

## NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

### QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

#### Briefing paper

**QOF indicator area:** Serious mental illness: pregnancy, conception and contraception advice

**Potential output:** Recommendation for indicator development

**Date of Primary Care QOF Indicator Advisory Committee meeting:** 12<sup>th</sup> & 13<sup>th</sup> of June 2013

#### Contents

Introduction .....	2
Topic suggestion.....	2
Proposed indicators .....	3
Overview of serious mental illness.....	4
Review of recommendations.....	8
Assessment of recommendations against current practice .....	12
Initial feasibility assessment.....	14
Key considerations.....	14
References.....	15
Appendix A: Evidence summary .....	16
Appendix B: Related QOF indicators .....	20

## **Introduction**

The QOF indicator area is serious mental illness; pregnancy, conception and contraception advice.

This briefing paper presents an assessment of the suitability of NICE and SIGN clinical guideline recommendations relevant to primary care that have been identified for potential QOF indicator development. The recommendations and underlying evidence are taken from the following guidelines:

‘Management of schizophrenia’ (SIGN guideline 131, 2013)

‘Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care’ (NICE clinical guideline 82, 2009)

‘Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care’ (NICE clinical guideline 38, 2006)

‘Antenatal and postnatal mental health: Clinical management and service guidance’ (NICE clinical guideline 45, 2007)

## **Topic selection**

This topic was identified following a review carried out by the NICE QOF team of SIGN clinical guideline 131 on the clinical management of schizophrenia which was published in March 2013. Additional existing NICE clinical guidelines for serious mental illness were also reviewed; NICE clinical guideline 38 on the clinical management of bipolar disorder which was published in 2006, NICE clinical guideline 82 on the treatment and management of schizophrenia published 2009 and NICE clinical guideline 45 on the clinical management of antenatal and postnatal mental health, published 2007. As part of the NICE process for ensuring that QOF clinical areas remain up to date with current recommended practice, the SIGN guidance was reviewed to assess the potential

## **ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

impact on the current mental health indicator set. In light of this review, one area was identified by the NICE team for consideration by the Advisory Committee.

The SIGN clinical guideline on schizophrenia recommends that women of child bearing potential who take psychotropic medication should be made aware of the potential effects of the medication in pregnancy. The NICE guideline on bipolar disorder recommends that contraception and the risks of pregnancy should be discussed with women of child-bearing potential, regardless of whether they are planning a pregnancy.

### **Supporting statement from the National Clinical Director for Mental Health**

The indicator presented in this briefing paper is clinically valid and important from a primary care perspective and therefore I would like to support the development of a Quality and Outcomes Framework (QOF) indicator on pregnancy, conception and contraception advice for women with serious mental illness. Pregnancy, conception and contraception advice is an important part of the discussions women of child bearing age should have when being prescribed medication for their illness. Evidence presented in the SIGN clinical guidelines and NICE clinical guideline found variable levels of advice were currently being given. Evidence has shown that there can be serious adverse effects from medication on pregnancy especially during early and unplanned pregnancy and a proactive approach to advice is required. There can also be a major impact on the women's perinatal mental health and an increased risk of relapse if their medication is not adjusted appropriately during this time. For women with serious mental illness planning a pregnancy requires effective communication between mental health specialists, primary care practitioners and prescribers, current organisational structures vary across the country and have a variable level of integration and joint working.

Primary care is the appropriate setting to ensure women with serious mental illness have the opportunity to discuss their plans for pregnancy and seek advice

## ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper

on contraception and I feel incentivising this through the QOF will improve the quality of care for women with serious mental illness.

Geraldine Strathdee,

National Clinical Director Mental Health

### **Overview of serious mental illness**

#### ***Epidemiological summary***

##### **Definition**

The two main categories of serious mental illness are schizophrenia and bipolar disorder.

Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour. It is characterised by 'positive symptoms' such as auditory hallucinations, bizarre delusions, and disrupted speech ('thought disorder') and by 'negative symptoms' such as social withdrawal, demotivation, self neglect, and the appearance of flat affect. Subtle cognitive impairment is also a feature.

