SIGN guideline for Perinatal Mental Health Conditions: Consultation on new SIGN guideline and shared decision-making toolkit

COMMENTS RECEIVED FROM EXTERNAL REFEREES AND OTHERS

All reviewers submitted declarations of interests which were viewed prior to the addressing of comments.

Please note that section numbers refer to the consultation version of the draft guideline unless otherwise noted.

Invited reviewers			Type of response and declared interests
AMc	Alana McLellan	Specialist Perinatal Mental Health Midwife, NHS Lanarkshire	*Individual response* NHS Lanarkshire is currently involved in research with MAP research project- Methods of assessing perinatal anxiety work packages. I am the principle investigator for NHS Lanarkshire.
AMi	Aimee Millington	Senior Perinatal and Infant Mental Health Co-ordinator, Home-Start Caithness	*Organisation response* Nothing declared
CM	Claire Mollison	Social Worker, Lanarkshire	*Individual response* Nothing declared
DG	Debra Grice	Team manager, NHS Borders CMHT	*Individual response* Nothing declared
FF	Fiona Fraser	Consultant Clinical Psychologist, Consultant Clinical Psychologist	*Individual response* Nothing declared

GA	Gillian Anderson	Consultant psychiatrist, NHS Forth Valley	*Individual response* Nothing declared
KM	Dr Katie Marwick	Higher Trainee in General Adult Psychiatry, NHS Lothian	*Individual response* I have a grant to investigate the epidemiology of postpartum psychosis - June 2023-June 2024, about 25K, from The University of Edinburgh. I don't think this influences my comments. I am hoping to publish a service evaluation of the impact of ethnicity on management in the Lothian mother and baby unit within the next year. I don't think this influences my comments though.
LM	Lynne Mosley	CPMHT Team Lead, NHS Fife	*Individual response* Nothing declared
MCS	Marie Claire Shankland	Head of Programme Specialist Practice Psychology, Head of Programme Specialist Practice Psychology	*Individual response* Nothing declared
MS	Meg Sherratt ace of work	Specialist Midwife for Perinatal Mental Health and Bereavement, NHS Lothian	*Individual response* Nothing declared
SMc	Dr Sarah McRobbie	ST7 Obstetrics and Gynaecology, NHS Grampian	*Individual response* Nothing declared
VR	Victoria Reid	Bipolar Scotland; Oxfam Person with lived experience of bipolar	*Individual response*

		disorder, mother of twins, support group facilitator with Bipolar Scotland	I am a representative/employee of a voluntary organisation supporting people with a condition or who use a service which relates to the topic under review. I have direct experience of the condition or the services under review (as either a service user/patient/carer of a person with a related condition). I am likely to be directly impacted by the topic under review.
--		Consultant Clinical Psychologist	*Individual response* Nothing declared
--		Clinical Associate in Applied Psychology	*Individual response* Nothing declared
Open consultation			**Type of response and declared interests**
AS	Andrea Sinesi	Research fellow, University of Stirling	*Individual response* Dr Andrea Sinesi, Professor Helen Cheyne and Professor Margaret Maxwell, all members of the MAP research team, developed and published one of the measures tested in the MAP research programme, the Stirling Antenatal Anxiety Scale (SAAS).
CRa	Dr C Rae	Consultant Anaesthetist, Glasgow Royal Infirmary	*Individual response* Nothing declared
	--	Trainee Health Visitor	*Individual response* Nothing declared
EMH	Eilidh Macdonald-Harte, Managing Coordinator,	CrossReach Perinatal Counselling Service	*No DoI submitted*

	Counselling East Christina Smiley, Head of Service, Children and Families Mairi McNaughton, Managing Coordinator Counselling North/West		
FH	Frances Hills	Consultant Obstetrician, perinatal mental health lead and Head of Service for obstetrics, University Hospitals of Leicester NHS Trust	*Individual response* Nothing declared
HG	Heike Gleser	Heike Gleser, NHS Tayside, Ninewells Hospital	*Individual response* Nothing declared
IMHDG		Perinatal IMH Steering Group, NHS Dumfries and Galloway	*Organisation response* Nothing declared

JD	Janet Dalzell	UNICEF UK Baby Friendly Initiative Professional Lead for Scotland UNICEF UK	*Individual response* Nothing declared
JH	Jo Holmes	BACP, Children, Young People and Families Lead	*Organisation response* Professional membership body for counsellors and psychotherapists across the UK, BACP would be strengthened following a recommendation for talking therapies as it would increase options for clients in Scotland and BACP members would likely be providing services
	--	Senior Manager - Children and Families (Universal Early Years)	*Individual response* Nothing declared
JM	Jane Morris	Vice Chair Royal College of Psychiatrists in Scotland, Hon Senior Lecturer, University of Aberdeen Royal College of Psychiatrists, Queen Street, Edinburgh	*Individual response* Author/editor of 2 textbooks on Eating Disorders, Chair of SIGN Guideline on Eating Disorders 2022
JMc	June McGill	Improvement Advisor, Healthcare Improvement Scotland	*Individual response* As well as being an Improvement Advisor on the Unpaid Carers Programme in Healthcare Improvement Scotland ihub I am also a carers of person with poor mental health.

