Antenatal and postnatal mental health

NICE guideline

Draft for consultation, July 2014

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence for the 2014 recommendations is contained in the full version of the 2014 guideline. Evidence for the 2007 recommendations is in the full version of the 2007 guideline.

Contents

Introduction

In pregnancy and the postnatal period, women are vulnerable to the same range of mental health problems as at other times. These usually have the same nature, course and potential for relapse (although bipolar disorder shows an increased rate of relapse and first presentation in pregnancy and the postnatal period). However, the management of mental health problems during these periods differs because of the transitional nature of the life stage and the potential impact of any difficulties and treatments on the woman and the baby. There are risks associated with taking psychotropic medication in pregnancy and during breastfeeding and risks of abruptly stopping medication taken for an existing mental health problem. There is also an increased risk, speed of onset and severity of psychosis in the immediate postnatal period (postpartum psychosis).

Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both. Depression and anxiety also affect 15–20% of women in the first year after childbirth. During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia, can occur on their own or can coexist with depression. Postpartum psychosis, characterised by psychotic depression, mania or atypical psychosis, affects between 1 and 2 in 1000 women who have given birth. This may be a relapse of an existing psychotic illness, such as schizophrenia or bipolar disorder, which can re-emerge or be exacerbated during pregnancy and the postnatal period; women with bipolar I disorder are at particular risk of postpartum psychosis. Changes to body shape, including weight gain, in pregnancy and after childbirth may be a concern for women with an eating disorder. Although the prevalence of anorexia nervosa and bulimia nervosa is lower in pregnant women, the prevalence of binge eating disorder is higher. Smoking and the use of illicit drugs and alcohol in pregnancy are common. Prematurity, intrauterine growth retardation and fetal

distress are more common in women who use these substances, particularly women who smoke, than those who do not.

Between 2006 and 2008 there were 1.27 maternal deaths per 100,000 maternal deliveries in the UK as a result of mental health problems. Although response to treatment is good, mental health problems frequently go unrecognised and untreated in pregnancy and the postnatal period. If untreated, women can continue to have symptoms, sometimes for many years, and these can also affect their babies and other family members.

This guideline makes recommendations for the recognition, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth), for the care of women with an existing mental health problem who are planning a pregnancy, and for the organisation of mental health services. The recommendations are relevant to all healthcare professionals providing interventions for mental health problems. This guideline should be read in conjunction with other NICE guidelines on the treatment and management of specific mental health problems. The guideline indicates where modifications to treatment and management are needed in pregnancy and the postnatal period.

The guideline draws on the best available evidence. However, there are significant limitations to the evidence base, including limited data on the risks of psychotropic medication in pregnancy and during breastfeeding.

Drug recommendations

No psychotropic medication has a UK marketing authorisation specifically for women who are pregnant or breastfeeding. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The woman (or those with authority to give consent on her behalf) should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

Patient-centred care

This guideline offers best practice advice on the recognition, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth). It also offers advice on the care of women with an existing mental health problem who are planning a pregnancy.

Women and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If someone does not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent, the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

If the service user is under 16, healthcare professionals should follow the guidelines in the Department of Health's Seeking consent: working with children. Families and carers should also be given the information and support they need to help the child or young person in making decisions about their treatment.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in Patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All health and social care providers working with people using adult NHS mental health services should follow the recommendations in Service user experience in adult mental health.

If a young person is moving between child and adolescent mental health services and adult mental health services, care should be planned and managed according to the best practice guidance described in the Department of Health's Transition: getting it right for young people.

Adult, neonatal and child healthcare teams should work jointly to provide assessment and services during pregnancy and the postnatal period for women with mental health problems and their babies. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also ‘Patient-centred care’).

Interventions that must (or must not) be used

We usually use ‘must’ or ‘must not’ only if there is a legal duty to apply the recommendation. Occasionally we use ‘must’ (or ‘must not’) if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a ‘strong’ recommendation

We use ‘offer’ (and similar words such as ‘refer’ or ‘advise’) when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, ‘Do not offer…’) when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use ‘consider’ when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to

have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Recommendation wording in guideline updates

NICE began using this approach to denote the strength of recommendations in guidelines that started development after publication of the 2009 version of 'The guidelines manual' (January 2009). This does not apply to any recommendations shaded in grey and ending **[2007]** (see 'Update information' box below for details about how recommendations are labelled). In particular, for recommendations labelled **[2007]**, the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Update information

This guidance is an update of NICE clinical guideline 45 (published 2007) and will replace it.

New recommendations have been added for assessment, treatment and monitoring in women who have, or are at risk of, mental health problems during pregnancy and the postnatal period (up to 1 year after childbirth).

You are invited to comment on the new and updated recommendations in this guideline. These are marked as:

- **[new 2014]** if the evidence has been reviewed and the recommendation has been added or updated
- **[2014]** if the evidence has been reviewed but no change has been made to the recommended action.

You are also invited to comment on recommendations that NICE proposes to delete from the 2007 guideline, because either the evidence has been reviewed and the recommendations have been updated, or NICE has updated other relevant guidance and has replaced the original recommendations. Appendix A sets out these recommendations and includes details of replacement recommendations. Where there is no replacement recommendation, an explanation for the proposed deletion is given.

Where recommendations are shaded in grey and end **[2007]**, the evidence has not been reviewed since the original guideline. We will not be able to accept comments on these recommendations. Yellow shading in these recommendations indicates wording changes that have been made for the purposes of clarification only.

The original NICE guideline and supporting documents are available here.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1.

Considerations for women of childbearing potential

- Discuss with all women of present and future childbearing potential who have a new, existing or past mental health problem:
  - the use of contraception and any plans for a pregnancy
  - how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
  - how a mental health problem and its treatment might affect the woman and the fetus or baby. **[new 2014] [1.1.1]**

- Do not offer valproate to treat a mental health problem in women of present and future childbearing potential. **[new 2014]** [**1.1.3]**

Principles of care for women with a mental health problem

Coordinated care

- Ensure that:
  - the woman's care is fully coordinated when different professional groups and agencies are involved
  - mental health (including mental wellbeing) is taken into account as part of all care plans, including those for women with physical health problems
  - there is effective sharing of information with all services involved and the woman herself
  - all interventions for mental health problems are delivered in a timely manner taking into account the stage of the pregnancy or age of the baby. **[new 2014] [1.2.6]**

Treatment decisions, advice and monitoring for women with a mental health problem

Information and advice

- Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period should include the following, depending on individual need:
  - that there is uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
  - likely benefits of each treatment, taking into account the severity of the mental health problem
  - response to any previous treatment
  - background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk associated with no treatment
  - the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
  - risks or harms to the woman and the fetus or baby associated with each treatment option
  - the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
  - risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment. **[new 2014] [1.3.6]**

Starting, using and stopping treatment

- Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk–benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention. **[new 2014] [1.3.11]**
- If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester:

- confirm the pregnancy as soon as possible
- explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
- offer screening for fetal abnormalities and counselling about continuing the pregnancy
- explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.

Seek specialist advice if there is uncertainty about the risks associated with specific drugs**. [new 2014] [1.3.16]**

TCAs, SSRIs, (S)NRIs

- When choosing a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI) or (serotonin-) noradrenaline reuptake inhibitor [(S)NRI][1], take into account reproductive safety and the uncertainty about whether any increased risk of fetal abnormalities and other problems for the woman or baby can be attributed directly to these drugs or may be caused by other factors. Note that:
  - TCAs, SSRIs and (S)NRIs taken in the first trimester may be associated with a small increased risk of fetal heart defects
  - TCAs, SSRIs and (S)NRIs taken after 20 weeks' gestation may be associated with a small increased risk of persistent pulmonary hypertension in the newborn baby
  - venlafaxine may be associated with an increased risk of maternal high blood pressure at high doses and higher toxicity in overdose in the woman than SSRIs
  - there is a risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs

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

- venlafaxine and paroxetine are associated with increased severity of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby
- TCAs have a higher fatal toxicity index than SSRIs in overdose. **[new 2014] [1.3.17]**

Recognising mental health problems and referral

- At a woman's first contact with primary care or her booking visit, and during the early postnatal period (for example, at 4 to 6 weeks and 3 to 4 months), ask the following depression identification questions as part of a general discussion about a woman's mental health:
  - During the past month, have you often been bothered by feeling down, depressed or hopeless?
  - During the past month, have you often been bothered by having little interest or pleasure in doing things?

Also ask about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?[2]
- During the past month have you not been able to stop or control worrying? **[new 2014] [1.4.3]**

Treating specific mental health problems

General principles

- All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times and the context in which they are treated (for example, maternity services). **[new 2014] [1.6.1]**

[2] An answer of 'Not at all' scores 0; 'Several days' scores 1; 'More than half the days' scores 2; 'Nearly every day' scores 3.

Considerations for women and their babies in the postnatal period

Traumatic birth, stillbirth and miscarriage

- Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the options of seeing a photograph of the baby, having mementos of the baby, seeing the baby or holding the baby. This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. **[new 2014] [1.7.8]**

1 Recommendations

The following guidance is based on the best available evidence. The full guideline [hyperlink to be added for final publication] gives details of the methods and the evidence used to develop the guidance.

Terms used in this guideline

Anxiety disorders These include generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, phobias, post-traumatic stress disorder and social anxiety disorder.

Baby refers to an infant aged between 0 and 12 months.

High-intensity intervention This is a formal psychological intervention usually delivered face to face (either in a group or individually) by a qualified therapist who has specific training in the delivery of the intervention. (As opposed to a 'low-intensity intervention', which is delivered by a trained coach or facilitator, rather than a therapist, to enable use of self-help materials.)

Postnatal period This is defined in this guideline as up to 1 year after childbirth.

Severe mental illness This is defined in this guideline as severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder and postpartum psychosis.

Valproate Refers to 3 formulations of valproate available in the UK: sodium valproate and valproic acid (licensed for the treatment of epilepsy) and semi-sodium valproate (licensed for the treatment of acute mania and continuation treatment in people whose mania responds to treatment). Both semi-sodium and sodium valproate are metabolised to valproic acid (also known as valproate), which is the pharmacologically active component.

Woman/women refer(s) to female(s) of present and future childbearing potential, including girls and young women under 18 years.