Bipolar disorder is a serious mental illness characterised by episodes of depressed mood and episodes of elated mood (mania or hypomania). For many people the predominant experience is of low mood. In its more severe forms, bipolar disorder is associated with significant impairment of personal and social functioning. In terms of classification, in DSM-IV a distinction is drawn between bipolar I disorder, in which the patient suffers full-blown manic episodes (most commonly interspersed with episodes of major depression), and bipolar II disorder, in which the patient experiences depressive episodes and less severe manic symptoms, classed as hypomanic episodes (it must be noted that ICD-10 does not include bipolar II disorder).

**Incidence, prevalence and evidence of variation by age, sex and ethnicity**

The overall prevalence of psychotic disorder within the population is 0.4%, 0.3% within men and 0.5% in women. In both men and women the highest prevalence is observed in those aged 35 to 44 years (0.7% and 1.1% respectively). The age standardised prevalence of psychotic disorder is significantly higher among black men (3.1%) than men from other ethnic groups (0.2% of white men)<sup>1</sup>.

Schizophrenia is a relatively common illness and the most common form of psychotic disorder; about 1% of the population will develop schizophrenia. Average rates for men and women are similar although the mean age of onset is about 5 years greater in women. The first symptoms tend to start in young adulthood, but can occur at any age, usually at a time when people are trying to make the transition to independent living. Rates of schizophrenia are also increased in urban, poor, immigrant and ethnic minority populations. The mean incidence of schizophrenia is 0.11 per 1000. The lifetime prevalence of schizophrenia is between 0.4 and 1.4%.

Community-based epidemiological studies consistently report the lifetime prevalence of bipolar I disorder to be approximately 1%. Bipolar I disorder occurs approximately equally in both sexes. The peak age of onset for bipolar disorder is in late adolescence or early adult life, with a further small increase in incidence in mid to late life. The symptom profile may differ between men and women; there is some evidence that women tend to experience more episodes of mixed or dysphoric mania than men. There is disputed evidence that bipolar II disorder is more common in females than males. There is evidence of an increased incidence of bipolar disorder in people from black and minority ethnic groups. Findings indicate that people with intellectual disability are at high risk of developing comorbid serious mental illness, including bipolar disorder.

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<sup>1</sup> Adult Psychiatric Morbidity in England - 2007  
Primary Care Quality and Outcomes Framework Advisory Committee  
12<sup>th</sup> and 13<sup>th</sup> June 2013

## **ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

The 2008 Kings Fund report, Paying the Price; the cost of mental health in England to 2026, estimates that in 2007 the total cost of lost employment relating to schizophrenia was £1.78 billion and £3.57 billion for bipolar disorder and related conditions.

### **Morbidity and mortality**

Although many people with schizophrenia do achieve remission of symptoms, the associated difficulties can be persistent and the individual can experience repeated episodes in between periods of remission. It is increasingly recognised that recovery from schizophrenia is more than the reduction or remission of symptoms in isolation. About three quarters of people who meet diagnostic criteria for schizophrenia will experience a relapse. People diagnosed with schizophrenia have a shorter life expectancy than the general population but with similar causes of premature death including cardiovascular disease, respiratory illness and cancer.

Mortality among people with schizophrenia is approximately 50% above that of the general population, partly as a result of an increased incidence of suicide (about 10% die by suicide) and violent death, and partly as a result of an increased risk of a wide range of physical health problems. Young Caribbean and African men, and middle-aged women from diverse ethnic or cultural backgrounds, are at higher risk of suicide.

Although mania or hypomania are the defining characteristics of bipolar disorder, throughout the course of the illness depressive symptoms are more common than manic symptoms. The risk of suicide is greatly elevated during depressive episodes. Approximately 17% of patients with bipolar I disorder and 24% of patients with bipolar II disorder attempt suicide during the course of their illness.

## ***Impact on health services***

### **Primary care**

Surveys suggest that about 10 to 20% of service users with schizophrenia are treated solely in primary care.

