National Institute for Health and Care Excellence

4-year surveillance (2017) – Antenatal and postnatal mental health (2014) NICE guideline CG192

Appendix B: stakeholder consultation comments table

Consultation dates: 7 to 20 March 2017

Do you agree with the proposal not to update the guideline?

Stakeholder	Overall response	Comments	NICE response
Royal College of Nursing	Yes	We agree with the proposal not to update the guideline based on the review of the recent evidence.	Thank you for your comment.
University Hospitals of Leicester NHS Trust (on behalf of the UK Drugs in Lactation Advisory Service)	No	**General comment.** The Guideline gives recommendations regarding various antipsychotics which should not be used during the breastfeeding period. We do not believe that the evidence base for this has been considered, and that such statements are based on pregnancy data only. 1.4.17 Guidelines states: *Seek advice from a specialist (preferably from a specialist perinatal mental health service) if there is uncertainty about specific drugs* *Consideration to be given to a recommendation to contact the UK Drugs in Lactation Advisory Service* *(now funded by NHS England)* www.sps.nhs.uk/articles/ukdilas/ 1.4.27 The overall recommendation by our Service, having considered all the evidence, is that valproate can be used with caution in breastfeeding with adequate monitoring. It is not contra-indicated. www.sps.nhs.uk/medicines/sodium-valproate/ (scroll all the way down to the lactation section near the bottom of the page. See also: Breastfeeding in Children of Women Taking Antiepileptic Drugs Cognitive Outcomes at Age 6 Years. Meador KJ; Baker GA; Browning N et al, JAMA Pediatr. 2014;168(8):729-736. [Additional evidence can be provided if required] 1.4.30	Thank you for your comment. We have considered your suggestion to add to recommendations 1.9.9 and 1.4.17 advising people to contact the UK Drugs in lactation Advisory Service. However, we do not think this should replace the recommendation to seek advice from a specialist perinatal mental health service. As such, we feel the addition of a footnote would be the most appropriate action. In relation to amending recommendation 1.9.11, no evidence was identified through the surveillance review to support the suggested additions. We have reviewed the information supplied on the use of valproate, carbamazepine and lithium when breastfeeding. The study by Meador et al (2014) would not meet the criteria for inclusion in the surveillance review as it was an observational study rather than a clinical trial. Additionally, the study by Uguz and Sharma (2016) would not meet the criteria for consideration in the surveillance review as only one database was searched and no results data is reported in the abstract. In terms of mental health conditions, valproate is only licensed for the treatment of manic episodes in bipolar disorder when lithium is contraindicated or not tolerated. In developing the guideline, the committee was of the view

