The inclusion of eating disorders, learning disabilities and physical disabilities in this guideline is also welcomed	Thank you for your comment.
69	SH	Sheffield Health and Social Care Trust	2		3.1 k	4	Management of substance misuse and / or alcohol use in pregnancy was covered in the guideline on Pregnancy and complex social factors (I was on this GDG) and there was little evidence available. The	Thank you for your comment.

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
							full report is on the NICE website. It is due for review in Sept 2013. However, this guideline was 'A model for service provision' and did not cover dual diagnosis and we welcome the inclusion of substance misuse in this guideline	
77	SH	Sheffield Health and Social Care Trust	4		3.1 l	5	We think that personal history factors should also include whether there have been periods under the care of Social Services	Thank you for your comment. We will be including personal history in the guideline.
95	SH	Sheffield Health and Social Care Trust	6		4.1.1c	7	We welcome the inclusion of interventions for subthreshold symptoms of depression and / or anxiety and would like the role of peer support to be included as a clinical issue to be covered	Thank you for your comment. Psychosocial interventions including peer support are included.
96	SH	Sheffield Health and Social Care Trust	5		4.1.1 c	7	This guideline aims to address inequalities and so the groups to be given specific consideration; black and minority ethnic groups, needs to include asylum seekers and socioeconomic groups needs to include care leavers	Thank you for your comment. These groups will be included in the guideline. Already included
135	SH	Sheffield Health and Social Care Trust	7		4.4 i	9	The link between mother's mental health and birth weight and prematurity should be looked at and included as an outcome	Thank you for your comment. We will be including all relevant foetal outcomes (please see section 4.4 bullet (i))
152	SH	Sheffield Health and Social Care Trust	8		4.5.1a. b	9-10	There is a need to provide recommendations on these two questions to provide guidance when women are told they are at risk of developing postnatal depression and to improve detection. However, acceptability to women in the use of these tools also needs to be considered	Thank you for your comment, this has been noted.

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
167	SH	Sheffield Health and Social Care Trust	9		4.5.2 a	10	Interventions to be considered should include peer support	Thank you for your comment, this will be included.
35	SH	Sheffield Teaching Hospitals	1		3.1 a	1	Re 'Pregnancy is not protective…' It is essential that this point is specifically highlighted in some way in the final guideline, as there appears to be a notion among some health care professionals and some who practice within generic (as opposed to specialist perinatal psychiatry) that somehow pregnancy will encourage patients to engage for psychiatric care – whereas in fact they do not engage due often to the belief that if they do their child (ren) may be removed from their care as a result of a psychiatric diagnosis.	Thank you for your comment.
36	SH	Sheffield Teaching Hospitals	2		3.1 a	1	There is further an issue with those who have a mental health diagnosis who are health care professionals themselves on the premise that some see this as a protective factor. Often these patients are not taken through the same processes deemed necessary for others – the assumption being that the patients would recognise their own relapse signature or somehow see their own deterioration. It is very important that the same processes are followed for every patient i) because their needs are the same as any other patient, as are the needs of the unborn child. ii) it also protects against omitting some part of the process. (Ref Daksha Empson enquiry 2002)	Thank you for your comment.
41	SH	Sheffield Teaching	3		3.1 b	2	Highlighting the difference between the response from generic as opposed to specialist perinatal	Thank you for your comment; we agree.

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		Hospitals					services is also vital. It is particular issue when (as a result of longstanding care arrangements for a client, or in the absence of a specialist perinatal team) a generic team maintains the care of that patient through-out pregnancy. There needs to be appropriate emphasis on effective and timely communication between generic and specialist services – where a client/patient remains under generic services there should be a jointly agreed plan (i.e. with the generic psychiatric service, the specialist perinatal service and the obstetric service) as to the management of care and medication, and a plan should there be an exacerbation of the patients condition during the pregnancy and the post partum period.	
42	SH	Sheffield Teaching Hospitals	4		3.1 b		Of particular issue is the cessation (or significant reduction) of medication by either the patient themselves or on the recommendation of the GP which can often result in a re-appearance of, or significant exacerbation of symptoms previously ameliorated or completely controlled by medication. Wherever possible pre-conceptual counselling is to be recommended and adjustment of medication as appropriate before pregnancy. This should be with specific reference to minimising any potential effects on the foetus whilst providing optimal symptom control – maintenance of stability by maintaining current medication may be preferable to having to manage a crisis precipitated by reduction or cessation of medication.	Thank you for your comment.