Many patients with bipolar disorder are now treated solely by their general practitioner without input from specialist services. Community care has reduced the number of patients living their lives in hospital.

### **Secondary care**

Most people with a diagnosis of schizophrenia in the care of the NHS are treated in secondary care mental health services. Service-level interventions for people with schizophrenia include both inpatient services and a variety of community team models. According to recent figures, services for people with schizophrenia account for 24% of the NHS spend on mental health (Mind, 2005). Two-thirds of that spend is on inpatient care where people with schizophrenia use over 60% of the provision.

The service costs to the NHS in 2007 for people with schizophrenia were estimated to be £2.23 billion and £1.64 billion for bipolar disorder<sup>2</sup>.

### ***Current management in primary care***

Primary care services provide a vital service for people with schizophrenia, who consult primary care practitioners more frequently and are in contact with primary care services for a longer cumulative time than patients without mental health problems.

Most people with bipolar disorder are cared for by their primary care practitioner. The treatment and management of bipolar disorder in women who are trying to conceive, and during the antenatal and postnatal periods, is challenging and

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<sup>2</sup> Paying the price; the cost of mental health in England to 2026. Kings Fund, 2008.  
Primary Care Quality and Outcomes Framework Advisory Committee  
12<sup>th</sup> and 13<sup>th</sup> June 2013

## **ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

complex. This is largely because the risks of taking medication during pregnancy are not always well understood and because the risk of relapse in women during this time is high.

Provision of preconception care and advice for people with epilepsy has been included in the QOF since 2011.

### ***NHS priorities and timeliness for guidance***

The NICE QOF team examined national clinical guidelines, policy documents and national strategies across the UK to assess timeliness of indicators in this topic area. The following were found to be relevant to serious mental illness and indicate that it is considered an area of high priority for the NHS.

- [Management of schizophrenia](#). SIGN guideline 131 (2013).
- [No health without mental health: implementation framework](#). Department of Health, 2012.
- [Maternal mental health pathway](#). Department of Health, 2012.
- [No health without mental health: a cross government mental health outcomes strategy for people of all ages](#). Department of Health, 2011.
- [Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care](#). NICE clinical guideline 82 (2009).
- [Adult psychiatric morbidity in England, 2007. Results of a household survey](#) The Health and Social Care information Centre. 2009.
- [Clinical knowledge summaries: Schizophrenia](#). NICE. 2009.
- [Paying the price; the cost of mental health in England to 2026](#). Kings Fund, 2008.

## ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper

- [Antenatal and postnatal mental health: Clinical management and service guidance.](#) NICE clinical guideline 45 (2007).
- [Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care.](#) NICE clinical guideline 38 (2006).

### Review of recommendations

#### ***Summary of guideline recommendations***

One recommendation from SIGN clinical guideline 131 has been identified as being potentially suitable for QOF indicator development.

#### ***SIGN recommendation 7.5.1***

All women with childbearing potential who take psychotropic medication should be made aware of the potential effects of the medications in pregnancy. The use of reliable contraceptive methods should be discussed.

One recommendation from NICE clinical guideline 38 has been identified as being potentially suitable for QOF indicator development.

#### ***NICE recommendation 1.4.1.2***

Contraception and the risks of pregnancy (including the risks of relapse, damage to the fetus, and the risks associated with stopping or changing medication) should be discussed with all women of child-bearing potential, regardless of whether they are planning a pregnancy. They should be encouraged to discuss pregnancy plans with their doctor.

One recommendation from NICE clinical guideline 45 has been identified as being potentially suitable for QOF indicator development.

## ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper

### NICE recommendation 1.1.1.4

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 should be encouraged to discuss pregnancy plans with their doctor.

### **Evidence summary**

This is a summary of the evidence supporting the proposed recommendations presented above. This section relates to the evidence summary table in appendix A of this briefing paper.