		The overall recommendation by our Service, having considered all the evidence, is that carbamazepine can be used with caution in breastfeeding with adequate monitoring. It is not contra-indicated. www.sps.nhs.uk/medicines/carbamazepine/ See also: Breastfeeding in Children of Women Taking Antiepileptic Drugs Cognitive Outcomes at Age 6 Years. Meador KJ; Baker GA; Browning N et al, JAMA Pediatr. 2014;168(8):729-736. [Additional evidence can be provided if required] 1.9.8 Again, the overall recommendation by our Service is that carbamazepine, lithium and valproate can be used with caution during breastfeeding. See above for links to recommendations we make regarding valproate and carbamazepine. See the following link for recommendation for lithium www.sps.nhs.uk/medicines/lithium/. See also Mood stabilizers during breastfeeding: a systematic review of the recent literature Faruk Uguz; Verinder Sharma. Bipolar Disord 2016; 18: 325–333. Viguera AC, Newport, DJ, Ritchie J, Stowe Z, Whitfield T, Mogielnicki J, Baldessarini RJ, Zurick A, Cohen LS. Lithium in breast milk and nursing infants: clinical implications. Am J Psychiatry 2007; 164(2):342-345. [Further evidence can be provided if required] 1.9.9 Guidelines states: *Seek advice from a specialist (preferably from a specialist perinatal mental health service) if there is uncertainty about specific drugs* *Consideration to be given to a recommendation to contact the UK Drugs in Lactation Advisory Service (now funded by NHS England) www.sps.nhs.uk/articles/ukdilas/* 1.9.11 Consider added the following: If a woman is taking psychotropic medication whilst breastfeeding, monitor the baby for adverse effects, *adequate feeding and weight gain*	that the evidence of significant harms (both congenital and neurodevelopmental) to the fetus associated with valproate was such that it should not be used in the acute or long-term treatment of a mental health problem in women of childbearing potential. This would also cover women that are breastfeeding. This lead to the development of the following recommendation: Do not offer valproate for acute or long-term treatment of a mental health problem in women of childbearing potential. [new 2014]. This is also consistent with recommendations made in NICE's guideline on bipolar disorder. During guideline development, evidence was identified showing carbamazepine was associated with an increased rate of congenital harms, albeit not at the same level as valproate and not at a level which would preclude the use of carbamazepine in women of childbearing potential. However, the risk of harm associated with carbamazepine was greater than that observed for lamotrigine and the committee recommended that carbamazepine is not offered for the treatment of a mental health problem to women who are planning a pregnancy, pregnant or considering breastfeeding. No new evidence on valproate or carbamazepine use in women of childbearing potential or breastfeeding was identified through the surveillance review to change current guidance. In terms of lithium, the British National Formulary states that lithium salts should be avoided when breastfeeding due to risk of toxicity in the infant. This information supports the current recommendation (1.9.8): Encourage women with a mental health problem to breastfeed, unless they are taking carbamazepine, clozapine or lithium (valproate is not recommended to treat a mental health problem in women of childbearing potential). However, support each woman in the choice of feeding method that best suits her and her family. **[new 2014]**
The Royal College of Midwives (RCM)	No	We disagree with the proposal as we consider that the following areas need updating at this point. Page 24: Why use the term **Anticonvulsants** for mental health problems (valproate, carbamazepine and lamotrigine). This should be updated to call them Antiepileptic drugs.	Thank you for your comment. We have considered your proposal to replace the term anticonvulsants with antiepileptic drugs. The term anticonvulsant is also used across NICE's guidelines on bipolar disorder, autism spectrum disorder in adults, low