KB	Katie Borland	Policy Officer, See Me	*Organisation response* National programme to tackle stigma and discrimination
LC	Lindsey Cullen	Music Therapist, Mother and Baby Unit, Livingston	*Individual response* Employment as a perinatal music therapist through NHS Lothian. Employment as a music therapist through NHS Lothian. Livingston MBU being unique in having a permanent Arts Therapist.
LF	Lorraine Farrow	Senior Educator, Women, Children, Young People and Families, NES	*Organisation response* NHS Board - Education and training body in Scotland. Comments and recommendations would strengthen a consistent and collaborative approach between SIGN guidance and NES Resources and recommendations for PIMH practitioners and collaborative workforce. Where not aligned confusion to the Scottish workforce and families supported may become disconnected and ineffective.
LIMc	Lynn Ingram McFarland, MBA PMH-C	Owner, Ingram Screening, LLC	*Organisation response* Ingram Screening is a consulting firm based in Portland Oregon. We focus on educating and training providers, clinics, and organizations in screening best practices and in creating working business models of screening for Perinatal Mood & Anxiety Disorders (PMADs). Our organization would be weakened following the recommendation of using solely the EPDS as a screening tool. It goes against everything that we stand for and educate against.
LN	Lindsay Noble	Lead Occupational Therapist, Leverndale Hospital	*Individual response* Non-financial personal interests - previous staff member in MBU, currently professionally lead/ supervise PMH occupational therapy staff in GG & C

MG	Dr Mari Greenfield	Research Associate, The Open University	*Individual response* Nothing declared
MMHA		Maternal Mental Health Alliance UK	*Organisation response* The Maternal Mental Health Alliance (MMHA) is a UK-wide charity and network of over 120 organisations, dedicated to ensuring women and families affected by perinatal mental health problems have access to high-quality, comprehensive perinatal mental health care. Draft recommendations in this SIGN guideline will have no discernible impact on the function or productivity of our organisation.
NES		NES Programme for Parenting and Infant Mental Health,	*Organisation response* NHS Education for Scotland (NES) is an education and training body and a national health board within NHS Scotland. We are responsible for developing and delivering healthcare education and training for the NHS, health and social care sector and other public bodies. We have a Scotland-wide role in undergraduate, postgraduate and continuing professional development. The acceptance of these SIGN guidelines may have implications for workforce training and development needs to ensure practitioners are skilled and knowledgeable to meet the needs of the target population.
PB	Paul Baughan	GP, NHS Forth Valley	*Individual response* Nothing declared
PMH		NHS GGC Perinatal Mental Health Team	*Individual response* Nothing declared
-	--	Parent and Mental Health Scotland	*Organisation response* Perinatal and infant mental health awareness and advocacy organisation.

			It would be a resource we could share. Please note I am also a parent with lived experience.
RCM		The Royal College of Midwives	*Organisation response* The Royal College of Midwives is a membership organization and sees this Guidance as an opportunity for the RCM as a professional organisation to influence its members in terms of communications and dissemination of the contents and enable them to engage with current recommendations/ and the evidence base on Perinatal Mental Health
RL	Rachael Leonard	Research and Service Development Officer, NCT	*Organisation response* A voluntary organisation providing support to expectant and new parents. Draft recommendations in this SIGN guideline will have no discernible impact on the function or productivity of our organisation.
SA	Susan Ayers	Professor of Maternal and Child Health, City, University of London	*Individual response* I received NIHR funding for many of the projects mentioned in my feedback. As above - my feedback is based on funded research projects we are currently conducting or recently completed. I am also lead author of the City Birth Trauma Scale referred to in the SIGN Guidelines.
SG		**Scottish Government , Supporting Maternal and Child Health Wellbeing Unit**	***Organisation response*** **Scottish Government - Policy unit has involved breastfeeding leadership team (professional advisors - breastfeeding and infant nutrition) in this response.** **No discernible impact**