### **Clinical effectiveness**

#### SIGN recommendation 7.5.1

The recommendation in SIGN clinical guideline 131 is based on expert opinion, and consideration of the Maudsley prescribing guidelines. Evidence on the effects of antipsychotic medication on fetal and infant outcomes was reviewed, and based on this (two observational studies and two systematic reviews), the developers concluded that the evidence base was too limited to draw definitive conclusions.

#### NICE recommendations

In order to develop the NICE recommendations (NICE CG38 1.4.1.2 and NICE CG45 1.1.1.4), the GDG drew on expert advice on the specific issue of the risk of psychotropic medication during the postnatal period. A consensus conference was held between the GDG members for bipolar disorder and antenatal and postnatal mental health and invited experts to develop recommendations for the pharmacological management of pregnant or lactating women with serious mental illness. The group acknowledged that there was a lack of evidence about the safety of psychotropic medication in pregnancy and breastfeeding. The reasons for this are the difficulty with distinguishing background congenital Primary Care Quality and Outcomes Framework Advisory Committee 12<sup>th</sup> and 13<sup>th</sup> June 2013

## ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper

abnormalities from abnormalities due to medication and as many drugs are new insufficient data has been collected.

This consensus group concluded the following;

- Lithium carries an increased risk of congenital heart disease when taken in the first trimester. There has also been shown to be an association with floppy baby syndrome, thyroid abnormalities and nephrogenic diabetes when used in the second and third trimesters.
- Sodium valproate is associated with a range of major fetal abnormalities including facial dysmorphisms, distal digit hypoplasia and neural tube defects. The effect on neural tube closure occurs before day 30 of gestation which is usually before a pregnancy is confirmed.
- Sodium valproate has a monotherapy major malformation rate (MMR) of 5.9%, compared to 2.3% for carbamazepine and 2.1% for lamotrigine.
- Carbamazepine is associated with increased congenital abnormalities, such as neural tube defects, distal digit hypoplasia and craniofacial abnormalities.
- There is inconsistent evidence that lamotrigine causes a significant increase in major malformation in children whose mothers took the drug during pregnancy.

The GDGs concluded that some psychotropic drugs have high teratogenic risks during the first trimester of pregnancy. And as many pregnancies may not be confirmed until the pregnancy is advanced, it is important that women of child bearing potential are given information on the risks of psychotropic medication on pregnancy, the risks of untreated illness and appropriate information about contraception.

### **Cost effectiveness**

No health economic evidence was presented in SIGN clinical guideline 131, NICE clinical guideline 38, 45 for the recommendations presented.

### **Assessment of recommendations against current practice**

#### **Current practice**

The management of bipolar disorder in women of reproductive age is complicated by several issues. These include the following:

- the effect of bipolar illness on conception (mania can lead to sexual disinhibition and unplanned pregnancy)
- the effect of medication on fertility
- medication prescribed during pregnancy is found to cause adverse obstetric and neonatal outcomes, including teratogenesis.
- the effect of pregnancy and childbirth on the natural course of bipolar disorder. In women with a diagnosis of bipolar disorder there is approximately a 50% chance of an episode of psychosis in the postnatal period.
- the risk of bipolar disorder in the offspring of parents with the condition

Women need to be provided with information regarding the importance of contraception, including the option of long-term reversible contraception.

It is important that women are aware of the potential for medication to cause adverse obstetric and neonatal outcomes, including teratogenesis. Women who are considering conceiving should discuss the matter with their psychiatrist, in particular the issue of medication and maintenance treatment for their bipolar disorder. The advice that is given will depend on the individual's history and circumstances.

## **ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

There has been increasing use of antipsychotics in women with bipolar disorder planning pregnancy and this based on antimanic efficacy and antidepressant properties. There is no evidence of teratogenicity with antipsychotics, though caution is needed with more recently introduced agents due to the limited pharmacovigilance data from women who have conceived while prescribed the drug.

Often a pregnancy will be unplanned and healthcare professionals will be faced with a woman who has conceived while taking her existing medication. All major structural teratogenic effects, including neural tube defects occur in the first trimester. Screening for major anomalies should be carried out for all women who receive psychotropic drugs in early pregnancy and all should receive urgent referral to specialist feto-maternal medicine services.