		1.4.28 please add to this statement: Ensure women are aware of the importance of maintaining effective contraception until valproate is completely withdrawn. There should be clear documented evidence at each medical consultation that any woman continuing to take valproate has been provided with the valproate toolkit and that the valproate consultation checklist has been completed and signed by the prescriber and patient. Available from: https://www.gov.uk/drug-safety-update/valproate-and-of-risk-of-abnormal-pregnancy-outcomes-new-communication-materials 1.4.32 If an increase in lamotrigine is made during pregnancy, it is important to have a postpartum medication plan in place to taper the lamotrigine dosage back to preconception levels following the birth. This is to avoid lamotrigine toxicity which can adversely affect the mother and her baby if she is breast feeding[1,2]. It is important to include this because waiting for a serum level to return can be protracted (in some units this takes up to 4 weeks). This wait can seriously impact on the health of the mother and her baby if the medication has not been reduced whilst waiting for this result. **Women with epilepsy who are taking antiepileptic drugs in pregnancy should be encouraged to breastfeed** [3,4,5] Why is the latest evidence based information not included about breast feeding for women taking antiepileptic drugs for mental health illness in these guidelines? The information on pregnancy exposure teratogenecity and breast feeding advice for any drugs used for mental health illness in pregnancy in these guidelines lacks review of the latest evidence-based research. **Please note, women on SSRI's were found to have a significant increased risk of preterm birth[6]** As this is a systematic review and meta analysis this should be discussed in this guideline as it is in contrast to the findings from Malm et al. (2015)[7] **References** 1. Sabers A (2012) Algorithm for lamotrigine dose adjustment before, during, and after pregnancy. *Acta Neurol Scand* 126: e1-4. 2. Kinney, M, & Morrow, J 2016, 'Epilepsy in pregnancy', *BMJ (Online),* 353, Scopus®, EBSCOhost, viewed 15 March 2017 3. Royal College of Obstetricians and Gynaecologists (2016) Epilepsy in Pregnancy. Green-top Guideline No. 68. Royal College of Obstetricians and Gynaecologists 4. Veiby, G, Bjørk, M, Engelsen, B, & Gilhus, N 2015, 'Epilepsy and recommendations for breastfeeding', Seizure, 28, pp. 57-65, MEDLINE, EBSCOhost, viewed 15 March 2017. 5. Meador KJ, Baker GA, Browning N, Clayton-Smith J, Combs-Cantrell DT, Cohen M, et al (2010) NEAD Study Group. Effects of breastfeeding in children of women taking antiepileptic drugs. *Neurology* 75:1954–60.	back pain and sciatica in over 16s and generalised anxiety disorder and panic disorder in adults as the medicines are being referred to for non-epilepsy indications. As a result, we do not feel that this change is needed. We agree with your proposal to add a footnote to the Drug safety Update on valproate and risk of abnormal pregnancy outcomes at recommendation 1.4.28. Your feedback will be passed over to the NICE editorial team when considering the wording of the footnote. We have considered the studies by Sabers (2012) and Kinney (2016) and the suggestion to add more detail around tapering lamotrigine in the postnatal period. Neither study would meet the inclusion criteria for the surveillance review which considered randomised controlled trials and systematic reviews. Overall we believe that the highlighted issue is already covered by guideline recommendation 1.9.1: 'After childbirth, review and assess the need for starting, restarting or adjusting psychotropic medication as soon as a woman with a past or present severe mental illness is medically stable. **[new 2014]'** Unfortunately we are unable to consider the following: • Green Top guideline 68 – we recognise the importance of speciality-specific guidelines produced by other organisations. However we do not include guidelines as a source of evidence in surveillance reviews. Instead we can check the sources used by other guidelines. The Green Top guideline 68 specifically focuses on women with epilepsy and included studies published 2009-2013 (in the section on antiepileptic drugs in women who are breastfeeding) which would have been available to the committee during the development of CG192, therefore we are unable to consider this evidence in this surveillance review. • Veiby et al (2015) – this is a literature review, rather than a systematic review, and does not meet the study type inclusion criteria used in surveillance • Meador et al (2010) – this study published outside the search period for the surveillance review which was April 2014 to 2017.