1.1 Considerations for women of childbearing potential

1.1.1 Discuss with all women of present and future childbearing potential who have a new, existing or past mental health problem:

- the use of contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
- how a mental health problem and its treatment might affect the woman and the fetus or baby. **[new 2014]**

1.1.2 When prescribing for women of present and future childbearing potential, take account of the latest data on the risks to the fetus and baby associated with psychotropic medication. **[new 2014]**

1.1.3 Do not offer valproate to treat a mental health problem in women of present and future childbearing potential. **[new 2014]**

1.2 Principles of care for women with a mental health problem

Improving the experience of care

1.2.1 Use this guideline in conjunction with NICE clinical guidance on service user experience in adult mental health and patient experience in adult NHS services to improve the experience of care for women with a mental health problem in pregnancy or the postnatal period. **[new 2014]**

Support and decision-making

1.2.2 Acknowledge and reinforce the woman's role in caring for her baby and do so in a non-judgmental and compassionate way. **[new 2014]**

1.2.3 Involve the woman, and if she agrees her partner, family or carer, in all decisions about her care and the care of her baby. **[new 2014]**

Supporting girls and young women

1.2.4 When working with girls and young women with a mental health problem in pregnancy or the postnatal period:

- be familiar with local and national guidelines on confidentiality and the rights of the child
- obtain appropriate consent, bearing in mind the girl's or young woman's understanding (including Gillick competence), parental consent and responsibilities, child protection issues, and the use of the Mental Health Act (2007) and of the Children Act (2004). **[2007]**

Supporting partners, families and carers

1.2.5 Take into account and, if appropriate, assess and address the needs of partners, families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period. These include:

- the welfare of the baby and other dependent children and adults
- the role of the partner, family or carer in providing support
- the effect of any mental health problem on the woman's relationship with her partner, family or carer. **[new 2014]**

Coordinated care

1.2.6 Ensure that:

- the woman's care is fully coordinated when different professional groups and agencies are involved
- mental health (including mental wellbeing) is taken into account as part of all care plans, including those for women with physical health problems
- there is effective sharing of information with all services involved and the woman herself
- all interventions for mental health problems are delivered in a timely manner taking into account the stage of the pregnancy or age of the baby. **[new 2014]**

1.3 Treatment decisions, advice and monitoring for women with a mental health problem

Information and advice

1.3.1 Provide culturally relevant information on mental health problems in pregnancy and the postnatal period. Ensure that the woman understands that mental health problems are not uncommon during these periods and instil hope about treatment. **[new 2014]**

1.3.2 Refer a woman with a mental health problem who is planning a pregnancy and is established on psychotropic medication to a specialist perinatal mental health service for preconception counselling. **[new 2014]**

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

- the likely benefits of psychological interventions and psychotropic medication

- the possible consequences of no treatment
- the possible harms associated with treatment
- what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly. **[new 2014]**

1.3.4 Discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. Explain to them the benefits of breastfeeding and the risks associated with breastfeeding while taking psychotropic medication, or with stopping medication in order to breastfeed. Discuss treatment options that would enable her to breastfeed if she wishes and support women who choose not to breastfeed. **[new 2014]**

1.3.5 If more detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period is needed, seek help from a secondary mental health service (preferably a specialist perinatal mental health service). **[new 2014]**

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

- that there is uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- likely benefits of each treatment, taking into account the severity of the mental health problem
- response to any previous treatment
- background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk associated with no treatment

- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
- risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment. **[new 2014]**

1.3.7 When discussing likely benefits and risks of treatment with the woman, and if she agrees her partner, family or carer:

- acknowledge the woman's central role in reaching a decision about her treatment and that the role of the professional is to inform that decision with balanced and up-to-date information and advice
- use absolute values based on a common denominator (that is, numbers out of 100 or 1000)
- acknowledge and describe, if possible, the uncertainty around any estimate of risk, harm or benefit
- use high-quality decision aids in a variety of numerical and pictorial formats that focus on a personalised view of the risks and benefits, in line with the guidance on patient experience in adult NHS services (NICE clinical guidance 138)
- consider providing records of the consultation, in a variety of visual, verbal or audio formats if possible. **[new 2014]**

Monitoring and increased contact

1.3.8 Monitor regularly throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth, all women with a mental health problem and women assessed at high risk of developing one. **[new 2014]**

1.3.9 If a pregnant woman with a mental health problem chooses not to have treatment or stops treatment:

- discuss and plan how symptoms will be monitored (for example, by using validated self-report questionnaires, such as the Edinburgh Postnatal Depression Scale [EPDS] or the 7-item Generalized Anxiety Disorder scale [GAD-7])
- assess and agree with her the need for increased contact and support in pregnancy and the postnatal period. **[new 2014]**

Using and modifying NICE guidelines for specific mental health problems

1.3.10 Interventions for mental health problems in pregnancy and the postnatal period should be informed by the NICE guideline for a specific mental health problem (see the related NICE guidance in section 3.2), and should take into account:

- any variations in the nature and presentation of the mental health problem in pregnancy or the postnatal period
- the setting (for example, primary or secondary care services or in the community, the home or remotely by phone or computer) in which the interventions are delivered
- recommendations 1.3.11 to 1.3.39 about starting, using and stopping treatment in pregnancy and the postnatal period
- recommendations 1.6.6 to 1.6.23 about the treatment of specific mental health problems in pregnancy and the postnatal period. **[new 2014]**

Starting, using and stopping treatment

General advice

1.3.11 Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk–benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention. **[new 2014]**

1.3.12 If the optimal treatment for a mental health problem is psychotropic medication combined with a psychological intervention, but a woman declines or stops taking psychotropic medication in pregnancy or the postnatal period, ensure that she is adequately supported and is offered or continues with a psychological intervention. **[new 2014]**

1.3.13 When psychotropic medication is started in pregnancy and the postnatal period, consider seeking advice, preferably from a specialist in perinatal mental health, and:

- choose the drug with the lowest risk profile for the woman, fetus and baby
- use the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may also expose the fetus to risks
- use a single drug, if possible, in preference to 2 or more drugs
- take into account the impact of fluctuating drug plasma levels during pregnancy. **[2014]**

1.3.14 When a woman with severe mental illness decides to stop psychotropic medication in pregnancy and the postnatal period, discuss with her:

- her reasons for doing so
- the possibility of:

  - restarting the medication
  - switching to other medication with a lower risk profile
- increasing the level of monitoring and support.

Ensure she knows about any risks to herself, the fetus or baby when stopping medication. **[new 2014]**

1.3.15 When a woman with depression or an anxiety disorder decides to stop taking psychotropic medication in pregnancy and the postnatal period, discuss with her:

- her reasons for doing so
- the possibility of:
  - having a psychological intervention
  - restarting the medication if the depression or anxiety disorder is severe and there has been a previous good response to treatment
  - switching to other medication with a lower risk profile
- increasing the level of monitoring and support while she is not taking any medication.

Ensure she knows about any risks to herself, the fetus or baby when stopping medication. **[new 2014]**

1.3.16 If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester:

- confirm the pregnancy as soon as possible
- explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
- offer screening for fetal abnormalities and counselling about continuing the pregnancy
- explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.

Seek specialist advice if there is uncertainty about the risks associated with specific drugs. **[new 2014]**

TCAs, SSRIs, (S)NRIs

1.3.17 When choosing a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI) or (serotonin-) noradrenaline reuptake inhibitor [(S)NRI][3], take into account reproductive safety and the uncertainty about whether any increased risk of fetal abnormalities and other problems for the woman or baby can be attributed directly to these drugs or may be caused by other factors. Note that:

- TCAs, SSRIs and (S)NRIs taken in the first trimester may be associated with a small increased risk of fetal heart defects
- TCAs, SSRIs and (S)NRIs taken after 20 weeks' gestation may be associated with a small increased risk of persistent pulmonary hypertension in the newborn baby
- venlafaxine may be associated with an increased risk of maternal high blood pressure at high doses and higher toxicity in overdose in the woman than SSRIs
- there is a risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs
- venlafaxine and paroxetine are associated with increased severity of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby
- TCAs have a higher fatal toxicity index than SSRIs in overdose. **[new 2014]**

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

1.3.18 When assessing the risks and benefits of TCAs, SSRIs or (S)NRIs[4] for a woman who is considering breastfeeding, take into account:

- the uncertainty about the safety of these drugs for the breastfeeding baby
- the risks associated with switching from a previously effective medication.

Seek specialist advice (preferably from a specialist in perinatal mental health) if there is uncertainty about specific drugs. **[new 2014]**

Benzodiazepines

1.3.19 Do not offer benzodiazepines to women in pregnancy and the postnatal period except for the short-term treatment of extreme anxiety and agitation. **[2014]**

1.3.20 Consider gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding. **[2014]**

Antipsychotic medication

1.3.21 When assessing the risks and benefits of antipsychotic medication[5] for a pregnant woman, take into account risk factors for gestational diabetes and excessive weight gain. **[new 2014]**

1.3.22 When choosing an antipsychotic, take into account that there are limited data on the safety of these drugs in pregnancy and the postnatal period. **[new 2014]**

1.3.23 Measure prolactin levels in women who are taking prolactin-raising antipsychotic medication and planning a pregnancy, because

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

raised levels are associated with some antipsychotics and reduce the chances of conception. If prolactin levels are raised, offer a different antipsychotic. **[2014]**

1.3.24 If a pregnant woman is stable on an antipsychotic and likely to relapse without medication, advise her to continue the antipsychotic. **[new 2014]**

1.3.25 Advise pregnant women taking antipsychotic medication about diet and monitor for excessive weight gain, in line with NICE guidance on weight management before, during and after pregnancy (NICE public health guidance 27). **[new 2014]**

1.3.26 Monitor for gestational diabetes in pregnant women taking antipsychotic medication in line with the NICE guideline on diabetes in pregnancy (NICE clinical guideline 63). **[new 2014]**

1.3.27 Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication. This is because there are limited data on safety in pregnancy and babies may show extrapyramidal symptoms several months after administration of the depot. **[new 2014]**

Anticonvulsants (valproate, carbamazepine and lamotrigine)

1.3.28 Do not offer valproate or carbamazepine to stabilise mood in women who are planning a pregnancy, pregnant or considering breastfeeding. **[new 2014]**

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

1.3.29 If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy. Take into account the risks and benefits of other treatments and offer another drug (for example, quetiapine[6] for treating bipolar disorder). **[2014]**

1.3.30 If a woman is already taking valproate and becomes pregnant, stop the drug because of the risk of fetal malformations and adverse neurodevelopmental outcomes. Take into account the risks and benefits of other treatments and offer another drug (for example, quetiapine for treating bipolar disorder). **[2014]**

1.3.31 If a woman is already taking carbamazepine and is planning a pregnancy or becomes pregnant, consider, in discussion with the woman, stopping the drug (because of the possible risk of adverse drug interactions or fetal malformations) and switching to another drug (usually an antipsychotic, for example, quetiapine for treating bipolar disorder). **[new 2014]**

