NICE National Institute for Health and Care Excellence

NICE quality standard

Antenatal and postnatal mental health

Quality standard

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Contents

This standard is based on CG192.

This standard should be read in conjunction with QS105, QS95, QS88, QS80, QS53, QS46, QS37, QS34, QS32, QS22, QS14, QS11, QS8, QS128, QS129, QS179, QS48, QS69, QS189 and QS192.

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Quality statement 1: Valproate

Quality statement

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

Rationale

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

Valproate must not be used in pregnancy. It must not be used in girls and women of childbearing potential (including young girls who are likely to need treatment into their childbearing years) unless other options are unsuitable and a pregnancy prevention programme in place, in line with the Medicines and Healthcare products Regulatory Agency (MHRA) safety advice on valproate use by women and girls and valproate use in people younger than 55 years. This is because of the risk of malformations and developmental abnormalities in the baby.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, for example clinical protocols.

Process

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

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

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

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

Commissionersof primary care and specialist and general mental health services specify within contracts that providers should not prescribe valproate to women and girls of childbearing potential to treat a mental health problem.

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

Source guidance

Antenatal and postnatal mental health. NICE guideline CG192 (2014, updated 2020), recommendations 1.2.3 and 1.4.27

Definitions of terms used in this quality statement

Valproate

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

Valproate must not be used in pregnancy. It must not be used in girls and women of childbearing potential (including young girls who are likely to need treatment into their childbearing years) unless other options are unsuitable and a pregnancy prevention programme in place, in line with the Medicines and Healthcare products Regulatory Agency (MHRA) safety advice on valproate use by women and girls and valproate use in people younger than 55 years. This is because of the risk of malformations and developmental abnormalities in the baby.

Women and girls of childbearing potential

Childbearing potential should be determined for women and girls on an individual basis. It should not be determined solely by age because childbearing potential can be dependent on factors other than age. It includes girls and young women under 18 and pregnant women. It also includes younger girls who are likely to need treatment into their childbearing years. [Adapted from NICE's guideline on antenatal and postnatal mental health]

Equality and diversity considerations

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

Quality statement 2: Pre-conception information

Quality statement

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

Rationale

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

Valproate must not be used in pregnancy. It must not be used in girls and women of childbearing potential (including young girls who are likely to need treatment into their childbearing years) unless other options are unsuitable and a pregnancy prevention programme is in place, in line with the Medicines and Healthcare products Regulatory Agency (MHRA) safety advice on valproate use by women and girls and valproate use in people younger than 55 years. This is because of the risk of malformations and developmental abnormalities in the baby.

There is a possible association between valproate use in men around the time of conception and an increased risk of neurodevelopmental disorders in their children; see the MHRA safety advice on valproate use in men.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example care protocols.

Process

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

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

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

Mental health professionals provide information at the annual review for women of childbearing potential with a severe mental health problem about how their mental health

problem and its treatment might affect them or their baby if they become pregnant.

Commissioners specify and check that annual reviews for women of childbearing potential with a severe mental health problem include giving women information about how their mental health problem and its treatment might affect them or their baby if they become pregnant.

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

Source guidance

Antenatal and postnatal mental health. NICE guideline CG192 (2014, updated 2020), recommendations 1.2.1, 1.4.4 and 1.4.6

Definitions of terms used in this quality statement

Annual review

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

Information

The following information should be discussed with women of childbearing potential who have a mental health problem:

- the use of contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
- how a mental health problem and its treatment might affect the woman, the fetus and

baby

- how a mental health problem and its treatment might affect parenting.

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

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

- the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- the likely benefits of each treatment, taking into account the severity of the mental health problem
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk to mental health and parenting associated with no treatment
- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
- the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment.

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

Valproate must not be used in pregnancy. It must not be used in girls and women of childbearing potential (including young girls who are likely to need treatment into their childbearing years) unless other options are unsuitable and a pregnancy prevention programme is in place, in line with the MHRA safety advice on valproate use by women and girls and valproate use in people younger than 55 years. This is because of the risk of

malformations and developmental abnormalities in the baby.