		6. Eke, A, Saccone, G, Berghella, V, & Eke, A 2016, 'Selective serotonin reuptake inhibitor (SSRI) use during pregnancy and risk of preterm birth: a systematic review and meta-analysis', *BJOG: An International Journal Of Obstetrics & Gynaecology*, 123, 12, pp. 1900-1907, CINAHL Plus with Full Text, EBSCOhost, viewed 15 March 2017. 7. Malm, H, Sourander, A, Gissler, M, Gyllenberg, D, Hinkka-Yli-Salomäki, S, McKeague, I, Artama, M, & Brown, A (2015) 'Pregnancy complications following prenatal exposure to SSRIs or maternal psychiatric disorders: Results from population-based national register data', *The American Journal Of Psychiatry*, 172, 12, pp. 1224-1232, PsycINFO, EBSCOhost, viewed 15 March 2017	When developing the guideline, the committee used data that was primarily drawn from women with epilepsy as they considered the evidence to be relevant to women with mental health conditions. However, recommendations in different guidelines (including antenatal and postnatal mental health and epilepsy) on use of anticonvulsants when breastfeeding are dependent on the condition they are being used for. No new evidence was identified through the surveillance review to suggest that the recommendations in CG192 should be updated. Finally, the study you have highlighted by Eke et al (2016) on selective serotonin reuptake inhibitor use during pregnancy has already been included in Appendix A: Summary of new evidence. This was considered alongside other evidence on antidepressant use during pregnancy. However, it was concluded that much of the evidence is derived from non-randomised studies and the results should be taken with caution. Malm et al (2015) was identified through the surveillance search but was excluded because, as a cohort study, it didn't meet the study type criteria for the surveillance reviews, which restricted eligible studies to randomised controlled trials and systematic reviews.
Birth Trauma Association	No	We disagree with the provisional decision not to update the clinical guideline CG192 Antenatal and postnatal mental health: clinical management and service guidance. As an organisation, we represent women who suffer from postnatal PTSD – most conservatively estimated at 10,000 a year, though more recent estimates put it as high as 20,000 or 30,000. The condition, which arises from the experience of a traumatic birth, is both under-diagnosed and often misdiagnosed as postnatal depression, with sometimes devastating consequences. We understand the argument that there is not enough new evidence to justify updating the guideline. However, PTSD is unusual among mental illnesses in that it is always triggered by a specific event or events. By preventing the event, it is possible to prevent the illness. Currently guideline CG192 offers only a paragraph on postnatal PTSD. Its recommendation is to: "Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological	Thank you for your comment. NICE guideline CG192: Antenatal and postnatal mental health addresses the management of mental health during pregnancy and after birth. The matter of what staff can do during labour to reduce the trauma to the woman is outside the scope of CG192, but it is addressed by NICE guideline CG190 on intrapartum care, which includes the following recommendation: 'Treat all women in labour with respect. Ensure that the woman is in control of and involved in what is happening to her, and recognise that the way in which care is given is key to this. To facilitate this, establish a rapport with the woman, ask her about her wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used. Use this information to support and guide her through her labour (recommendation 1.2.1). In addition, CG192 includes recommendations to offer advice and support to women who have had a traumatic birth and wish to talk about their experience. As such, we believe

		intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the guideline on post-traumatic stress disorder (PTSD)." Guideline CG192 currently has nothing to say about the prevention of postnatal PTSD. But guidance on how to reduce the incidence of traumatic birth would also reduce the incidence of PTSD, not only reducing the distress of new mothers and their families, but reducing the cost burden to the NHS of providing mental health services to women experiencing PTSD. While it is inevitable that birth will sometimes be attended by complications, women who experience postnatal PTSD invariably say that their PTSD was not caused by the specific event (such as emergency caesarean or postpartum haemorrhage) but the way that healthcare professionals handled the event. Including information on what staff can do during labour to reduce the trauma to the woman would be immensely valuable in reducing the incidence of postnatal PTSD. Last year the BTA asked that the committee drawing up the new NICE guidelines on PTSD consider postnatal PTSD separately from other kinds of PTSD because the particular circumstances of new mothers differentiate them from other groups with PTSD. NICE rejected this suggestion, on the basis that the trauma associated with childbirth had been reviewed in the NICE guideline CG192 and that the PTSD guideline will refer to CG192. In fact, CG192, as indicated above, simply refers to the PTSD guideline CG26. We are left with a situation in which the two guidelines that might deal specifically with postnatal PTSD refer, in circular fashion, to each other. Given that the PTSD guideline won't now look specifically at postnatal PTSD, updating guideline CG192 offers the best opportunity to deal in detail with both the prevention and treatment of a condition that affects thousands of women every year.	that this area has been suitably covered in NICE guidance. NICE guideline CG192 found no evidence for statistically or clinically significant benefits (or harms) associated with post-traumatic birth counselling on PTSD outcomes for women who had a diagnosis of PTSD, and hence concluded that there were no grounds for recommending postnatal-specific interventions. Instead, CG192 recommended that women with PTSD which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death should be treated in line with the guideline on PTSD. The current surveillance review for CG192 found no new evidence relating to postpartum PTSD, so the position has not changed. This area will be considered again at the next surveillance review of CG192: Antenatal and postnatal mental health.
London South Bank University	Yes	At this time there is no significant research completed to suggest any changes are necessary to existing guidance. As stated in the consultation rationale, there are a number of research studies currently in progress that may inform this decision at the next point of review.	Thank you for your comment.
Royal College of Paediatrics and Child Health	Yes	Our reviewers agree with the reasoning for not updating the guideline at the moment but reviewing over the next 3-4 years is correct.	Thank you for your comment.
Swansea University	No	Section 1.4.6 We suggest that this section might be usefully updated to reflect that there are now fewer uncertainties surrounding the administration of SSRI antidepressants in the 1st trimester: a large primary care cohort study offers a precise estimate of the increase in prevalence of stillbirth or major congenital anomalies from 6 in 200 to 7 in 200, while there is no evidence of association between depression and congenital anomalies	Thank you for your comment. The study by Jordan et al (2016) was identified through the surveillance review but excluded because it doesn't meet the study type inclusion criteria (randomised controlled trials and systematic reviews) used in surveillance. We identified new evidence through the