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43	SH	Sheffield Teaching Hospitals	5		3.1b	2	As a corollary to this, a discussion re breast feeding needs to take place during the pregnancy: this conversation should not be left until the baby is delivered as it can be quite distressing to the mother (in addition to coping with her psychiatric disorder) that she cannot breast feed her child due to her medication. This may be one of the only circumstances where the maintenance of the maternal well being/symptom control supersedes that of the baby for maternal breast milk, and this may aid in reducing the effects of maternal metal illness on the baby with its concomitant morbidity.	Thank you for your comment.
45	SH	Sheffield Teaching Hospitals	6		3.1c	2	I would agree with this statement – I would support the withdrawal of the use of this term due to the highlighted misuse #.	Thank you for your comment. We recognise that it is a problematic term, but it is commonly used and we believe it would be inappropriate not to use it. We will define terms in the guideline.
54	SH	Sheffield Teaching Hospitals	7		3.1 e	2	Many pregnancy –related depressive episodes start in the ante-natal period that might previously have been wrongly called post-natal depression (see above #).	Thank you for your comment. We agree and believe this has been differentiated adequately in the scope.
59	SH	Sheffield Teaching Hospitals	8		3.1 g and h	3	These patients often take up significant amounts of time due to their behaviour. Some Mental Health Trusts have a Personality Disorder team to assist in their management. Basic training should be available to assist obstetric and midwifery staff in care delivery to minimise further trauma, manage aberrant behaviours, and assist in assessment of	Thank you, we have taken note of this.

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							parenting capability.	
64	SH	Sheffield Teaching Hospitals	9		3.1 j	4	Effective formal liaison with to the specialist Eating Disorders Service needs to be established to facilitate the requisite support for these clients; this should include training for staff. Clients with severe eating disorders associated with pregnancy require very careful (primary, secondary and tertiary) service monitoring throughout pregnancy and the pueperium. They may not disclose the disorder to midwifery or obstetric staff, and it is often not identified if the client appears somewhat thin rather than obviously anorexic/cachetic. However multi-disciplinary working needs to be established to optimise care delivery and robust routes of inter-agency communication, to continue planned and focused care, with a view to optimising outcomes for the mother and child, plus additionally minimising admissions during the antenatal period.	Thank you, we have taken note of this.
65	SH	Sheffield Teaching Hospitals	10		3.1 j	4	These clients often do attempt to control their food intake even more strictly than even is usual for them, notwithstanding the effect on the baby. Additionally there may be significant dietary imbalance particularly in the younger patients. Dental reviews which are recommended, doubly important if the patient is vomiting. Hyperemesis may be an additional complicating issue, particularly where starvation is already a factor, as in anorexia nervosa. Excessive exercise may also be an issue. The risk of relapse and/or complications and deterioration in their condition is	Thank you, we have taken note of this.

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							high, with a concomitant effect on the baby. Additionally there is an increased risk of caesarean section due to poor skeletal growth in the mother, and also of significant growth retardation in the infant - these clients may also have osteoporosis.	
66	SH	Sheffield Teaching Hospitals	11		3.1 j	4	There may also be safeguarding concerns as to the patients' ability and willingness to feed her child with the added concern that the feeding may be used for 'non-nutritive' purposes, with Lacey and Smith (1987) reporting that 15% of mothers in their series attempted to 'slim down' their children. Additionally these clients are more at risk than the normal population of post partum depression (CG 09 2004), with concomitant developmental risk to the child.	Thank you, we have taken note of this.
75	SH	Sheffield Teaching Hospitals	12		3.1 l	5	Re Personal history. There is little or no support for patients who have suffered sexual abuse or rape. These patients do not always disclose that they have been abused in such a way. If they do bravely disclose, these clients need to be made aware that there may be a problem for them regarding intimate examinations and pain associated with the genital area. They may well cope with pregnancy itself, however during labour the feelings they endured before (during the abuse) may resurface and they may need to use techniques previously learned to manage their symptoms. These symptoms may become overwhelming if the labour is long and painful, or if the delivery is very distressing and painful. Judicious use of analgesia/anaesthesia	Thank you for your comment. We will be liaising with the developers of the 'High Risk Intrapartum Care' guideline to ensure this issue is adequately covered by one of the guidelines under development.