1.3.32 If a woman is taking lamotrigine[7] during pregnancy, check lamotrigine levels frequently because they vary substantially at this time. **[new 2014]**

1.3.33 Offer high-dose (5 mg per day) folic acid to all women who are planning a pregnancy and taking an anticonvulsant for a mental health problem. Continue high-dose folic acid up to the end of the first trimester. **[new 2014]**

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

[7] At the time of consultation (July 2014), lamotrigine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

Lithium

1.3.34 Do not offer lithium[8] to women who are planning a pregnancy or pregnant, unless no other medication is likely to be effective. **[new 2014]**

1.3.35 If lithium is the only medication that is likely to be effective, ensure the woman knows that:

- there is a risk of fetal heart malformations when lithium is taken in the first trimester, but the size of the risk is uncertain
- lithium levels need to be monitored more frequently throughout pregnancy and the postnatal period. **[new 2014]**

1.3.36 If a woman taking lithium becomes pregnant, consider stopping the drug gradually over 4 weeks if she is well and not at high risk of relapse. Explain that this may not remove the risk of fetal heart malformations. **[2014]**

1.3.37 If a woman taking lithium becomes pregnant and is not well or is at high risk of relapse, consider:

- switching gradually to an antipsychotic, **or**
- stopping lithium and restarting it in the third trimester (if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past), **or**
- continuing with lithium if she is at high risk of relapse and no other medication is likely to be effective. **[new 2014]**

1.3.38 If a woman continues taking lithium during pregnancy, check serum lithium levels every 4 weeks, then weekly from the 36th week, and within 24 hours of childbirth. Adjust the dose to keep serum levels

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

in the therapeutic range, and ensure that the woman maintains an adequate fluid intake. **[2014]**

1.3.39 Women taking lithium should give birth in hospital and be monitored during labour by the obstetric team. Monitoring should include fluid balance, because of the risk of dehydration and lithium toxicity. Monitor serum lithium levels when labour is prolonged for more than 12 hours. **[2014]**

1.4 Recognising mental health problems and referral

1.4.1 Recognise that women who have a mental health problem (or are worried that they might have) may be unwilling to disclose or discuss their problem because of fear of stigma, negative perceptions of them as a mother or fear that their baby might be taken into care. **[new 2014]**

1.4.2 Ensure that all communications with maternity services (including those relating to initial referral) include sharing of information on any past and present mental health problem. **[2014]**

Depression and anxiety disorders

1.4.3 At a woman's first contact with primary care or her booking visit, and during the early postnatal period (for example, at 4 to 6 weeks and 3 to 4 months), ask the following depression identification questions as part of a general discussion about a woman's mental health:

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

Also ask about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?[9]
- During the past month have you not been able to stop or control worrying? **[new 2014]**

1.4.4 If a woman responds positively to either of the depression identification questions in recommendation 1.4.4, consider:

- using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) for further assessment, or
- providing, or referring to a specialist mental health practitioner for, full assessment and treatment. **[new 2014]**

1.4.5 If a woman scores 3 or more on the GAD-2 scale, consider:

- using the GAD-7 scale for further assessment, or
- providing, or referring to a specialist mental health practitioner for, full assessment and treatment. **[new 2014]**

1.4.6 If a woman scores less than 3 on the GAD-2 scale, but you are still concerned she may have an anxiety disorder, ask the following question:

- Do you find yourself avoiding places or activities and does this cause you problems?

If she responds positively, consider:

- using the GAD-7 scale for further assessment, or
- providing, or referring to a specialist mental health practitioner for, full assessment and treatment. **[new 2014]**

[9] An answer of 'Not at all' scores 0; 'Several days' scores 1; 'More than half the days' scores 2; 'Nearly every day' scores 3.

Severe mental illness

1.4.7 At a woman's first contact with services in pregnancy and the postnatal period, ask about:

- any past or present severe mental illness
- previous treatment by a specialist mental health service, including inpatient care
- any severe perinatal mental illness in a first-degree relative (mother, sister or daughter). **[2014]**

1.4.8 Refer to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment, all women who:

- have or are suspected to have severe mental illness
- have any history of severe mental illness (during a pregnancy or at any other time).

Ensure that the woman's GP knows about the referral. **[new 2014]**

1.4.9 If a woman has any past or present severe mental illness or there is a family history of severe perinatal mental illness in a first-degree relative, be alert for possible symptoms of postpartum psychosis in the first 2 weeks after childbirth. **[new 2014]**

1.4.10 If a woman has sudden onset of psychotic symptoms in the postnatal period, refer her without delay to a secondary mental health service (preferably a specialist perinatal mental health service) for urgent assessment. **[new 2014]**

Alcohol and drug misuse

1.4.11 If alcohol misuse is suspected, use the Alcohol Use Disorders Identification Test (AUDIT) as an identification tool in line with recommendation 1.2.1.4 of the guideline on alcohol-use disorders (NICE clinical guideline 115). **[new 2014]**

1.4.12 If drug misuse is suspected, follow the recommendations on identification and assessment in section 1.2 of the guideline on drug misuse – psychosocial interventions (NICE clinical guideline 51). **[new 2014]**

1.5 Assessment and initial care of mental health problems

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

- history of any mental health problem, including in pregnancy and the postnatal period
- physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem
- alcohol and drug misuse
- any current or past treatment for a mental health problem, and response to any treatment
- social networks and quality of interpersonal relationships
- living conditions and social isolation
- family history (first-degree relative) of mental health problems
- domestic violence, sexual abuse, trauma or childhood maltreatment
- housing, employment, economic and immigration status
- responsibilities as a carer for other children and young people or other adults. **[new 2014]**

1.5.2 When assessing or treating a mental health problem in pregnancy or the postnatal period, take account of any learning disabilities or acquired cognitive impairments, and assess the need to consult with a specialist when developing treatment plans. **[new 2014]**

1.5.3 Carry out a risk assessment in conjunction with the woman, and If she agrees, her partner, family or carer. Focus on areas that are likely to present possible risk such as self-neglect, self-harm,

suicidal thoughts and intent, risks to others (including the baby), smoking, drug or alcohol misuse and domestic violence. **[new 2014]**

1.5.4 If there are concerns about suspected child maltreatment, follow local safeguarding protocols and consult the guideline on when to suspect child maltreatment (NICE clinical guideline 89). **[new 2014]**

1.5.5 If there is a risk of self-harm or suicide:

- assess whether the woman has adequate social support and is aware of sources of help
- arrange help appropriate to the level of risk
- advise the woman, and her partner, family or carer, to seek further help if the situation deteriorates. **[new 2014]**

1.5.6 Professionals in secondary mental health services, including specialist perinatal mental health services, should develop a written care plan in collaboration with a woman who has or has had a severe mental illness. If she agrees, her partner, family or carer should also be involved. The plan should cover pregnancy, childbirth and the postnatal period (including the potential impact of the illness on the baby) and should include:

- a clear statement of jointly agreed treatment goals and how outcomes will be routinely monitored
- increased contact with and referral to specialist perinatal mental health services
- the names and contact details of key professionals.

The care plan should be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes) and a copy given to the woman and all involved professionals. **[new 2014]**

1.5.7 If hazardous drug or alcohol misuse is identified in pregnancy or the postnatal period, refer or offer brief interventions in line with section 1.3.1 of the guideline on drug misuse – psychosocial interventions (NICE clinical guideline 51) or the NICE guidance on alcohol-use disorders: preventing harmful drinking (NICE public health guidance 24). **[new 2014]**

1.5.8 If harmful or dependent drug or alcohol misuse is identified in pregnancy or the postnatal period refer the woman to a specialist substance misuse service for advice and treatment. **[new 2014]**

1.6 Treating specific mental health problems

General principles

1.6.1 All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times and the context in which they are treated (for example, maternity services). **[new 2014]**

1.6.2 All interventions for mental health problems in pregnancy and the postnatal period should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions practitioners should:

- receive regular high-quality supervision
- use routine outcome measures and ensure that the woman is involved in reviewing the efficacy of the treatment
- engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio

tapes, and external audit and scrutiny where appropriate. **[new 2014]**[10]

1.6.3 When a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, assess for treatment within 2 weeks of referral and provide psychological interventions normally within 1 month of initial assessment. **[new 2014]**

1.6.4 When offering psychotropic medication during pregnancy and the postnatal period, follow the principles in recommendations 1.3.11 to 1.3.39. **[new 2014]**

1.6.5 Provide interventions for mental health problems in pregnancy and the postnatal period within a stepped-care model of service delivery in line with recommendation 1.5.1.3 in the guideline on common mental health disorders (NICE clinical guideline 123). **[new 2014]**

Interventions for depression and anxiety disorders

1.6.6 For a woman with persistent subthreshold depressive symptoms, or mild to moderate depression, in pregnancy or the postnatal period, consider facilitated self-help (delivered as described in recommendation 1.4.2.2 of the guideline on depression in adults [NICE clinical guideline 90]). **[new 2014]**

1.6.7 For a woman with a history of severe depression who initially presents with mild depression in pregnancy or the postnatal period, consider a TCA, SSRI or (S)NRI. **[new 2014]**

1.6.8 For a woman with a history of depression or an anxiety disorder, who has a moderate to severe episode in pregnancy or the postnatal period, consider:

- a high-intensity psychological intervention specifically for the depression or anxiety disorder, or

[10] Adapted from the guideline on depression in adults (NICE clinical guideline 90).