		(Jordan et al 2016). These estimates are congruent with the current literature, and could usefully be made available to guideline readers. It might be argued that these figures suggest a presumption against new prescriptions of SSRIs in women of childbearing age in primary care, entailing a departure from the current guidelines. It is unlikely that these figures would affect prescribing decisions in seriously ill women in secondary care. However, the additional risks associated with substance misuse and the implications for additional care are relevant. Jordan S., Morris JK , et al (2016) Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants in Pregnancy and Congenital Anomalies: analysis of linked databases in Wales, Norway and Funen, Denmark. *Plos One* 11(12): e0165122. doi: 10.1371/journal.pone.0165122 Article Source: **Selective Serotonin Reuptake Inhibitor (SSRI) Antidepressants in Pregnancy and Congenital Anomalies: Analysis of Linked Databases in Wales, Norway and Funen, Denmark**	surveillance review on antidepressant use during pregnancy but it generally showed a trend towards an increased risk of adverse events with the use of antidepressants during pregnancy. On that basis, we considered the new evidence to be in line with current recommendations which advise of the risks associated with pharmacological treatment and the varying adverse effects that may occur.
British Association for Psychopharmacology	Yes	There are no major changes in the literature that necessitate an update at this time.	Thank you for your comment.
Community Practitioners & Health Visitors Association (CPHVA)	No answer	Please see section 4 below	Thank you.
Royal College of Obstetricians and Gynaecologists	Yes	The Guidelines Committee agree with the proposal not to update this NICE guideline.	Thank you for your comment.
Association for Improvements in the Maternity Services	No	1.3.4 While we agree that it is important to look at the needs of other family members, we are getting continuous feedback from women that professionals are concentrating on the needs and potential risks to the fetus or baby and the woman herself does not feel cared for, or cared about. – she is merely the transport for the fetus or infant. Please could a sentence be included about caring for the mother? 1.4.1. “Culturally relevant”. We are hearing more from our help-line on racism as a cause and contributor to mental illness. Our knowledge of the literature is small, but there is evidence that this is important: http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.301906 http://www.sciencedirect.com/science/article/pii/S0277953615300770 http://bjp.rcpsych.org/content/208/1/49 We suggest that NICE does a literature search on this and that it is added to factors which professionals should look for. The women who came to us with these problems had never been asked about it. 1.51. Recognition by professionals that women may be afraid to reveal illness for fear their baby may be taken into care does not solve the problem. We know that women are still concealing illness for this reason. It is caused by the government policy to increase adoptions and social workers’ ignorance of many aspects of maternity care.	Thank you for your comment. In relation to the needs of the mother during pregnancy, we believe this is already covered in the guideline which recommends: • Use this guideline in conjunction with the guidance on service user experience in adult mental health (NICE guideline CG136) and patient experience in adult NHS services (NICE guideline CG138) to improve the experience of care for women with a mental health problem in pregnancy or the postnatal period. **[new 2014]** • 1.3.2 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]** We considered your comment on racism as a cause and contributor to mental illness and the study you highlighted (Bécares 2015). However, we don’t believe this study is directly applicable to the guideline because the study does