### **Health inequalities**

People with serious mental illness experience severe health inequalities. Women with serious mental illness are more likely to have a higher incidence of unplanned or unwanted pregnancy. There is also an increased incidence of serious mental health in black and minority ethnic groups. Rates of schizophrenia are also increased in urban, poor, immigrant populations.

There is no evidence that these recommendations can directly impact health inequalities. [Relevance to health inequalities: moderate]

### **Will implementation of these recommendations lead to cost-effective improvements in the delivery of primary care?**

All recommendations would be expected to lead to a moderate shift in practice and the NICE QOF team consider that some form of preconception advice is likely to be cost-effective in reducing major malformations.

## **Initial feasibility assessment**

A feasibility assessment was carried out by the NICE QOF programme team who considered the concept of providing contraception advice to women with serious mental illness. The team considered that there may need to be a definition of what constitutes 'information and advice' and that practices may need to link the advice code to the appropriate pregnancy intention code. Consideration may be needed to define the upper and lower age limits for women of child bearing age.

The team noted that the indicator mirrored the 2012/13 QOF epilepsy indicator around pre-conception care and advice<sup>3</sup>.

## **Key considerations**

The following key considerations summarise the main points made in the briefing paper and should be used by the Committee in their discussions.

- Indicators on pregnancy, conception and contraception care and advice are already included in the QOF for women with epilepsy and this form part of current practice.
- Indicators on pregnancy, conception and contraception care and advice are under consideration of the Committee for women with diabetes
- The medication prescribed for serious mental illness is known to cause adverse obstetric and neonatal outcomes, including teratogenesis when used in pregnancy.
- Pre-conception advice is recommended as the fetal abnormalities associated with psychotropic drugs occur during the first trimester, usually before 30 days from conception.

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<sup>3</sup> The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the previous 15 months.

## ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper

- The risk of relapse for women during pregnancy is high and medication needs should be assessed for the individual.

### ***Assessment against NICE's prioritisation criteria***

The condition is considered to have population prevalence that is moderate and fully meets the criteria for diagnosis, treatment and monitoring in primary care (by general practitioners or directly employed practice staff). The recommendations selected are considered feasible. The evidence of clinical effectiveness is based on the expert opinion and evidence on the increased need for information around pregnancy, conception and contraception. No evidence of cost effectiveness was presented for these recommendations. The expected change in practice is considered to be moderate.

### **References**

Management of schizophrenia. SIGN guideline 131 (2013). Available from [www.sign.ac.uk/guidelines/fulltext/131/index.html](http://www.sign.ac.uk/guidelines/fulltext/131/index.html)

Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. NICE clinical guideline 82 (2009). Available from [www.nice.org.uk/guidance/CG82](http://www.nice.org.uk/guidance/CG82)

Antenatal and postnatal mental health: Clinical management and service guidance. NICE clinical guideline 45 (2007). Available from [www.nice.org.uk/guidance/CG45](http://www.nice.org.uk/guidance/CG45)

Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. NICE clinical guideline 38 (2006). Available from [www.nice.org.uk/guidance/CG38](http://www.nice.org.uk/guidance/CG38)

[Adult psychiatric morbidity in England, 2007. Results of a household survey](http://www.hscic.gov.uk/doc/mental-health-statistics/mental-health-statistics-2007). The Health and Social Care information Centre. 2009.

[Paying the price; the cost of mental health in England to 2026](http://www.kingsfund.org.uk/reviews/cost-mental-health-2026). Kings Fund, 2008.