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							(Lumbar Epidural) may help to reduce the risk of this happening, particularly when an operative or instrumental delivery is required. It should be emphasised that every effort should be made not to add to that original trauma during pregnancy and labour and delivery.	
85	S H	Sheffield Teaching Hospitals	13		3.2 b	6	There should be a further emphasis on specialist perinatal services as the gold standard for reasons I have stated earlier. Many areas rely on generic services.	Thank you for your comment. The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand.
113	S H	Sheffield Teaching Hospitals	14		4.3.1 d and e	8	More detailed guidance for obstetricians as to any additional screening test that may be required as a result of patients being in receipt of drugs in early pregnancy would be exceedingly useful helpful as part of any update to Section 7(possibly as an appendix). Additionally, it would provide more detailed information to Paediatricians who may be required to attend at birth and have care of the infant following, with specific reference to higher dosages and their significance.	Thank you for your comment we have taken note of this.
118	S H	Sheffield Teaching Hospitals	15		4.3.1 h	8	Identification of risk to self and others including the baby. This can be a contentious issue. See my comment earlier re patient who are health care professionals	Thank you for your comment

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							themselves. Information from the relatives and family, plus other professionals involved as to observations of the patients' behaviour should be taken into account. Recent media reports of a patient who killed both her children in Manchester stated that the family and patient had asked for help repeatedly – when that help was not forthcoming, her mental distress resulted in the deaths of the children. Often the symptoms of puerperal psychosis can be quite subtle and even experienced mental health professionals (not specialist perinatal) can be known to miss these, sometimes with tragic consequences for mother, baby and other children.	
126	SH	Sheffield Teaching Hospitals	16		4.3.2 a	8	A sentence or two re attachment issues and possible post natal depression in partners (Ballard 1996) might be appropriate even if not fully covered.	Thank you for your comment.
161	SH	Sheffield Teaching Hospitals	17		4.5.2	10	Feedback re long term outcomes – is there a plan to follow this up locally or nationally?	Thank you for your comment. Following up long term outcomes locally or nationally is beyond the scope of the guideline.
30	SH	South London and Maudsley NHS Trust	7		General		There is significant evidence of the interaction between couple relationship satisfaction/hostility/conflict and maternal ante/postnatal mental health and recovery and with infant care. This should be considered in the guidelines	Thank you for your comment. This will be covered in the guideline under identification and assessment.

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31	SH	South London and Maudsley NHS Trust	8		General		The scope specifically includes mother-infant interaction but does not explicitly include other aspects of infant care, nurture and protection which are important.	Thank you for your comment. We agree and have added more explicit reference to this (please see section 4.4 bullet (h)).
32	SH	South London and Maudsley NHS Trust	9		General		Many women are seen in perinatal mental health and psychotherapy services who do not fit neatly into one diagnostic category, and who have chaotic lifestyles. These women may not fit criteria for, or may "self select" out of , RCTs/ NICE-guideline approved therapies. If there are not alternatives they can end up untreated. This group need to be represented and thought about when considering service provision as they are often the most needy.	Thank you for your comment. This group of women will be included in the guideline.
89	SH	South London and Maudsley NHS Trust	1		4.1.1 a	7	Personality Disorder is mentioned in the previous section (3.1). It is not clear whether the intention is to include this in section 4.1. We would welcome the inclusion of personality disorder in the updated guideline.	Thank you for your comment. 'Mental health disorders' specified in 4.1 is intended to cover the mental disorders previously described in the scope.
105	SH	South London and Maudsley NHS Trust	5		4.3.1 a	7	We welcome the inclusion of the impact of the mother's mental health on the quality of the mother-baby interaction.	Thank you for your comment
107	SH	South London and Maudsley NHS Trust	2		4.3.1 c	7	There is accumulating but still sparse evidence for parent-infant therapy, but there is a considerable wealth of clinical experience now accumulating which should be considered in any guideline. For example most providers would recommend more robust attempts to engage than would be the norm for formal psychotherapy, and more akin to the practice with adolescents. There is also a growing	Thank you for your comment. The literature search will seek to identify the evidence in the area.