There is a possible association between valproate use in men around the time of conception and an increased risk of neurodevelopmental disorders in their children; see the MHRA safety advice on valproate use in men.

Healthcare professionals discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. This should include an explanation of the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed. Healthcare professionals should discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed. [NICE's guideline on antenatal and postnatal mental health, recommendation 1.4.4]

Postnatal period

Up to 1 year after childbirth. [NICE's guideline on antenatal and postnatal mental health]

Severe mental health problem

A severe mental health problem includes severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder or postpartum psychosis. [NICE's guideline on antenatal and postnatal mental health]

Equality and diversity considerations

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

Quality statement 3: Information for pregnant women

Quality statement

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

Rationale

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, for example care protocols.

Process

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

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

Denominator – the number of pregnant women with a previous severe mental health problem or any current mental health problem attending their booking appointment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

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

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

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

Women who are pregnant and who have had a severe mental health problem in the past or have any current mental health problem are given information at their booking appointment about how their mental health problem might affect them or their baby during

pregnancy and after their baby is born. They are also given information about the possible benefits and harms of any treatment they might have for their mental health problem during this time and while breastfeeding, if they choose to breastfeed. This will help them to make decisions about pregnancy and their treatment.

Source guidance

Antenatal and postnatal mental health. NICE guideline CG192 (2014, updated 2020), recommendations 1.4.3, 1.4.4 and 1.4.6 and expert opinion

Definitions of terms used in this quality statement

Information

Ensure that comprehensive information about the nature of, and treatments and services for, their mental health problems is available. Discuss treatment and prevention options and any particular concerns the woman has about the pregnancy or the fetus or baby. Include discussion of the following, depending on individual circumstances:

- the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- the likely benefits of each treatment, taking into account the severity of the mental health problem
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk to mental health and parenting associated with no treatment
- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt treatment because of the potential effect of an untreated mental

health problem on the fetus or baby

- the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment.

[NICE's guideline on antenatal and postnatal mental health, recommendations 1.4.3 and 1.4.6]

Healthcare professionals discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. This should include an explanation of the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed. Healthcare professionals should discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed. [NICE's guideline on antenatal and postnatal mental health, recommendation 1.4.4]

Postnatal period

Up to 1 year after childbirth. [NICE's guideline on antenatal and postnatal mental health]

Severe mental health problem

A severe mental health problem includes severe and incapacitating depression, psychosis, schizophrenia, bipolar disorder, schizoaffective disorder or postpartum psychosis. [NICE's guideline on antenatal and postnatal mental health]

Equality and diversity considerations

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

Quality statement 4: Asking about mental health and wellbeing

Quality statement

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

Rationale

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example care protocols.

Process

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

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

Denominator – the number of routine antenatal and postnatal contacts.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

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

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

b) Identification of mental health problems.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

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

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

Commissioners specify and check that antenatal and postnatal care providers have protocols in place to ensure that healthcare professionals ask women about their emotional wellbeing at each routine antenatal and postnatal contact.

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

Source guidance

Antenatal and postnatal mental health. NICE guideline CG192 (2014, updated 2020), recommendations 1.5.4 and 1.5.8

Definitions of terms used in this quality statement

Mental health and wellbeing

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

- The depression identification questions:
  - During the past month, have you often been bothered by feeling down, depressed or hopeless?
  - During the past month, have you often been bothered by having little interest or pleasure in doing things?
- Questions about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):
  - Over the last 2 weeks, have you been feeling nervous, anxious or on edge?
  - Over the last 2 weeks, have you not been able to stop or control worrying?

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

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

Routine antenatal contacts

Routine antenatal contacts include:

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

[NHS Your antenatal appointments]

Routine postnatal contacts

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

Postnatal period

Up to 1 year after childbirth. [NICE's guideline on antenatal and postnatal mental health]

Equality and diversity considerations

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

- have a history of substance misuse (alcohol and/or drugs)

- have recently arrived as a migrant, asylum seeker or refugee
- have difficulty speaking or understanding English
- are aged under 20
- have experienced domestic abuse
- are living in poverty
- are homeless.