SHS	Sarah Hallam Stewart	Change Manager- Perinatal and Infant Mental Health, Fife H&SCP	*Individual response* Nothing declared
SMu	Susan Munro	SLT Operational Lead (Mental Health & Learning Disability), NHS Fife Speech and Language Therapy Service	*Organisation response* We would welcome inclusion in local provision around peri-natal mental health to promote the best quality service.
ZD	Zoe Darwin	Reader in Health Research, University of Huddersfield	*Individual response* I am an author of work that has been cited here concerning LGBTQ+ perinatal experiences and therefore providing feedback on ensuring appropriateness of language throughout. I also am an author of work concerning assessment of fathers, other non-birthing parents and partners, which I am suggesting to consider including, given recent international interest in this work in developing perinatal mental health guidelines (in Australia). I am a parent.
Group members			
SM	Susan McConachie Regional Perinatal Nurse Consultant	Regional Perinatal Nurse Consultant, NHS Lothian	Individual response Nothing declared

Section	Comments received		Development group response
Section 1 - Introduction			
General	**JM**	In general this is well -researched and well written. I am concerned that Eating Disorders are not listed together with other diagnostic categories, given their physical consequences, growing prevalence and potential consequences for future family relationships. It is entirely appropriate to signpost readers to the Eating Disorders SIGN guidance, but this does not mean it can then be virtually ignored in the rest of this document, any more than the existence of guidelines on bipolar disorder allow that to be relegated to a cross reference.	We would prefer to signpost people to the full eating disorders guideline to get a more comprehensive view of care for people with eating disorders. This is in line with the approach we are taking with other conditions such as substance use. We envisage that the toolkit will be the main point of reference for people with lived experience, and it includes a dedicated section on eating disorders.
General	**ZD**	It is encouraging to see reference to literature on perinatal mental health and LGBTQ+ people (references 66-69) Throughout, please check usage of birthing parent (used to refer to gestational/carrying parents) vs. birth parent (which is frequently used in the context of removal into social care).	*A new section, 1.1.2 has been added to explain the terminology used and what it includes. Birth parent ahs been changes to birthing parent throughout.*
General	**HG**	I only had a quick look over your draft guideline but noted that hormonal side effects of contraceptives as contributing factor to MH issues postnatally and hormonal treatment approaches seem to have overlooked. Hormonal side effects on mental health are quite common and should be mentioned as part of the differential diagnosis in women with MH issues post partum. I also find that most of the patients I see with PMS /PMDD also	We have added some information on allopregnalonone and other progesterone metabolites to section 4.2.4: other pharmacological therapies. However, they are not yet licensed in the UK so no reocmmendation for use has been included.

		suffer from postnatal mental health issues and are progestogen sensitive too. PMS/PMDD is of course suppressed during pregnancy but can return very quickly, especially in women who are not breastfeeding. Please mention this differential diagnosis for HCP to consider in women with MH issues postnatally as it if often quite easily treated with hormones – see RCOG PMS guideline. Thank you for considering to add this to the guideline.	
General	--	Documents appeared well set out with clear information provided. The detail given was accessible and understandable which will ensure it is supportive to in achieving good clinical standards. Recommendations appear right for NHS Scotland. Easy to access and use. It provided helpful resources such as the Cope Guidelines & Shared decision-making toolkit, amongst others. Useful to ensure same high level of practice across board with understanding of each available support/service and lead to quicker, more responsive and least invasive access to correct support/treatment which is most beneficial to improving and promoting positive outcome for patients and their families. The document focuses a lot of women supported by secondary care; however, many women, arguably more	*Thank you*

		women, are supported by primary care and community supports. For example, in North Ayrshire we have a dedicated Perinatal Wellbeing Team who supports new and expectant mums experiencing low level mental health difficulties, many of whom are also supported by their GP and are on prescribed medication. Additionally, other professionals including community midwives, health visitors and family nurses provide ongoing support to all mums from those experiencing poorer mental wellbeing to those with a diagnosis of mental illness. The document would benefit from reflecting this more explicitly. Encouraging to see that specific mention has been made of dads, both in terms of their role in supporting a mum, but also in the context of family-supported care planning. Mental health of dads is a significant factor in our child protection cases and whilst community and primary care-based services are available, a greater focus needs to be placed on dads in terms of their mental health in the perinatal period. More as an observation, anecdotally within health visiting services, we are hearing of many stories of trauma for women who delivered during the COVID pandemic when tight restrictions were in place in hospitals. With this impacting on a women, and indeed their partner's willingness and confidence to have another child. There is no mention of this in the paper, but this may impact on the PTSD prevalence.	*Section 1.3.2 Target users of the guideline has been rewritten to cover more groups.* *We have not included treatment for dads in the remit as fathers cannot currently access treatment in perinatal services at the moment. We have added further signposting to third sector organisations in section 2.* *An additional paragraph has been added on COVID-19 to section 1.1.*