		Suggestion: In the section on Research Needed, add 'outcomes of referrals to social services.' There is already evidence from a large USA randomised trial that our current type of social work does extensive long term harm: (2006) Extended Follow-up Study of Minnesota Assessment Research Final Report. Institute of Applied Research 2006) 1.6.1 Assessment and care planning. Please add, when women have had previous mental illness, ask about their views on the care they received. This greatly affects women's willingness to reveal mental illness or cooperate with care. E.g. women who have been admitted to acute psychiatric units because mother and baby placements were not available, have invariably reported strongly negative views (which include experiences of sexual assault from male patients and lack of care for physical postnatal problems). Assurance that a place in a mother and baby unit will be found in case of recurrence would be a great help. 1.95 We are glad that post-partum PTSD is now included, but we do not think it helpful to place it under a combined heading with miscarriage and stillbirth. It should stand alone. We would also point out that this is still going undiagnosed because at postnatal checks women are not asked the right questions, like "What was the birth like for you?" and "Have you had any nightmares or flashbacks?" Since PTSD may surface some time after the birth, health visitors need to be more aware of it. 2.1 Research recommendations: Post partum psychosis. May we suggest more work on fish oil for reducing episodes http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.159.3.477 since there already seems to ber some evidence of benefit, although as yet inadequate	not cover women who have, or are at risk of, mental health disorders during pregnancy and the postnatal period. Thank you for highlighting the extended follow-up study of Minnesota assessment research report to support your comment relating to fear of revealing illness. As this published outside of the surveillance period (April 2014 to 2017) we are unable to consider it in this surveillance review. An equality impact assessment was carried out during guideline development to ensure that equality issues (including stigma) and protected characteristics (including race) were considered in each stage of the guideline production process. Thank you for your feedback on post-partum PTSD. NICE has a guideline on PTSD which includes recommendations on recognition of PTSD beyond the timeframe covered in CG192. Both the antenatal and postnatal mental health and PTSD guidelines have been linked together in this NICE interactive flowchart. We have considered your suggestion to expand the recommendation on assessment and care planning but no evidence was identified through the surveillance review to support this view. This area will be considered again at the next surveillance review of the guideline. Thank you for highlighting the study by Nemets et al, 2002 investigating omega 3 fatty acids as maintenance medication for recurrent unipolar depressive disorder. As this study was published and available to developers during the time the guideline was developed, we are unable to consider the study in our surveillance review.

Do you agree with the proposal to add a footnote?

Footnote with a link to the MHRA toolkit to recommendations 1.2.3 and 1.4.27–1.4.29 relating to the risks of taking valproate medicines during pregnancy.

Full details are included in appendix A: summary of evidence from surveillance.

Stakeholder	Overall response	Comments	NICE response
Royal College of Nursing	Yes	We support the proposal to include the suggested footnote linking the MHRA toolkit to the indicated recommendations. More information is required on this, especially in primary care.	Thank you for your comment.

University Hospitals of Leicester NHS Trust (on behalf of the UK Drugs in Lactation Advisory Service)	Yes	However, note that this guidance makes no recommendation to avoid valproate during the breastfeeding period. It relates to pregnancy only. See also comment regarding 1.4.27 above.	See the response to your comment above.
The Royal College of Midwives (RCM)	Yes	We agree with the proposal to add this footnote	Thank you for your comment.
Birth Trauma Association	Yes	No comment	Thank you.
London South Bank University	Yes	No further comments	Thank you.
Royal College of Paediatrics and Child Health	No answer	No comments	Thank you.
Swansea University	Yes	No comments	Thank you.
British Association for Psychopharmacology	No answer	No comments	Thank you.
Community Practitioners & Health Visitors Association (CPHVA)	Yes	We welcome the addition	Thank you for your comment.
Royal College of Obstetricians and Gynaecologists	No answer	No comments	Thank you.
Association for Improvements in the Maternity Services	Yes	No comment	Thank you.