Primary Care Quality and Outcomes Framework Advisory Committee  
12<sup>th</sup> and 13<sup>th</sup> June 2013

Agenda item 26: Serious mental illness: Contraception and pregnancy advice – briefing paper

## Appendix A: Evidence summary

### Evidence summary of NICE clinical guideline 38, 45 and SIGN clinical guideline 131 selected recommendations.

	Recommendation	Level of evidence	Key outcomes considered	Specific considerations highlighted by guideline developers	Cost-effectiveness evidence
<b>Serious mental illness: Pregnancy, conception and contraception care and advice</b>					
SIGN clinical guideline 131 recommendation 7.5.1	All women with childbearing potential who take psychotropic medication should be made aware of the potential effects of the medications in pregnancy. The use of reliable contraceptive methods should be discussed.	GDG expert opinion	<p>Structural teratogenicity</p> <p>Stillbirth rates Gestational age at birth Congenital abnormalities Perinatal syndromes</p>	<p>The group considered the Maudsley prescribing guidelines which states that the possibility of pregnancy should always be discussed where there are known teratogenic effects.</p> <p>They considered two systematic reviews which concluded no association between second generation anti-psychotics and structural teratogenicity although the studies acknowledged that the evidence base was too limited to draw definitive conclusions.</p> <p>A further two observational studies concluded no association between antipsychotic drugs and pregnancy complications.</p>	None identified

**ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

	<b>Recommendation</b>	<b>Level of evidence</b>	<b>Key outcomes considered</b>	<b>Specific considerations highlighted by guideline developers</b>	<b>Cost-effectiveness evidence</b>
NICE clinical guideline 38 recommendation 1.4.1.2	Contraception and the risks of pregnancy (including the risks of relapse, damage to the fetus, and the risks associated with stopping or changing medication) should be discussed with all women of child-bearing potential, regardless of whether they are planning a pregnancy. They should be encouraged to discuss pregnancy plans with their doctor.	GDG expert opinion	Neonatal and fetal outcome Drug efficacy	<p>Lithium carries an increased risk of congenital heart disease when taken in the first trimester.</p> <p>Sodium valproate is associated with a range of major fetal abnormalities including facial dysmorphisms, distal digit hypoplasia and neural tube defects. The effect on neural tube closure occurs before day 30 of gestation which is usually before a pregnancy is confirmed.</p> <p>Sodium valproate has a monotherapy major malformation rate (MMR) of 5.9%, compared to 2.3% for carbamazepine and 2.1 for lamotrigine.</p> <p>Carbamazepine is associated with increased congenital abnormalities, such as neural tube defects, distal digit hypoplasia and craniofacial abnormalities.</p> <p>There is inconsistent evidence that lamotrigine causes a significant increase in major malformation in children whose mothers took the drug during pregnancy; however there does appear to be a relatively high rate</p>	

**ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

	<b>Recommendation</b>	<b>Level of evidence</b>	<b>Key outcomes considered</b>	<b>Specific considerations highlighted by guideline developers</b>	<b>Cost-effectiveness evidence</b>
				of cleft palate within infants. The dose of lamotrigine should be increased when prescribed to a woman taking oral contraceptives, or the use of another contraceptive method since oral contraceptives seem to reduce lamotrigine plasma levels.	
NICE clinical guideline 45 recommendation 1.1.1.4	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 should be	GDG expert opinion	Neonatal and fetal outcome Drug efficacy	Lithium carries an increased risk of congenital heart disease when taken in the first trimester. Sodium valproate is associated with a range of major fetal abnormalities including facial dysmorphisms, distal digit hypoplasia and neural tube defects. The effect on neural tube closure occurs before day 30 of gestation which is usually before a pregnancy is confirmed. Sodium valproate has a monotherapy major malformation rate (MMR) of 5.9%, compared to 2.3% for carbamazepine and 2.1 for lamotrigine. Carbamazepine is associated with increased congenital abnormalities, such as neural tube defects, distal digit hypoplasia and	None identified

## ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper

	<b>Recommendation</b>	<b>Level of evidence</b>	<b>Key outcomes considered</b>	<b>Specific considerations highlighted by guideline developers</b>	<b>Cost-effectiveness evidence</b>
	encouraged to discuss pregnancy plans with their doctor.			craniofacial abnormalities. There is inconsistent evidence that Lamotrigine causes a significant increase in major malformation in children whose mothers took the drug during pregnancy; however there does appear to be a relatively high rate of cleft palate within infants. The dose of lamotrigine should be increased when prescribed to a woman taking oral contraceptives, or the use of another contraceptive method since oral contraceptives seem to reduce lamotrigine plasma levels.	