		Stakeholder	Order no	Doc	Section no	Page No	Comments	Developer's Response
							clinical experience of what does and doesn't work in this period. In the absence of 'higher level' evidence, it is hoped that consensus opinion from experts in the fields will be considered.	
108	S H	South London and Maudsley NHS Trust	3		4.3.1 c	7	Family and couple therapies were not included in the previous version of the guideline. Will these be covered in the updated version?	Thank you for your comment. Family and couple therapies will be included if the relevant evidence is identified.
111	S H	South London and Maudsley NHS Trust	4		4.3.1 d	8	It would be helpful to include a section on the evidence of the impact of untreated mental illness on the foetus. This would help prescribers and women when weighing up the risks and benefits of medications in pregnancy.	Thank you we will be covering this in the guideline.
127	S H	South London and Maudsley NHS Trust	6		4.3.2 a	8	The guideline does not intend to cover : " The needs of infants, other children and partners of women who have developed mental health disorders in pregnancy and the postnatal period" .We are concerned about this being totally excluded given that there are few if any other places where the needs of the affected infants and children can be considered.	Thank you for your comments. However, the mental health of the partner and the children is beyond the scope of the guideline.
37	S H	Tees Esk and Wear Valley NHS Foundation Trust	1		3.1 a	1	Excellent to have highlighted that pregnancy is not protective. However, second half of that sentence is misleading as pregnancy does affect the probability of relapse.	Thank you for your comment. We have amended the second half of this sentence for greater clarity.
44	S H	Tees Esk and Wear Valley NHS Foundation Trust	2		3.1b	2	Further issue which may be included is poor evidence base for treatment of disorders in the perinatal period.	Thank you for your comment.
98	S	Tees Esk and	3		4.2	7	It would be very helpful for clinicians trying to set up	Thank you for your comment.

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	H	Wear Valley NHS Foundation Trust					perinatal services if recommendations were included about the benefits of specialist perinatal teams, highlighting evidence including from CEMACH. Headings in NICE CG 45 were "Service organisation" and "organisation of care" – would it be possible to update/expand these?	The scoping of the literature identified no new evidence for service organization and delivery. It was therefore decided an update in this area was not required in the current guideline and the recommendations set out in the original guideline still stand.
112	S H	Tees Esk and Wear Valley NHS Foundation Trust	6		4.3.1 d	8	Comment that "guideline recommendations will normally fall within licensed indications". Are any psychotropic drugs licensed for use in pregnancy? Clear statement will be required.	Thank you for your comment. The use of psychotropic drugs is a central concern of this guideline. We will carefully consider the issue of licensing when developing our recommednations.

These stakeholder were approached but did not comment;

2gether NHS Foundation Trust
~~4 Children~~
Academic Division of Midwifery, University of Nottingham
Action on Postpartum Psychosis
Action on Pre-Eclampsia
Anglesey Local Health Board
Association for Family Therapy and Systematic Practice in the UK
Association for Improvements in the Maternity Services
Association for Post Natal Illness
Association for Psychoanalytic Psychotherapy in the NHS
Association of Anaesthetists of Great Britain and Ireland
Association of Chartered Physiotherapists in Women's Health
Association of Child Psychotherapists, The
Association of Radical Midwives
Astrazeneca UK Ltd
Avon and Wiltshire Mental Health Partnership NHS Trust
Baby Lifeline
Barnsley Hospital NHS Foundation Trust
Barnsley Primary Care Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Birmingham Women's Health Care NHS Trust
~~Birth Trauma Association~~
BirthChoice UK
Bolton Hospitals NHS Trust
Bonpharma Ltd
Bradford District Care Trust
Breastfeeding Network
Bristol Health Services Plan
British Association for Counselling and Psychotherapy
British Association for Psychopharmacology
British Association of Art Therapists
British Association of Behavioural and Cognitive Psychotherapies