- a TCA, SSRI or (S)NRI if she understands the risks associated with the medication and the mental health problem in pregnancy and the postnatal period and has expressed a preference for it or she declines, or her symptoms have not responded to, psychological interventions, or
- a high-intensity psychological intervention in combination with medication if there is no response, or a limited response to a high-intensity psychological intervention or medication alone, provided the woman understands the risks associated with the medication and the mental health problem. **[new 2014]**

1.6.9 For a woman with a severe episode of depression or an anxiety disorder in pregnancy or the postnatal period, consider the options in recommendation 1.6.8. **[new 2014]**

1.6.10 For women with tokophobia (an extreme fear of childbirth), offer an opportunity to discuss their fears with a healthcare professional with expertise in providing perinatal mental health support. **[new 2014]**

1.6.11 If a woman who is taking a TCA, SSRI or (S)NRI for mild to moderate depression or an anxiety disorder becomes pregnant, advise her to stop the medication gradually and consider facilitated self-help (delivered as described in recommendation 1.4.2.2 of the guideline on depression in adults [NICE clinical guideline 90]). **[new 2014]**

1.6.12 If a woman who is taking a TCA, SSRI or (S)NRI for moderate to severe depression or an anxiety disorder becomes pregnant and wants to stop her medication, take into account previous response to treatment, risk of relapse and risk associated with medication and her preference, and discuss:

- a high-intensity psychological intervention (for example, CBT or IPT)

- changing to medication with lower risk of adverse effects. **[new 2014]**

1.6.13 If a woman who is taking a TCA, SSRI or (S)NRI for severe depression or an anxiety disorder becomes pregnant, take into account previous response to treatment, risk of relapse and risk associated with medication and her preference, and discuss:

- combining medication with a high-intensity psychological intervention (for example, CBT or IPT)
- changing to medication with a lower risk of adverse effects
- switching to a high-intensity psychological intervention (for example, CBT or IPT) if she decides to stop taking medication. **[new 2014]**

Psychological interventions for eating disorders

1.6.14 For a woman with an eating disorder in pregnancy or the postnatal period:

- offer a psychological intervention in line with the guideline on eating disorders (NICE clinical guideline 9)
- monitor the woman's condition carefully throughout pregnancy and the postnatal period
- discuss the importance of healthy eating during pregnancy and the postnatal period in line with guidance on maternal and child nutrition (NICE public health guidance 11)
- advise her about feeding the baby in line with guidance on maternal and child nutrition (NICE public health guidance 11) and support her with this. **[new 2014]**

Interventions for alcohol and drug misuse

1.6.15 Offer assisted alcohol withdrawal to pregnant women who are dependent on alcohol and want to undertake it. Work with a woman who does not want assisted alcohol withdrawal to help her reduce her alcohol intake. **[new 2014]**

1.6.16 Assisted alcohol withdrawal should be undertaken in collaboration with specialist mental health and alcohol services, preferably in an inpatient setting. **[new 2014]**

1.6.17 Offer detoxification in collaboration with specialist mental health and substance misuse services to pregnant women who are dependent on opioids. Monitor closely after completion of detoxification. Work with a woman who does not want detoxification to help her reduce her opioid intake. **[new 2014]**

Interventions for severe mental illness

1.6.18 Consider psychological interventions for women with bipolar disorder. This includes:

- an intervention such as CBT, IPT and behavioural couples therapy for bipolar depression
- individual, group and family interventions for reducing the risk of relapse, particularly when medication is changed or stopped. **[new 2014]**

1.6.19 If a pregnant woman develops mania or psychosis and is not taking psychotropic medication, offer an antipsychotic. **[new 2014]**

1.6.20 Consider psychological interventions (CBT or family intervention) delivered as described in section 1.3.7 of the guideline on psychosis and schizophrenia in adults (NICE clinical guideline 178) for a woman with psychosis or schizophrenia who becomes pregnant and:

- is at risk of relapse arising from stress associated with pregnancy or the postnatal period or from a change in medication
- has stopped taking antipsychotic medication. **[new 2014]**

1.6.21 Offer a woman with bipolar disorder who is taking psychotropic medication a drug that can be used if she plans to breastfeed. Offer an antipsychotic (for example, quetiapine) as first choice. **[new 2014]**

1.6.22 Offer antipsychotic medication (for example, quetiapine) if a woman with bipolar disorder becomes pregnant and is stopping lithium as prophylactic medication. **[new 2014]**

1.6.23 If a pregnant woman with bipolar disorder develops mania while taking prophylactic medication:

- check the dose of the prophylactic medication and adherence
- increase the dose if the prophylactic medication is an antipsychotic
- suggest changing to an antipsychotic if she is taking another type of prophylactic medication
- consider lithium if there is no response to an increase in dose or change of drug and the woman has severe mania
- consider electroconvulsive therapy (ECT) if there has been no response to lithium. **[new 2014]**

Interventions for sleep problems

1.6.24 Advise pregnant women who have a sleep problem about sleep hygiene (including having a healthy bedtime routine, avoiding caffeine and reducing activity before sleep). For women with a severe or chronic sleep problem, consider promethazine[11]. **[new 2014]**

Electroconvulsive therapy

1.6.25 Consider electroconvulsive therapy (ECT) for pregnant women with severe depression, severe mixed affective states or mania, or catatonia, whose physical health or that of the fetus is at serious risk. **[2014]**

Rapid tranquillisation

1.6.26 A pregnant woman requiring rapid tranquillisation should be treated according to the NICE clinical guidelines on the short-term management of disturbed/violent behaviour, schizophrenia and bipolar disorder (see the related NICE guidance in section 3.2 for details), except that:

- she should not be secluded after rapid tranquillisation
- restraint procedures should be adapted to avoid possible harm to the fetus
- when choosing an agent for rapid tranquillisation in a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used, it should be at the minimum effective dose because of neonatal extrapyramidal symptoms; if a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account
- during the perinatal period, the woman's care should be managed in close collaboration with a paediatrician and an anaesthetist. **[2007]**

1.7 Considerations for women and their babies in the postnatal period

Reviewing treatment for women with severe mental illness

1.7.1 After childbirth, review and assess the need for starting, restarting or adjusting psychotropic medication in a woman with a severe mental illness as soon as she is medically stable (once the fluid balance is established). **[new 2014]**

Monitoring babies for effects of psychotropic medication taken in pregnancy

1.7.2 If a woman has taken drugs during pregnancy that may carry a risk of harm to the fetus or baby, a full neonatal assessment of the newborn baby should be undertaken by a specialist, preferably by a neonatologist. **[new 2014]**

1.7.3 If a woman has taken psychotropic medication in pregnancy, assess the baby in the first 2 weeks after childbirth for adverse drug effects, drug toxicity and neonatal adaptation syndrome (for example, floppy baby syndrome, irritability, constant crying, shivering, tremor, restlessness, increased tone, feeding and sleeping difficulties and, rarely, seizures). Note that if the woman was taking a SSRI or (S)NRI in the last trimester, symptoms may result from serotonergic toxicity syndrome rather than neonatal adaptation syndrome. **[new 2014]**

Care of women and their babies if there has been alcohol or drug misuse in pregnancy

1.7.4 If there has been alcohol or drug misuse in pregnancy, offer treatment and support after childbirth to both the woman and the baby, including:

- a full neonatal assessment for any congenital abnormalities or neonatal adaptation syndrome
- continuing psychological treatment and support for the woman

- monitoring of the baby. **[new 2014]**

Traumatic birth, stillbirth and miscarriage

1.7.5 Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends. If the woman wishes, refer her for a specialist mental health assessment. **[new 2014]**

1.7.6 Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth. **[new 2014]**

1.7.7 Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the guideline on post-traumatic stress disorder (PTSD) (NICE clinical guideline 26). **[new 2014]**

1.7.8 Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the options of seeing a photograph of the baby, having mementos of the baby, seeing the baby or holding the baby. This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. **[new 2014]**

Psychotropic medication and breastfeeding

1.7.9 Encourage women with a mental health problem to breastfeed, except in rare circumstances. However, support each woman in the choice of feeding method that best suits her and her family. **[new 2014]**

1.7.10 When assessing the risks and benefits of TCAs, SSRIs or (S)NRIs for women who are breastfeeding, take into account:

- that there is uncertainty about the safety of these drugs
- the risks associated with switching from a previously effective medication.

Seek specialist advice (preferably from a specialist in perinatal mental health) if there is uncertainty about specific drugs. **[new 2014]**

1.7.11 When assessing the risks and benefits of antipsychotic medication for women who are breastfeeding, take into account:

- the limited data on the safety of these drugs, and
- the level of antipsychotic medication in breast milk depends on the drug. **[new 2014]**

1.7.12 Do not routinely offer the following drugs to women who are breastfeeding:

- carbamazepine (because of the risk of liver toxicity in the baby)
- clozapine (because of the risk of agranulocytosis and seizures in the baby)
- depot antipsychotics (because of the risk of extrapyramidal symptoms in the baby several months after administration)
- lithium (because of the potentially high levels of the drug in breast milk and the risks of toxicity in the baby). **[new 2014]**

1.7.13 If a woman is taking psychotropic medication while breastfeeding, monitor the baby for adverse effects. **[2014]**

The mother–baby relationship

1.7.14 Recognise that mental health problems may affect the mother–baby relationship, but reassure the woman that any problems with the relationship are likely to improve with effective treatment of the mental health problem. **[new 2014]**

1.7.15 Assess the nature of the mother–baby relationship as part of all routine postnatal assessments, monitoring the effects on the relationship of any interventions for a mental health problem. Consider referral to an infant mental health service if problems in the relationship have not resolved. **[new 2014]**

1.8 The organisation of services

1.8.1 Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so. **[2007]**

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

- there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment
- staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways. **[2007]**

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

- a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding

- clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved. **[2007]**

1.8.4 Each managed perinatal mental health network should have designated specialist inpatient services and cover a population where there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates. **[2007]**

1.8.5 Specialist perinatal inpatient services should:

- provide facilities designed specifically for mothers and babies (typically with 6–12 beds)
- be staffed by specialist perinatal mental health staff
- be staffed to provide appropriate care for infants
- have effective liaison with general medical and mental health services
- have available the full range of therapeutic services
- be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay. **[2007]**

2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline.

2.1 Preventing postpartum psychosis

What methods can improve the identification of women at high risk of postpartum psychosis and reduce this risk?

Why this is important

Postpartum psychosis is a severe mental illness with a rapid onset and a major impact on the woman and her ability to care for her baby. It is associated with an increased risk of mortality in both the woman and her baby. Prophylactic treatment can be effective for women who are known to be at high risk, but for some women postpartum psychosis may be their first episode of severe mental illness. Better identification of women at high risk and a greater understanding of prophylactic and acute treatment would have a significant impact on maternal and child welfare, and on service costs.

The question should be addressed by a programme of research into the prevention, treatment and management of postpartum psychosis comprising:

- The development of a tool for routine clinical use to improve the identification of women at high risk of developing postpartum psychosis. This should be tested in a prospective cohort study.
- The development of a set of interventions intended to prevent the onset of postpartum psychosis and a method for their effective and efficient delivery.
- The testing of the clinical and cost effectiveness of the interventions in a large scale randomised controlled trial.
- The development and testing of a programme for the implementation of an effective strategy for preventing and identifying postpartum psychosis.

2.2 The safety of drugs for bipolar disorder in pregnancy and the postnatal period

How safe are drugs used to treat bipolar disorder in pregnancy and the postnatal period?