## Appendix B: Related QOF indicators

### ***Related existing QOF indicators from 2013/14 indicator set***

Serious mental illness is part of the existing QOF clinical domain as defined in the 2013/14 GMS contract guidance. QOF indicators for England for this domain are outlined below. Indicators for Scotland, Wales and Ireland can be found from the relevant countries web pages.

#### **QOF domain 2013/14: Mental Health**

Indicator	Points	Achievement thresholds
<b>Records</b>		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	
<b>Ongoing management</b>		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6	40-90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months <i>NICE 2010 menu ID: NM17</i>	4	50-90%
MH004. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months <i>NICE 2010 menu ID: NM18</i>	5	45-80%
MH005. The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months <i>NICE 2011 menu ID: NM42</i>	5	45-80%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months <i>NICE 2010 menu ID: NM16</i>	4	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other	4	50-90%

**ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

psychoses who have a record of alcohol consumption in the preceding 12 months <i>NICE 2010 menu ID: NM15</i>		
MH008. The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years <i>NICE 2010 menu ID: NM20</i>	5	45-80%
MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months <i>NICE 2010 menu ID: NM21</i>	1	50–90%
MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months <i>NICE 2010 menu ID: NM22</i>	2	50–90%

***Related indicators from the NICE menu of indicators***

All mental health related indicators on the NICE menu have been negotiated into the 2013/14 QOF and listed above.

***Related indicators under consideration by the Advisory Committee***

The committee is asked to consider the briefing paper on diabetes - pregnancy, conception and contraception advice.

## Appendix C: Assessment of topic and recommendations against prioritisation checklist criteria status

The overall topic and recommendation(s) produced by the QOF programme team have been assessed by comparing information in this briefing paper with the revised prioritisation checklist as agreed at the June 2012 Advisory Committee meeting.

### **Topic status**

This topic meets the prioritisation criteria for prevalence, primary care management and disease severity as outlined in 1A, 1B and 1C below.

<b>1A Population</b>	
The condition is considered to have population prevalence that is high	<input type="checkbox"/>
The condition is considered to have population prevalence that is medium	<input checked="" type="checkbox"/>
The condition is considered to have population prevalence that is low	<input type="checkbox"/>

<b>1B Management</b>			
	Fully meets criteria	Partly meets criteria	Doesn't meet criteria
Score:	[3]	[2]	[1]
The condition is diagnosed in primary care*	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
The condition is treated in primary care*	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The condition is monitored in primary care*	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* by general practitioners or directly employed practice staff

**ITEM 26 – Serious mental illness: Contraception and pregnancy advice – briefing paper**

<b>1C Disease Severity</b>		
Score	Scoring criteria	
1	Minor quality-of-life impact, no disability, limited morbidity impact	<input type="checkbox"/>
2	Definite quality-of-life impact, no disability, limited morbidity impact	<input type="checkbox"/>
3	Definite quality-of-life impact, some disability and/or intermediate morbidity impact	<input type="checkbox"/>
4	Definite quality-of-life impact, significant disability and/or significant morbidity impact	<input checked="" type="checkbox"/>

***Recommendation status***

The individual recommendations are assessed on feasibility, strength of clinical and cost-effectiveness evidence and expected change in practice.

<b>Feasibility of each recommendation</b>	
SIGN 131 recommendation 7.5.1	Green
NICE 38 recommendation 1.4.1.2	Green
NICE 45 recommendation 1.1.1.4	Green

<b>Scores for each recommendation</b>			
	<b>Evidence of clinical effectiveness</b>	<b>Evidence of cost effectiveness</b>	<b>Expected change in practice</b>
SIGN 131 recommendation 7.5.1	Low	No evidence presented	Moderate
NICE 38 recommendation 1.4.1.2	Low	No evidence presented	Moderate
NICE 45 recommendation 1.1.1.4	Low	No evidence presented	Moderate