Do you have any comments on areas excluded from the scope of the guideline?

Stakeholder	Overall response	Comments	NICE response
Royal College of Nursing	No	No comment	Thank you.

University Hospitals of Leicester NHS Trust (on behalf of the UK Drugs in Lactation Advisory Service)	No	No comment	Thank you.
The Royal College of Midwives (RCM)	No	No comment	Thank you.
Birth Trauma Association	No	No comment	Thank you.
London South Bank University	No	No comment	Thank you.
Royal College of Paediatrics and Child Health	No	No comment	Thank you.
Swansea University	No	No comment	Thank you.
British Association for Psychopharmacology	No answer	No comments	Thank you.
Community Practitioners & Health Visitors Association (CPHVA)	Yes	Increasing we are lobbied by our members to include fathers and partners who may show signs of perinatal mental illness. Also we are asked may questions why partners (same sex etc.) are not included in the guidance. This would also be a comment on equalities.	Thank you for your comment. The remit of this guideline is limited to antenatal and postnatal mental health and specifically focuses on women who have, or are at risk of, mental health disorders during pregnancy and the postnatal period to allow the balance of risk and benefit of interventions for the mother, foetus and baby. NICE has a suite of guidelines covering diagnosis and management of mental health conditions including (but not limited to) generalised anxiety disorder, depression and bipolar disorder. These guidelines include the care and treatment of people with these conditions and also recognise the role of families in the treatment and support of individuals.
Royal College of Obstetricians and Gynaecologists	No answer	No comments	Thank you.

Association for Improvements in the Maternity Services	No	No comment	Thank you.

Do you have any comments on equalities issues?

Stakeholder	Overall response	Comments	NICE response
Royal College of Nursing	No	No comment	Thank you.
University Hospitals of Leicester NHS Trust (on behalf of the UK Drugs in Lactation Advisory Service)	No	No comment	Thank you.
The Royal College of Midwives (RCM)	No	No comment	Thank you.
Birth Trauma Association	No	No comment	Thank you.
London South Bank University	No	No comment	Thank you.
Royal College of Paediatrics and Child Health	No	No comment	Thank you.
Swansea University	No	No comment	Thank you.
British Association for Psychopharmacology	No answer	No comments	Thank you.
Community Practitioners & Health Visitors Association (CPHVA)	No answer	We still do not have robust guidance on how to care of clients who's first language is not English. This group is often ignored and do not received appropriate or sensitive care. It is not acceptable to say provide 'culturally appropriate' care especially when this can be subjective and in some cases wholly inappropriate.	Thank you for your comment. Recommendation 1.1.1 in the NICE guideline states the CG192 recommendations are to be read in conjunction with the guidance on patient experience in adult NHS services (NICE clinical guideline 138) which states that healthcare practitioners should establish the most

			effective way of communicating with patients which may include different languages and involving an interpreter or family members, Furthermore, NICE guideline CG138 recommends that patient information should be provided in an accessible format including different languages, if needed, see recommendations 1.5.4-1.5.5, 1.5.9 and 1.5.13.
Royal College of Obstetricians and Gynaecologists	No answer	No comments	Thank you.
Association for Improvements in the Maternity Services	Yes	The strong association between poverty and increased risk of antenatal and postnatal mental illness is not even mentioned. Nor is racism as a risk factor covered	Thank you for your comment. An equality impact assessment was conducted as part of the guideline development process to demonstrate that all equality issues have been given due consideration. An issue was identified around access to services for women who are in a BME group or low socioeconomic groups. In response to this, the updated guideline has a number of recommendations to help identify women who may be at higher risk and who may be disadvantaged in being able to access services. See NICE recommendation 1.6.1 and 1.7.1.

NHS England
We can confirm that there are no comments to be made on behalf of NHS England.