Why this is important

Drugs are effective for the acute treatment of bipolar disorder and for preventing relapse. All drugs used to treat mental health problems may carry some risk for the woman, fetus and baby. For some drugs such as sodium valproate these risks are well described, but the data are drawn from epilepsy case registers. For others such as lithium, the data are very limited. In

addition, the prevalence of adverse outcomes for the woman, fetus or baby in untreated bipolar disorder is not well described.

The question should be addressed by establishing a long-term register of women with bipolar disorder who have been pregnant to provide data on:

- the drugs used for treating bipolar disorder in pregnancy
- the following outcomes (by drug type and for women who had no treatment for bipolar disorder in pregnancy):
  - maternal outcomes (for example, episodes of mood disorder in pregnancy and the postnatal period, miscarriage, preterm delivery)
  - congenital malformations (for example, spinal cord and cardiac malformation)
  - baby outcomes (for example, mortality, birthweight)
  - childhood outcomes (for example, cognitive development).

2.3 Psychological interventions focused on the mother–baby relationship

Are interventions designed to improve the quality of the mother–baby relationship in the first year after childbirth effective in women with a diagnosed mental health problem?

Why this is important

Problems in the mother–baby relationship in the first year after childbirth may increase maternal mental health problems and are associated with a range of problems for the baby, including delayed cognitive and emotional development. A number of interventions are effective in improving the interaction between women and their babies, but it is not known if these are effective in women with a diagnosed mental health problem.

The question should be addressed in a randomised controlled trial comparing an intervention (proven to be effective in improving the quality of mother–baby interactions in women without a diagnosed mental health problem) against standard care. The trial should report the following outcomes, with a follow-up period of at least 2 years:

- the mental health of the woman
- the emotional and cognitive development of the baby
- the quality of the interaction.

The trial should also examine the cost effectiveness of the intervention.

2.4 Structured clinical management for moderate to severe personality disorders in pregnancy and the postnatal period

Is structured clinical management for moderate to severe personality disorders in pregnancy and the postnatal period effective at improving outcomes for women and their babies?

Why is this important

Personality disorders are associated with poor engagement with maternity services and perinatal mental health services and this leads to poor mental and physical health outcomes for the woman and her baby. The complex psychological interventions that are effective for treating personality disorder may present problems for engagement even in those motivated to seek treatment. Structured clinical management is a psychologically-informed model of case management, which is effective for treating personality disorder and may have greater flexibility and capacity to engage women with personality disorder in pregnancy and the postnatal period.

The question should be addressed in a randomised controlled trial comparing structured clinical management of personality disorder in pregnancy and the postnatal period against standard care. The trial should report the following outcomes, with a follow-up period of at least 2 years:

- the mental and physical health of the woman
- the physical health of the fetus
- the mental and physical health of the baby
- the quality of the mother–baby relationship.

The trial should also examine the cost effectiveness of the intervention.

2.5 Psychological interventions for moderate to severe anxiety disorders in pregnancy

Are psychological interventions effective for treating moderate to severe anxiety disorders (including obsessive-compulsive disorder, panic disorder and social anxiety disorder) in pregnancy?

Why is this important

Anxiety disorders are often not identified or treated in pregnancy. In addition, many women who are taking medication for such problems stop taking it when they are pregnant. The development of effective psychological interventions is therefore important. Although there are effective psychological interventions for anxiety disorders, there is limited evidence about their effectiveness in pregnancy and how these interventions might be adapted for use in pregnant women.

The question should be addressed by a programme of research evaluating psychological interventions (including individual and group approaches) for moderate to severe anxiety disorders in pregnancy, comprising:

- A development programme to establish the adaptations to effective interventions (for example, mode of delivery, duration, content, and intensity of treatment) that are needed for use in pregnancy.
- The testing of the adapted interventions in a series of pilot studies.
- The testing of the clinical and cost effectiveness of the adapted interventions in large scale randomised controlled trials.
- The development and testing of a programme for the implementation of psychological interventions for moderate to severe anxiety disorders.

3 Other information

3.1 Scope and how this guideline was developed

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see section 4), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

3.2 Related NICE guidance

Details are correct at the time of consultation on the guideline (July 2014). Further information is available on the NICE website.

Published

General

- Patient experience in adult NHS services. NICE clinical guidance 138 (2012).
- Service user experience in adult mental health. NICE clinical guidance 136 (2011).
- Medicines adherence. NICE clinical guidance 76 (2009).

Condition-specific

- Psychosis and schizophrenia in adults. NICE clinical guideline 178 (2014).
- Smoking cessation in secondary care: acute, maternity and mental health services. NICE public health guidance 48 (2013).
- Social anxiety disorder. NICE clinical guideline 159 (2013).
- Psychosis and schizophrenia in children and young people. NICE clinical guideline 155 (2013).
- Ectopic pregnancy and miscarriage. NICE clinical guideline 154 (2012).
- Caesarean section. NICE clinical guideline 132 (2011).
- Multiple pregnancy. NICE clinical guideline 129 (2011).

- Common mental health disorders. NICE clinical guideline 123 (2011).
- Alcohol dependence and harmful alcohol use. NICE clinical guideline 115 (2011).
- Anxiety. NICE clinical guideline 113 (2011).
- Aripiprazole for the treatment of schizophrenia in people aged 15 to 17 years. NICE technology appraisal guidance 213 (2011).
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010).
- Hypertension in pregnancy. NICE clinical guideline 107 (2011).
- Weight management before, during and after pregnancy. NICE public health guidance 27 (2010).
- Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26 (2010).
- Alcohol-use disorders: preventing harmful drinking. NICE public health guidance 24 (2010).
- Alcohol-use disorders: physical complications. NICE clinical guideline 100 (2010).
- Depression in adults. NICE clinical guideline 90 (2009).
- When to suspect child maltreatment. NICE clinical guideline 89 (2009).
- Borderline personality disorder. NICE clinical guideline 78 (2009).
- Antisocial personality disorder. NICE clinical guideline 77 (2009).
- Diabetes in pregnancy. NICE clinical guideline 63 (2008).
- Antenatal care. NICE clinical guideline 62 (2008).
- Maternal and child nutrition. NICE public health guidance 11 (2008).
- Intrapartum care. NICE clinical guideline 55 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Bipolar disorder. NICE clinical guideline 38 (2006).
- Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal guidance 97 (2006).
- Postnatal care. NICE guideline 37 (2006).
- Obsessive-compulsive disorder. NICE clinical guideline 31 (2005).
- Depression in children and young people. NICE clinical guideline 28 (2005).

- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).
- Eating disorders. NICE clinical guideline 9 (2004).
- Guidance on the use of electroconvulsive therapy. NICE technology appraisal guidance 59 (2003).

Under development

NICE is developing the following guidance (details available from the NICE website):

Update of the guideline on bipolar disorder. NICE clinical guideline. Publication expected September 2014.

Update of the guideline on intrapartum care. NICE clinical guideline. Publication expected October 2014.

Update of the guideline on diabetes in pregnancy. NICE clinical guideline. Publication expected February 2015.

Challenging behaviour and learning disabilities. NICE clinical guideline. Publication expected May 2015.

Children's attachment. NICE clinical guideline. Publication expected October 2015.

Preterm labour and birth. NICE clinical guideline. Publication expected June 2016.

Mental health of people in prison. NICE clinical guideline. Publication expected November 2016.

Mental health problems in people with learning disability. NICE clinical guideline. Publication date to be confirmed.

4 The Guideline Development Group, National Collaborating Centre and NICE project team

4.1 Guideline Development Group

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Appendix A: Recommendations from NICE clinical guideline CG45 (2007) that have been deleted or changed

Recommendations to be deleted

The table shows recommendations from 2007 that NICE proposes deleting in the 2014 update. The right-hand column gives the replacement recommendation, or explains the reason for the deletion if there is no replacement recommendation

Recommendation in 2007 guideline	Comment
Women with an existing mental disorder who are pregnant or planning a pregnancy, and women who develop a mental disorder during pregnancy or the postnatal period, should be given culturally sensitive information at each stage of assessment, diagnosis, course and treatment about the impact of the disorder and its treatment on their health and the health of their fetus or child. This information should cover the proper use and likely side effects of medication.[1.1.1.1]	This recommendation has been deleted. The evidence has been reviewed and the GDG have drafted new recommendations on providing information and advice on mental health problems and the benefits and the risks of treatment in pregnancy and the postnatal period, for more detail see recommendations 1.3.1 to 1.3.7.
Healthcare professionals should work to develop a trusting relationship with the woman, and where appropriate and acceptable to the woman, her partner and family members and carers. In particular, they should: - explore the woman's ideas, concerns and expectations and regularly check her understanding of the issues - discuss the level of involvement of the woman's partner, family members and carers, and their role in supporting the woman - be sensitive to the issues of stigma and shame in relation to mental illness. [1.1.1.2]	This recommendation has been deleted because the evidence on experience of care has been reviewed and new recommendations relating to providing information and support to the woman can be found in recommendations 1.2.1 to 1.2.6 and 1.3.1 to 1.3.7.
Healthcare professionals should ensure that adequate systems are in place to ensure continuity of care and effective transfer of information, to reduce the need for multiple assessments.[1.1.1.3]	Replaced by: Ensure that: - the woman's care is fully coordinated when different professional groups and agencies are involved - mental health (including mental wellbeing) is taken into account as part of all care plans, including those for women with physical health problems - there is effective sharing of information with all services involved and the woman herself - all interventions for mental health problems are delivered in a timely manner taking into account the stage of the pregnancy or age of the baby. [new 2014] [1.2.6]
Healthcare professionals should discuss contraception and the risks of pregnancy (including relapse, risk to the fetus and risks associated with stopping or changing medication) with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women	This recommendation has been deleted because the GDG agreed that more detail on the information given to all women of childbearing potential with a mental health problem were needed. See section

should be encouraged to discuss pregnancy plans with their doctor.[1.1.1.4]	1.1.
Healthcare professionals should assess and, where appropriate address, the needs of the partner, family members and carers of a woman with a mental disorder during pregnancy and the postnatal period, including: - the welfare of her infant, and other dependent children and adults -the impact of any mental disorder on relationships with her partner, family members and carers. [1.1.1.5]	Replaced by: Take into account and, if appropriate, assess and address the needs of partners, families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period. These include: - the welfare of the baby and other dependent children and adults - the role of the partner, family or carer in providing support - the effect of any mental health problem on the woman's relationship with her partner, family or carer. [new 2014] [1.2.5]
In all communications (including initial referral) with maternity services, healthcare professionals should include information on any relevant history of mental disorder. [1.2.1.1]	Replaced by: Ensure that all communications with maternity services (including those relating to initial referral) include sharing of information on any past and present mental health problem. [2014] [1.4.2]
At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression. - During the past month, have you often been bothered by feeling down, depressed or hopeless? - During the past month, have you often been bothered by having little interest or pleasure in doing things? A third question should be considered if the woman answers 'yes' to either of the initial questions[3]. - Is this something you feel you need or want help with? [1.2.1.3]	Replaced by: At a woman's first contact with primary care or her booking visit, and during the early postnatal period (for example, at 4 to 6 weeks and 3 to 4 months), ask the following depression identification questions as part of a general discussion about a woman's mental health: - During the past month, have you often been bothered by feeling down, depressed or hopeless? - During the past month, have you often been bothered by having little interest or pleasure in doing things? Also ask about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2): -During the past month, have you been feeling nervous, anxious or on edge? -During the past month have you not been able to stop or control worrying? [new 2014] [1.4.3]