British Association of Perinatal Medicine
British Association of Psychodrama and Sociodrama
British Association of Social Workers
British Dietetic Association
British Maternal & Fetal Medicine Society
British Medical Association
British Medical Journal
British National Formulary
British Paediatric Mental Health Group
Calderdale and Huddersfield NHS Trust
Calderdale Primary Care Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire & Peterborough Mental Health Trust
Camden Link
Camden PCT, Postnatal Depression Steering Group
Care Quality Commission (CQC)
Care Services Improvement Partnership
Central & North West London NHS Foundation Trust
Central London Community Healthcare
Central Manchester and Manchester Children's Hospital NHS Trust
Centre for Mental Health
Chartered Physiotherapists Promoting Continence
Chartered Society of Physiotherapy
Child Bereavement Charity
Christian Medical Fellowship
City Hospitals Sunderland NHS Foundation Trust
City University
Cochrane Pregnancy & Childbirth Group
College of Mental Health Pharmacists
College of Mental Health Pharmacy
College of Occupational Therapists
Commission for Social Care Inspection
Community District Nurses Association
Community Practitioners' & Health Visitors Association
Confidential Enquiry into Maternal and Child Health
Co-operative Pharmacy Association
Counselling and Psychotherapy Trust
Critical Psychiatry Network
Croydon Primary Care Trust
Department of Health, Social Services and Public Safety - Northern Ireland
Det Norske Veritas - NHSLA Schemes
~~Devon Partnership NHS Trust~~
Doncaster and South Humber Healthcare NHS Trust
Dorset Mental Health Forum
Dorset Primary Care Trust
Doula UK
Drinksense
Eastbourne District General Hospital
Eaton Foundation
Eli Lilly and Company
English National Forum of LSA Midwifery Officers
Equalities National Council
Evidence based Midwifery Network
Faculty of Public Health
Fatherhood Institute
Fibroid Network Charity
Food for the Brain Foundation
Forum for Advancement in Psychological Intervention
Foundation for the Study of Infant Deaths
Foundation Trust Network
GE Healthcare
George Eliot Hospital NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Gloucestershire LINk
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hafal
Hammersmith and Fulham Primary Care Trust
Hampshire Partnership NHS Trust
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Healthcare Inspectorate Wales
Hertfordshire Partnership NHS Trust
Heywood, Middleton and Rochdale Primary Care Trust
Hindu Council UK

Homerton Hospital NHS Foundation Trust
Humber NHS Foundation Trust
Independent Healthcare Advisory Services
Independent Midwives Association
Independent Midwives UK
Information Centre for Health and Social Care
Institute for Womens Health
Kent and Medway NHS and Social Care Partnership Trust
La Leche League GB
Lambeth Primary Care Trust
Lancashire Care NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust and Leeds Radiology Academy
Leicestershire Partnership NHS Trust
Lincolnshire Teaching Primary Care Trust
Liverpool Primary Care Trust
Liverpool Women's NHS Foundation Trust
London and the South Perinatal Psychiatry Clinical Network
Lundbeck UK
Luton and Dunstable Hospital NHS Trust
Maidstone and Tunbridge Wells NHS Trust
Maternal Mental Health Alliance
Maternity Action
Maternity and Mental Health Network
McDonald Obstetric Medicine Society
Medicines and Healthcare products Regulatory Agency
Mental Health Act Commission
Mental Health Foundation
Mental Health Nurses Association
Meriden Family Programme
Mid and West Regional Maternity Service Liasion Committee
midwifeexpert.com
Midwifery Studies Research Unit
Midwives Information and Resource Service
Mind
Mind Wise New Vision
Ministry of Defence
Multiple Births Foundation
Mumsnet
National Childbirth Trust
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Institute for Health Research Health Technology Assessment Programme
National Institute for Mental Health in England
National Obesity Forum
National Patient Safety Agency
~~National Perinatal Epidemiology Unit~~
National Public Health Service for Wales
National Treatment Agency for Substance Misuse
Netmums
Newcastle, North Tyneside and Northumberland Mental Health NHS Trust
NHS Clinical Knowledge Summaries
NHS Confederation
NHS Connecting for Health
NHS Devon
NHS Dudley
NHS Gloucestershire
NHS Herefordshire
NHS Midlands and East
NHS Milton Keynes
NHS Newcastle
NHS North East Essex
NHS Plus
NHS Sheffield
NHS South Central
NHS Trafford
NHS Warwickshire Primary Care Trust
NHS West Kent
NHS Yorkshire and the Humber Strategic Health Authority
Norfolk and Waveney Mental Health NHS Foundation Trust
North Cumbria Maternal MH Alliance
North Essex Mental Health Partnership Trust
North Staffordshire Combined Healthcare NHS Trust
North Tees and Hartlepool NHS Foundation Trust