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

Quality statement 5: Comprehensive mental health assessment

Quality statement

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

Rationale

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example care protocols.

Process

Proportion of women with a suspected mental health problem in pregnancy or within

12 months of giving birth who receive a comprehensive mental health assessment.

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

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

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

Commissioners specify that comprehensive mental health assessments are carried out for women with a suspected mental health problem in pregnancy or the postnatal period.

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

Source guidance

Antenatal and postnatal mental health. NICE guideline CG192 (2014, updated 2020), recommendation 1.6.1

Definitions of terms used in this quality statement

Comprehensive mental health assessment

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

- history of any mental health problem, including in pregnancy or the postnatal period
- physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem
- alcohol and drug misuse
- the woman's attitude towards the pregnancy, including denial of pregnancy
- the woman's experience of pregnancy and any problems experienced by her, the fetus or the baby
- the mother–baby relationship
- any past or present treatment for a mental health problem, and response to any treatment
- social networks and quality of interpersonal relationships
- living conditions and social isolation
- family history (first-degree relative) of mental health problems
- domestic violence and abuse, sexual abuse, trauma or childhood maltreatment
- housing, employment, economic and immigration status
- responsibilities as a carer for other children and young people or other adults.

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

Postnatal period

Up to 1 year after childbirth. [NICE's guideline on antenatal and postnatal mental health]

Suspected mental health problem

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

Equality and diversity considerations

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

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

Quality statement 6: Psychological interventions

Quality statement

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

Rationale

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example care protocols.

Process

Note that process measures have been included to reflect that the 6 weeks to treatment set out in the quality statement comprises 2 weeks to assessment and 4 weeks to treatment, as recommended in NICE's guideline on antenatal and postnatal mental health, recommendation 1.7.3.

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

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

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

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (general mental health services, primary care psychological therapy services and specialist secondary care mental health services) have service capacity to

ensure that women who are referred for psychological interventions in pregnancy or the postnatal period are assessed within 2 weeks of referral and treatment is started within 6 weeks of referral.

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

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

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

Source guidance

Antenatal and postnatal mental health. NICE guideline CG192 (2014, updated 2020), recommendation 1.7.3

Definitions of terms used in this quality statement

Psychological interventions

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

Equality and diversity considerations

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

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

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

Developmental quality statement

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

Rationale

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

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to provide specialist multidisciplinary perinatal community services.

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example care protocols.

What the quality statement means for different audiences

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

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

Commissioners commission specialist multidisciplinary perinatal community mental health services and inpatient psychiatric mother and baby units for women with a mental health problem in pregnancy or the postnatal period.

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

appropriate.

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

Source guidance

Antenatal and postnatal mental health. NICE guideline CG192 (2014, updated 2020), recommendations 1.5.10, 1.10.1 and 1.10.3

Definitions of terms used in this quality statement

Specialist multidisciplinary perinatal mental health service

A specialist multidisciplinary perinatal mental health service that provides direct services, consultation and advice to maternity services, other mental health services and community services, and is available in all localities. [NICE's guideline on antenatal and postnatal mental health, recommendation 1.10.3]

Update information

Minor changes since publication

September 2025: We removed the link to the Medicines and Healthcare products Regulatory Agency (MHRA) temporary advice on the valproate pregnancy prevention programme during the COVID-19 pandemic and added links to additional relevant safety advice from the MRHA in the rationale section of statement 1. Information about valproate and links to relevant safety advice from the MHRA were added to the rationale and definitions sections of statement 2.

August 2024: Changes have been made to the source guidance recommendation references to align with updated NICE guidelines on mental health. The guidelines were simplified by removing recommendations on general principles of care that are covered in other NICE guidelines.

February 2020: We updated statement 1 to reflect changes to the NICE guideline on antenatal and postnatal mental health. Warnings have been updated in line with the MHRA safety advice on valproate use by women and girls.

April 2018: Information has been added to statement 1 to update the advice and link to resources from the MHRA on the use of valproate in women and girls.

About this quality standard

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

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

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

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

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Endorsing organisation

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

Supporting organisations

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

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