Healthcare professionals may consider the use of self-report measures such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire-9 (PHQ-9) as part of a subsequent assessment or for the routine monitoring of outcomes. [1.2.1.4]	This recommendation has been deleted because the evidence on case identification has been reviewed and new recommendations drafted – see 1.4.3 to 1.4.6.
After identifying a possible mental disorder in a woman during pregnancy or the postnatal period, further assessment should be considered, in consultation with colleagues if necessary. - If the healthcare professional or the woman has significant concerns, the woman should normally be referred for further assessment to her GP. - If the woman has, or is suspected to have, a severe mental illness (for example, bipolar disorder or schizophrenia), she should be referred to a specialist mental health service, including, if appropriate, a specialist perinatal mental health service. This should be discussed with the woman and preferably with her GP. - The woman's GP should be informed in all cases in which a possible current mental disorder or a history of significant mental disorder is detected, even if no further assessment or referral is made. [1.2.1.5]	This recommendation has been deleted because the evidence on assessment has been reviewed and new recommendations drafted – see section 1.5.
If a woman has a current mental disorder or a history of severe mental illness, she should be asked about her mental health at all subsequent contacts. [1.2.1.6]	Replaced by: At a woman's first contact with services in pregnancy and the postnatal period, ask about: - any past or present severe mental illness - previous treatment by a specialist mental health service, including inpatient care - any severe perinatal mental illness in a first-degree relative (mother, sister or daughter). [new 2014] [1.4.7]
A written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of severe mental illness, usually in the first trimester. It should: - be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals - include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services)	Replaced by: Professionals in secondary mental health services, including specialist perinatal mental health services, should develop a written care plan in collaboration with a woman who has or has had a severe mental illness. If she agrees, her partner, family or carer should also be involved. The plan should cover pregnancy, childbirth and the postnatal period (including the potential impact of the

- be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes) and communicated to the woman and all relevant healthcare professionals. [1.2.1.7]	illness on the baby) and should include: - a clear statement of jointly agreed treatment goals and how outcomes will be routinely monitored - increased contact with and referral to specialist perinatal mental health services - the names and contact details of key professionals. The care plan should be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes) and a copy given to the woman and all involved professionals. [new 2014] [1.5.6]
For pregnant women who have symptoms of depression and/or anxiety that do not meet diagnostic criteria but significantly interfere with personal and social functioning, healthcare professionals should consider: - for women who have had a previous episode of depression or anxiety, offering individual brief psychological treatment (four to six sessions), such as interpersonal psychotherapy (IPT) or cognitive behavioural therapy (CBT) - for women who have not had a previous episode of depression or anxiety, offering social support during pregnancy and the postnatal period; such support may consist of regular informal individual or group-based support. [1.3.1.1]	Replaced by: For a woman with persistent subthreshold depressive symptoms, or mild to moderate depression, in pregnancy or the postnatal period, consider facilitated self-help (delivered as described in recommendation 1.4.2.2 of the guideline on depression in adults [NICE clinical guideline 90]). [new 2014] [1.6.6]
Psychosocial interventions (for example, group psychoeducation) designed specifically to reduce the likelihood of developing a mental disorder during pregnancy or the postnatal period should not be part of routine antenatal and postnatal care. [1.3.1.2]	This recommendation has been deleted because the evidence on psychosocial interventions has been reviewed and new recommendations drafted.
Single-session formal debriefing focused on the birth should not be routinely offered to women who have experienced a traumatic birth. However, maternity staff and other healthcare professionals should support women who wish to talk about their experience, encourage them to make use of natural support systems available from family and friends, and take into account the effect of the birth on the partner. [1.3.1.3]	This recommendation has been deleted because the evidence on psychosocial interventions has been reviewed and new recommendations drafted.
Mothers whose infants are stillborn or die soon after birth should not be routinely encouraged to	Replaced by: Discuss with a woman whose baby is

see and hold the dead infant. These women should be offered an appropriate follow-up appointment in primary or secondary care. [1.3.1.4]	stillborn or dies soon after birth, and her partner and family, the options of seeing a photograph of the baby, having mementos of the baby, seeing the baby or holding the baby. This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. [new 2014] [1.7.8]
Women requiring psychological treatment should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological therapies during pregnancy and the postnatal period arising from the changing risk–benefit ratio for psychotropic medication at this time. [1.4.1.1]	Replaced by: When a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, assess for treatment within 2 weeks of referral and provide psychological interventions normally within 1 month of initial assessment. [new 2014] [1.6.3]
Discussions about treatment options with a woman with a mental disorder who is planning a pregnancy, pregnant or breastfeeding should cover: - the risk of relapse or deterioration in symptoms and the woman's ability to cope with untreated or subthreshold symptoms - severity of previous episodes, response to treatment and the woman's preference - the possibility that stopping a drug with known teratogenic risk after pregnancy is confirmed may not remove the risk of malformations - the risks from stopping medication abruptly - the need for prompt treatment because of the potential impact of an untreated mental disorder on the fetus or infant - the increased risk of harm associated with drug treatments during pregnancy and the postnatal period, including the risk in overdose - treatment options that would enable the woman to breastfeed if she wishes, rather than recommending she does not breastfeed. [1.4.1.2]	This recommendation has been deleted because it has been replaced by more comprehensive recommendations relating to giving information and advice to all women of childbearing potential, who are planning a pregnancy and who are pregnant.
When prescribing a drug for a woman with a mental disorder who is planning a pregnancy, pregnant or breastfeeding, prescribers should: - choose drugs with lower risk profiles for the mother and the fetus or infant - start at the lowest effective dose, and slowly increase it; this is particularly important	Replaced by: When psychotropic medication is started in pregnancy and the postnatal period, consider seeking advice, preferably from a specialist in perinatal mental health, and: -choose the drug with the lowest risk

where the risks may be dose related - use monotherapy in preference to combination treatment - consider additional precautions for preterm, low birthweight or sick infants. [1.4.1.3]	profile for the woman, fetus and baby -use the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may also expose the fetus to risks -use a single drug, if possible, in preference to 2 or more drugs -take into account the impact of fluctuating drug plasma levels during pregnancy. [2014] [1.3.13]
When stopping a drug in a woman with a mental disorder who is planning a pregnancy, pregnant or breastfeeding, take into account: - NICE guidance on the specific disorder (see section 6) - the risk to the fetus or infant during the withdrawal period - the risk from not treating the disorder. [1.4.1.4]	Replaced by: When a woman with severe mental illness decides to stop psychotropic medication in pregnancy and the postnatal period, discuss with her: - her reasons for doing so - the possibility of: -restarting the medication -switching to other medication with a lower risk profile -increasing the level of monitoring and support. Ensure she knows about any risks to herself, the fetus or baby when stopping medication. [new 2014] [1.3.14] When a woman with depression or an anxiety disorder decides to stop taking psychotropic medication in pregnancy and the postnatal period, discuss with her: -her reasons for doing so -the possibility of: -having a psychological intervention -restarting the medication if the depression or anxiety disorder is severe and there has been a previous good response to treatment -switching to other medication with a lower risk profile -increasing the level of monitoring and support while she is not taking any medication. Ensure she knows about any risks to herself, the fetus or baby when stopping medication. [new 2014] [1.3.15]

Before treatment decisions are made, healthcare professionals should discuss with the woman the absolute and relative risks associated with treating and not treating the mental disorder during pregnancy and the postnatal period. They should: - acknowledge the uncertainty surrounding the risks - explain the background risk of fetal malformations for pregnant women without a mental disorder - describe risks using natural frequencies rather than percentages (for example, 1 in 10 rather than 10%) and common denominators (for example, 1 in 100 and 25 in 100, rather than 1 in 100 and 1 in 4) - if possible use decision aids in a variety of verbal and visual formats that focus on an individualised view of the risks - provide written material to explain the risks (preferably individualised) and, if possible, audio-taped records of the consultation. [1.4.1.5]	Replaced by: When discussing likely benefits and risks of treatment with the woman, and if she agrees her partner, family or carer: - acknowledge the woman's central role in reaching a decision about her treatment and that the role of the professional is to inform that decision with balanced and up-to-date information and advice - use absolute values based on a common denominator (that is, numbers out of 100 or 1000) - acknowledge and describe, if possible, the uncertainty around any estimate of risk, harm or benefit - use high-quality decision aids in a variety of numerical and pictorial formats that focus on a personalised view of the risks and benefits, in line with the guidance on patient experience in adult NHS services (NICE clinical guidance 138) - consider providing records of the consultation, in a variety of visual, verbal or audio formats if possible. [new 2014] [1.3.7]
If a woman taking paroxetine is planning a pregnancy or has an unplanned pregnancy, she should be advised to stop taking the drug. [1.4.1.6]	This recommendation has been deleted because the evidence relating to pharmacological interventions has been reviewed.
When choosing an antidepressant for pregnant or breastfeeding women, prescribers should, while bearing in mind that the safety of these drugs is not well understood, take into account that: - tricyclic antidepressants, such as amitriptyline, imipramine and nortriptyline, have lower known risks during pregnancy than other antidepressants - most tricyclic antidepressants have a higher fatal toxicity index than selective serotonin reuptake inhibitors (SSRIs) - fluoxetine is the SSRI with the lowest known risk during pregnancy - imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels -citalopram and fluoxetine are present in breast	This recommendation has been deleted because the evidence relating to pharmacological interventions has been reviewed.