North West London Perinatal Network
North Yorkshire & York Primary Care Trust
Northamptonshire Primary Care Trust
Northumberland, Tyne & Wear NHS Trust
Nottingham City Hospital
Nottinghamshire Acute Trust
Nottinghamshire Healthcare NHS Trust
Nutrition Society
Nuture Antenatal
Obstetric Anaesthetists' Association
Oxleas NHS Foundation Trust
Partneriaeth Prifysgol Abertawe
Peninsula Primary Care Psychology & Counselling Services
PERIGON Healthcare Ltd
Pharmacosmos
Pilgrim Projects
PNI ORG UK
Positively Pregnant
Post Natal Illness Support & Help Association Address1 = c/o Hawthorne House Address2 = Offcote Address3 =
Public Health Wales NHS Trust
Queen Mary's Hospital NHS Trust
Regional Maternity Survey Office
Rethink Mental Illness
Rotherham Primary Care Trust
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
~~Royal College of General Practitioners~~
Royal College of General Practitioners in Wales
~~Royal College of Midwives~~
~~Royal College of Nursing~~
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Psychiatrists in Scotland
Royal College of Radiologists
Royal College of Surgeons of England
Royal Pharmaceutical Society
Royal Society of Medicine
RSPH health visitor steering group
Safeline
Sands, the stillbirth and neonatal death charity
Sandwell and West Birmingham Hospitals NHS Trust
SANE
Scarborough and North Yorkshire Healthcare NHS Trust
Scottish Intercollegiate Guidelines Network
SEE BETSI CADWALADR - North Wales NHS Trust
Servier Laboratories Ltd
Sheffield Care Trust - Sheffield Birth Centres group
Sheffield Perinatal Mental health service
Sheffield Primary Care Trust
SNDRi
Social Care Institute for Excellence
Society for Academic Primary Care
Society for Existential Analysis
Soldiers, Sailors, Airmen and Families Association
South Asian Health Foundation
South Devon Healthcare NHS Foundation Trust
South East Essex Primary Care Trust
South Essex Partnership NHS Foundation Trust
South Essex Partnership University Foundation Trust
~~South London & Maudsley NHS Trust~~
South West Yorkshire Partnership NHS Foundation Trust
Southern Health & Social Care Trust
Spacelabs Healthcare
Stockport Clinical Commissioning Pathfinder
Stockport Primary Care Trust
Suffolk Mental Health Partnership NHS Trust
Sure Start Ashfield
Sure Start Tamworth
Surrey and Border Partnership Trust
Sussex Partnership NHS Foundation Trust

Tavistock Centre for Couple Relationships
~~Tees, Esk and Wear Valleys NHS Trust~~
The Association for Infant Mental Health
The Association of the British Pharmaceutical Industry
RSPH health visitor steering group
Safeline
Sands, the stillbirth and neonatal death charity
Sandwell and West Birmingham Hospitals NHS Trust
SANE
Scarborough and North Yorkshire Healthcare NHS Trust
Scottish Intercollegiate Guidelines Network
SEE BETSI CADWALADR - North Wales NHS Trust
Servier Laboratories Ltd
Sheffield Care Trust - Sheffield Birth Centres group
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
SNDRi
Social Care Institute for Excellence
Society for Academic Primary Care
Society for Existential Analysis
Soldiers, Sailors, Airmen and Families Association
South Asian Health Foundation
South Devon Healthcare NHS Foundation Trust
South East Essex Primary Care Trust
South Essex Partnership NHS Foundation Trust
South Essex Partnership University Foundation Trust
South London & Maudsley NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health & Social Care Trust
Spacelabs Healthcare
Stockport Clinical Commissioning Pathfinder
Stockport Primary Care Trust
Suffolk Mental Health Partnership NHS Trust
Sure Start Ashfield
Sure Start Tamworth
Surrey and Border Partnership Trust
Sussex Partnership NHS Foundation Trust
Tavistock Centre for Couple Relationships
Tees, Esk and Wear Valleys NHS Trust
The Association for Infant Mental Health
The Association of the British Pharmaceutical Industry
The College of Social Work
The For All Healthy Living Centre
The Hindu Forum of Britain
The Marce Society
The Miscarriage Association
The Pelvic Partnership
The Princess Alexandra Hospital NHS Trust
The Rotherham NHS Foundation Trust
The Samaritans
UK Clinical Pharmacy Association
UK National Screening Committee
UK Specialised Services Public Health Network
Ultrasis plc
Unison
Unite - the Union
United Kingdom Council for Psychotherapy
United Lincolnshire Hospitals NHS
University of Glamorgan
University College London Hospital NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University of West England
VBAC Information and Support
Victim Support
Warrington and Halton Hospitals NHS Foundation Trust
Welsh Government
Welsh Scientific Advisory Committee
West Hertfordshire Hospital Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
Western Cheshire Primary Care Trust
Wirral University Teaching Hospital NHS Foundation Trust
Worcestershire Acute Hospitals Trust
Worcestershire Health and Care NHS Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
Wye Valley NHS Trust

Wyre Forest Primary Care Trust
York Hospitals NHS Foundation Trust

YoungMinds