milk at relatively high levels - SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate - paroxetine taken in the first trimester may be associated with fetal heart defects - venlafaxine may be associated with increased risk of high blood pressure at high doses, higher toxicity in overdose than SSRIs and some tricyclic antidepressants, and increased difficulty in withdrawal - all antidepressants carry the risk of withdrawal or toxicity in neonates; in most cases the effects are mild and self-limiting. [1.4.1.7]	
Benzodiazepines should not be routinely prescribed for pregnant women, except for the short-term treatment of extreme anxiety and agitation. This is because of the risks to the fetus (for example, cleft palate) and the neonate (for example, floppy baby syndrome). Consider gradually stopping benzodiazepines in women who are pregnant. [1.4.1.8]	Replaced by: Do not offer benzodiazepines to women in pregnancy and the postnatal period except for the short-term treatment of extreme anxiety and agitation. [2014] [1.3.19]
Women taking antipsychotics who are planning a pregnancy should be told that the raised prolactin levels associated with some antipsychotics (notably amisulpride, risperidone and sulpiride) reduce the chances of conception. If prolactin levels are raised, an alternative drug should be considered. [1.4.1.9]	This recommendation has been deleted because the evidence relating to pharmacological interventions has been reviewed.
If a pregnant woman is taking clozapine, switching to another drug and careful monitoring should be considered. Clozapine should not be routinely prescribed for women who are pregnant (because there is a theoretical risk of agranulocytosis in the fetus) or for women who are breastfeeding (because it reaches high levels in breast milk and there is a risk of agranulocytosis in the infant). [1.4.1.10]	Replaced by: Do not routinely offer the following drugs to women who are breastfeeding: - carbamazepine (because of the risk of liver toxicity in the baby) - clozapine (because of the risk of agranulocytosis and seizures in the baby) - depot antipsychotics (because of the risk of extrapyramidal symptoms in the baby several months after administration) - lithium (because of the potentially high levels of the drug in breast milk and the risks of toxicity in the baby). [new 2014] [1.7.12]
When deciding whether to prescribe olanzapine to a woman who is pregnant, risk factors for gestational diabetes and weight gain, including family history, existing weight and ethnicity, should be taken into account. [1.4.1.11]	This recommendation has been deleted because the evidence relating to pharmacological interventions has been reviewed.

Depot antipsychotics should not be routinely prescribed to pregnant women because there is relatively little information on their safety, and their infants may show extrapyramidal symptoms several months after administration of the depot. These are usually self-limiting. [1.4.1.12]	Replaced by: Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication. This is because there are limited data on safety in pregnancy and babies may show extrapyramidal symptoms several months after administration of the depot. [new 2014] [1.3.27]
Anticholinergic drugs should not be prescribed for the extrapyramidal side effects of antipsychotic drugs except for acute short-term use. Instead, the dose and timing of the antipsychotic drug should be adjusted, or the drug changed. [1.4.1.13]	This recommendation has been deleted because the evidence relating to pharmacological interventions has been reviewed.
Valproate should not be routinely prescribed to women of child-bearing potential. If there is no effective alternative, the risks of taking valproate during pregnancy, and the importance of using adequate contraception, should be explained. [1.4.1.14]	Replaced by: Do not offer valproate to treat a mental health problem in women of present and future childbearing potential. [new 2014] [1.1.3]
Valproate should not be prescribed to women younger than 18 years because of the risk of polycystic ovary syndrome and increased risk of unplanned pregnancy in this age group. [1.4.1.15]	This recommendation has been deleted because the guideline update recommends that valproate should not be offered to any woman or girl of childbearing potential.
If a woman who is taking valproate is planning a pregnancy, or is pregnant, she should be advised to stop taking the drug. Where appropriate in the treatment of bipolar disorder, an alternative drug (usually an antipsychotic) should be considered.[1.4.1.16]	Replaced by: If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy. Take into account the risks and benefits of other treatments and offer another drug (for example, quetiapine for treating bipolar disorder). [2014] [1.3.29] And If a woman is already taking valproate and becomes pregnant, stop the drug because of the risk of fetal malformations and adverse neurodevelopmental outcomes. Take into account the risks and benefits of other treatments and offer another drug (for example, quetiapine for

	treating bipolar disorder). [2014] [1.3.30]
If there is no alternative to valproate, doses should be limited to a maximum of 1 gram per day, administered in divided doses and in the slow release form, with 5 mg/day folic acid. However, it is not clear how the serum level of valproate affects the risk of abnormalities. [1.4.1.17]	This recommendation has been deleted because the guideline update advises against the use of valproate.
Lithium should not be routinely prescribed for women, particularly in the first trimester of pregnancy (because of the risk of cardiac malformations in the fetus) or during breastfeeding (because of the high levels in breast milk). [1.4.1.18]	Replaced by: Do not offer lithium to women who are planning a pregnancy or pregnant, unless no other medication is likely to be effective. [new 2014] [1.3.34]
If a woman taking lithium is planning a pregnancy, and is well and not at high risk of relapse, she should be advised to stop taking the drug because of the risk of cardiac malformations in the fetus. [1.4.1.19]	Replace by: If a woman taking lithium becomes pregnant, consider stopping the drug gradually over 4 weeks if she is well and not at high risk of relapse. Explain that this may not remove the risk of fetal heart malformations. [2014] [1.3.36]
If a woman who is taking lithium becomes pregnant: - if the pregnancy is confirmed in the first trimester, and the woman is well and not at high risk of relapse, lithium should be stopped gradually over 4 weeks; it should be explained that this may not remove the risk of cardiac defects in the fetus - if the woman is not well or is at high risk of relapse, the following should be considered: - switching gradually to an antipsychotic, or - stopping lithium and restarting it in the second trimester if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past, or - continuing with lithium if she is at high risk of relapse. [1.4.1.20]	Replaced by: If a woman taking lithium becomes pregnant and is not well or is at high risk of relapse, consider: - switching gradually to an antipsychotic, or - stopping lithium and restarting it in the third trimester (if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past), or - continuing with lithium if she is at high risk of relapse and no other medication is likely to be effective. [new 2014] [1.3.37]
If a woman who is taking carbamazepine or lamotrigine is planning a pregnancy or has an unplanned pregnancy, healthcare professionals should advise her to stop taking these drugs because of the risk of neural tube defects and other malformations in the fetus. If appropriate an alternative drug (such as an antipsychotic) should be considered. [1.4.1.23]	Replaced by: If a woman is already taking carbamazepine and is planning a pregnancy or becomes pregnant, consider, in discussion with the woman, stopping the drug (because of the possible risk of adverse drug interactions or fetal malformations) and switching to another drug (usually an antipsychotic, for

	example, quetiapine for treating bipolar disorder). [new 2014] [1.3.31]
Carbamazepine or lamotrigine should not be routinely prescribed for women who are pregnant because of the lack of evidence of efficacy and the risk of neural tube defects in the fetus. [1.4.1.24]	Replaced by: Do not offer valproate or carbamazepine to stabilise mood in women who are planning a pregnancy, pregnant or considering breastfeeding. [new 2014] [1.3.28]
Lamotrigine should not be routinely prescribed for women who are breastfeeding because of the risk of dermatological problems in the infant, such as Stevens–Johnson syndrome. [1.4.1.25]	This recommendation has been deleted because the evidence on pharmacological interventions has been reviewed and the recommendations revised.
If a pregnant woman was taking drugs with known teratogenic risk (lithium, valproate, carbamazepine, lamotrigine and paroxetine) at the time of conception and/or in the first trimester, healthcare professionals should: - confirm the pregnancy as quickly as possible - offer appropriate screening and counselling about the continuation of the pregnancy, the need for additional monitoring and the risks to the fetus if the woman continues to take medication - undertake a full paediatric assessment of the newborn infant - monitor the infant in the first few weeks after delivery for adverse drug effects, drug toxicity or withdrawal (for example, floppy baby syndrome, irritability, constant crying, shivering, tremor, restlessness, increased tone, feeding and sleeping difficulties and, rarely, seizures); if the mother was prescribed antidepressants in the last trimester, these may result from serotonergic toxicity syndrome rather than withdrawal. [1.4.1.26]	Replaced by: If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester: - confirm the pregnancy as soon as possible - explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations - offer screening for fetal abnormalities and counselling about continuing the pregnancy - explain the need for additional monitoring and the risks to the fetus if she continues to take the medication. Seek specialist advice if there is uncertainty about the risks associated with specific drugs. [new 2014] [1.3.16]
Infants of mothers who are breastfeeding while taking psychotropic medication should be monitored for adverse reactions. [1.4.1.27]	Replaced by: If a woman is taking psychotropic medication while breastfeeding, monitor the baby for adverse effects. [2014] [1.7.13]
Pregnant women with a mental disorder who have sleep problems should initially be given general advice about sleep hygiene (including bedtime routines, the avoidance of caffeine, and the reduction of activity before sleep). For women with serious and chronic problems, low-dose chlorpromazine or low-dose amitriptyline may be considered. [1.4.1.28]	Replaced by: Advise pregnant women who have a sleep problem about sleep hygiene (including having a healthy bedtime routine, avoiding caffeine and reducing activity before sleep). For women with a severe or chronic sleep problem, consider promethazine. [new 2014] [1.6.24]
If a woman being treated for mild depression is taking an antidepressant, the medication should	This recommendation has been deleted because the psychosocial

be withdrawn gradually and monitoring ('watchful waiting') considered. If intervention is then needed the following should be considered: - self-help approaches (guided self-help, computerised CBT [C-CBT], exercise) or - brief psychological treatments (including counselling, CBT and IPT). [1.4.1.31]	evidence has been reviewed and the recommendations have been revised.
If a woman is taking an antidepressant and her latest presentation was a moderate depressive episode, the following options should be discussed with the woman, taking into account previous response to treatment, her preference, and risk: - switching to psychological therapy (CBT or IPT) - switching to an antidepressant with lower risk. [1.4.1.32]	The recommendation has been deleted because the evidence relating to treatment interventions has been reviewed and the recommendations revised.
If a woman is taking an antidepressant and her latest presentation was a severe depressive episode, the following options should be discussed with the woman, taking into account previous response to treatment, her preference, and risk: - combining drug treatment with psychological treatment, but switching to an antidepressant with lower risk - switching to psychological treatment (CBT or IPT). [1.4.1.33]	The recommendation has been deleted because the evidence relating to treatment interventions has been reviewed and the recommendations revised.
For a woman who develops mild or moderate depression during pregnancy or the postnatal period, the following should be considered: - self-help strategies (guided self-help, C-CBT or exercise) - non-directive counselling delivered at home (listening visits) brief CBT or IPT. [1.4.1.34]	The recommendation has been deleted because the evidence relating to treatment interventions has been reviewed and the recommendations revised.
Antidepressant drugs should be considered for women with mild depression during pregnancy or the postnatal period if they have a history of severe depression and they decline, or their symptoms do not respond to, psychological treatments. [1.4.1.35]	The recommendation has been deleted because the evidence relating to treatment interventions has been reviewed and the recommendations revised.
For a woman with a moderate depressive episode and a history of depression, or with a severe depressive episode during pregnancy or the postnatal period, the following should be considered: - structured psychological treatment specifically for depression (CBT or IPT) - antidepressant treatment if the woman has expressed a preference for it	The recommendation has been deleted because the evidence relating to treatment interventions has been reviewed and the recommendations revised.

- combination treatment if there is no response, or a limited response to psychological or drug treatment alone, provided the woman understands the risks associated with antidepressant medication. [1.4.1.36]	
For pregnant women with treatment-resistant depression, a trial of a different single drug or ECT should be considered before combination drug treatment. Lithium augmentation should be avoided. [1.4.1.37]	The recommendation has been deleted because the evidence relating to treatment interventions has been reviewed and the recommendations revised.
If a woman is planning a pregnancy or becomes pregnant while being treated with medication for GAD, the following should be considered: - stopping medication and starting CBT if it has not already been tried - if necessary, switching to a safer drug, if the decision is to maintain medication. [1.4.1.38]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
A woman who has a new episode of GAD during pregnancy should be treated according to the NICE guideline on anxiety, and CBT should be offered. [1.4.1.39]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
If a woman is planning a pregnancy or becomes pregnant while being treated for panic disorder, the following should be considered: - stopping medication and starting CBT if it has not already been tried - if necessary, switching to a safer drug, if the decision is to maintain medication.	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
For women who have a new episode of panic disorder during pregnancy, psychological therapy (CBT), self-help or C-CBT should be considered before starting drug treatment. [1.4.1.41]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
For women who have a new episode of panic disorder during pregnancy, paroxetine should not be started and a safer drug should be considered.	The recommendation has been deleted because the evidence for psychological and pharmacological

[1.4.1.42]	interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
A woman with OCD who is planning a pregnancy or pregnant should be treated according to the NICE clinical guideline on OCD except that: - if she is taking medication alone, stopping the drug and starting psychological therapy should be considered - if she is not taking medication, starting psychological therapy should be considered before drug treatment - if she is taking paroxetine, it should be stopped and switching to a safer antidepressant considered.[1.4.1.43]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
A pregnant woman with OCD who is planning to breastfeed should be treated according to the NICE clinical guideline on OCD, except that the use of a combination of clomipramine and citalopram should be avoided if possible. [1.4.1.44]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
A woman who has a new episode of OCD while breastfeeding should be treated according to the NICE clinical guideline on OCD, except that the combination of clomipramine and citalopram should be avoided because of the high levels in breast milk. [1.4.1.45]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
A woman with PTSD who is planning a pregnancy or pregnant should be treated according to the NICE clinical guideline on PTSD, except that if she is taking an antidepressant the drug should be stopped and trauma-focused psychological therapy (for example, CBT or eye movement desensitisation and reprocessing therapy) offered. [1.4.1.46]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
For a woman with PTSD who is planning a pregnancy or pregnant, adjunctive olanzapine	The recommendation has been deleted because the evidence for

should not be prescribed.[1.4.1.47]	psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems, the recommendation was deleted.
A woman with anorexia nervosa who is planning a pregnancy, has an unplanned pregnancy or is breastfeeding should be treated according to the NICE clinical guideline on eating disorders. [1.4.1.48]	Replaced by: For a woman with an eating disorder in pregnancy or the postnatal period: - offer a psychological intervention in line with the guideline on eating disorders (NICE clinical guideline 9) - monitor the woman's condition carefully throughout pregnancy and the postnatal period - discuss the importance of healthy eating during pregnancy and the postnatal period in line with guidance on maternal and child nutrition (NICE public health guidance 11) - advise her about feeding the baby and support her with this in line with guidance on maternal and child nutrition (NICE public health guidance 11). [new 2014] [1.6.14]
A woman with binge eating disorder who is taking an antidepressant and is planning a pregnancy, has an unplanned pregnancy or is breastfeeding should be treated according to the section on depression in this guideline (recommendations 1.4.8.1–7). [1.4.1.49]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems
If a woman who is taking medication for bulimia nervosa is planning a pregnancy or pregnant, healthcare professionals should consider gradually stopping the medication after discussion with her. If the problem persists, referral for specialist treatment should be considered. [1.4.1.50]	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was not different from that specified in other NICE guidelines for mental health problems.
If a woman has an episode of bulimia nervosa while breastfeeding, psychological treatment should be offered, rather than fluoxetine at 60 mg. If a woman is already taking fluoxetine at 60 mg, she should be advised not to breastfeed.	The recommendation has been deleted because the evidence for psychological and pharmacological interventions was reviewed. Where the recommended treatment for a specific mental health problem was

[1.4.1.51]	not different from that specified in other NICE guidelines for mental health problems.
If a pregnant woman with bipolar disorder is stable on an antipsychotic and likely to relapse without medication, she should be maintained on the antipsychotic, and monitored for weight gain and diabetes. [1.4.1.52]	Replaced by: If a pregnant woman is stable on an antipsychotic and likely to relapse without medication, advise her to continue the antipsychotic. [new 2014] [1.3.24]
If a woman who needs antimanic medication plans to become pregnant, a low dose typical or atypical antipsychotic should be the treatment of choice. [1.4.1.53]	Replaced by: If a pregnant woman develops mania or psychosis and is not taking psychotropic medication, offer an antipsychotic. [new 2014] [1.6.19]
If a woman with bipolar disorder planning a pregnancy becomes depressed after stopping prophylactic medication, psychological therapy (CBT) should be offered in preference to an antidepressant because of the risk of switching to mania associated with antidepressants. If an antidepressant is used, it should usually be an SSRI (but not paroxetine) and the woman should be monitored closely. [1.4.1.54]	Replaced by: Consider psychological interventions for women with bipolar disorder. This includes: - an intervention such as CBT, IPT and behavioural couples therapy for bipolar depression - individual, group and family interventions for reducing the risk of relapse, particularly when medication is changed or stopped. [new 2014] [1.6.18]
If a woman with bipolar disorder has an unplanned pregnancy and is stopping lithium as prophylactic medication, an antipsychotic should be offered. [1.4.1.55]	Replaced by: Offer antipsychotic medication (for example, quetiapine) if a woman with bipolar disorder becomes pregnant and is stopping lithium as prophylactic medication. [new 2014] [1.6.22]
If a pregnant woman who is not taking medication develops acute mania, a typical or an atypical antipsychotic should be considered. The dose should be kept as low as possible and the woman monitored carefully.[1.4.1.56]	This recommendation has been deleted because the pharmacological evidence has been reviewed and new recommendations have been drafted.
If a pregnant woman develops acute mania while taking prophylactic medication, prescribers should: - check the dose of the prophylactic agent and adherence - increase the dose if the woman is taking an antipsychotic, or consider changing to an antipsychotic if she is not - if there is no response to changes in dose or drug and the patient has severe mania, consider the use of ECT, lithium and, rarely, valproate.	Replaced by: If a pregnant woman with bipolar disorder develops mania while taking prophylactic medication: - check the dose of the prophylactic medication and adherence - increase the dose if the prophylactic medication is an antipsychotic - suggest changing to an antipsychotic if she is taking

[1.4.1.57]	another type of prophylactic medication - consider lithium if there is no response to an increase in dose or change of drug and the woman has severe mania - consider electroconvulsive therapy (ECT) if there has been no response to lithium. [new 2014] [1.6.23]
If there is no alternative to valproate, augmenting it with antimanic medication (but not carbamazepine) should be considered. [1.4.1.58]	This recommendation has been deleted because the pharmacological evidence has been reviewed and new recommendations have been drafted.
For mild depressive symptoms in pregnant women with bipolar disorder the following should be considered, in this order: - self-help approaches such as guided self-help and C-CBT - brief psychological treatments (including counselling, CBT and IPT) [1.4.1.59]	This recommendation has been deleted because the pharmacological evidence has been reviewed and new recommendations have been drafted.
For moderate to severe depressive symptoms in pregnant women with bipolar disorder the following should be considered: - psychological treatment (CBT) for moderate depression - combined medication and structured psychological treatments for severe depression. [1.4.1.60]	This recommendation has been deleted because the psychological evidence has been reviewed and new recommendations have been drafted.
If prescribing medication for moderate to severe depressive symptoms in a pregnant woman with bipolar disorder, quetiapine alone, or SSRIs (but not paroxetine) in combination with prophylactic medication should be preferred because SSRIs are less likely to be associated with switching to mania than the tricyclic antidepressants. Monitor closely for signs of switching and stop the SSRI if the woman starts to develop manic or hypomanic symptoms. [1.4.1.61]	This recommendation has been deleted because the evidence on pharmacological interventions has been reviewed and new recommendations have been drafted.
After delivery, if a woman with bipolar disorder who is not on medication is at high risk of developing an acute episode, prescribers should consider establishing or reinstating medication as soon as the woman is medically stable (once the fluid balance is established). [1.4.1.62]	Replaced by: After childbirth, review and assess the need for starting, restarting or adjusting psychotropic medication in a woman with a severe mental illness as soon as she is medically stable (once the fluid balance is established). [new 2014] [1.7.1]
If a woman maintained on lithium is at high risk of a manic relapse in the immediate postnatal period, augmenting treatment with an	This recommendation has been deleted because the evidence on pharmacological interventions has

antipsychotic should be considered. [1.4.1.63]	been reviewed and new recommendations have been drafted.
Women with bipolar disorder who are taking psychotropic medication and wish to breastfeed should be offered a prophylactic agent that can be used when breastfeeding. The first choice should be an antipsychotic. [1.4.1.64]	This recommendation has been deleted because the evidence on pharmacological interventions has been reviewed and new recommendations have been drafted.
Women with schizophrenia who are planning a pregnancy or pregnant should be treated according to the NICE clinical guideline on schizophrenia, except that if the woman is taking an atypical antipsychotic consideration should be given to switching to a low-dose typical antipsychotic, such as haloperidol, chlorpromazine or trifluoperazine. [1.4.1.65]	This recommendation has been deleted because the evidence on pharmacological interventions has been reviewed and new recommendations have been drafted.
A woman with schizophrenia who is breastfeeding should be treated according to the NICE clinical guideline on schizophrenia, except that women receiving depot medication should be advised that their infants may show extrapyramidal symptoms several months after administration of the depot. These are usually self-limiting.[1.4.1.66]	This recommendation has been deleted because the evidence on pharmacological interventions has been reviewed and new recommendations have been drafted.