General	**TL**	I believe the recommendations are feasible. It's good to see 'The Promise' and GIRFEC so prominent in the introduction. I really like how much time is given to mental health conditions. I would have liked to have heard more about the experience of Minority Ethnic birthing parents too, and perhaps if the document could have aligned itself with the Whole family wellbeing principles that would help too. I believe it is a missed opportunity to not give more weight to the non birth parent or Dad. Fathers are mentioned 4 times in the whole of the document, when we know and understand they have a vital role to play in the mental health of the mum/birthing parent and child, also their own mental health is vital to good outcomes for the family and child. It feels short sighted in 2023 to develop guidance for one person, as opposed to the whole family. Health professionals have told us, they are frustrated at having a pathway of care for Mums/birthing parents and not one for the Dads/non birthing parents.	There is a limited evidence base around specific care for minority ethnic women/birthing parents. A call for further research has been added to section 9. The introduction has been restructured to give the role of fathers more prominence. We cannot provide a pathway of care for dads when services are not able to provide this care at the moment. We have cited GIRFEC which captures principles for whole family wellbeing. We have also included additional signposting to support for dads in section 2: Screening and assessment.
General	**SMu**	Stated target users of the guideline names many professions specifically but only includes one of the AHP professions. Acknowledgement of neurodiversity is strongly welcomed but the needs of neurodivergent parents are not overtly reflected in the wider document. Further, whilst	The target users has been rewritten to cover more general groups as it is not possible to produce an exhaustive list. There is a limited evidence base around neurodivergent parents which is why this area is not

		neurodivergent adults regularly experience communication differences (e.g. autism, ADHD) other conditions such as Developmental Language Disorder will present more significant communication challenges which may require specialist advice or input from Speech and Language Therapy.	covered more fully in the guideline, but the principles of care may still be relevant for these parents. Further research into the benefits of input from speech and language therapists has been added to the recommendations for further research. Intellectual disability has been ad*ded as a comorbidity.*
General	**FH**	Good.	Thank you
General	**NES**	The introduction outlines the importance of considering the importance of the needs of fathers, on-birthing parents and partners. It feels a missed opportunity to set context within the introduction of the crucial importance of considering Infant Mental Health also in this section.	Infant health is mentioned throughout and discussed in section 1.4.9: The parent-infant relationship, perinatal mental illness and infant mental health
General	**FF**	Overall the introduction is good and comprehensively covers all of the key areas. I find the reference to perinatal mood disorders as complications as jarring and dismissive and don't feel it sensitively and appropriately captures the relationship between the two	The first sentence has been changed to: It is well recognised that perinatal mood disorders are common conditions affecting pregnancy and the postnatal period.
General	**LM**	Introduction is well structured, flows well.	Thank you
General	**SMC**	Postnatal contraception - it would be good to see a comment of the importance of this and that all caregivers should take ownership and know how to direct a person to appropriate services to access this.	This has been added to section 3.5 as part of monitoring postnatal wellbeing.
General	**MG**	Throughout you refer to ' women and birth parents' when I think you probably mean 'women and gestational parents' or 'women and birthing people' or 'women and birthing parents'. It's good to see the attempt at	This has been changed to women and birthing parents and a paragraph added as section 1.1.2 to explain what is included in the terminology.

		inclusion, but the wording you have chosen is confusing because birth parents means the biological parents in fostering and adoption. You also refer to 'mother infant' interactions. Consistency in inclusion would be good.	
General	**--**	I feel structure and language is appropriate. I wonder whether there needs to be some emphasis /acknowledgement on maternity and neonatal Psychological Interventions (MNPI) work where this is more in relation to adjustment to some aspect of pregnancy or maternity journey that has not gone to plan and parents require psychological intervention re adjustment to this (e.g. adjustment to delivery of a preterm baby), grief and loss work (stillbirth, recurring miscarriage, birth trauma (loss of hoped for birth). The reason I raise this is that there is a spectrum of perinatal mood disorders/ways in which parents are affected and I feel adjustment to situations where the maternity experience is different to that hoped for is vital for health parent infant relationships and for perinatal mood.	In section 1.1.3 we have added a link to the Managed Clinical Network's five national pathways which cover this spectrum.
General	**RCM**	The Royal College of Midwives (RCM) welcomes the development of this Guideline as an update and replacement for the previous Guideline (SIGN 127). Of importance is the wider context within which the Guideline is placed in terms of mental health conditions and highlighting birth trauma. It is also propitious that the Scottish Mental Health Strategy which is under review and appropriate to embed Perinatal Mental Health within	The following sentence has been added to section 1.5, with reference to the See Me report: Stigma remains a significant barrier to women and families reaching for help and may be increased in some populations such as amongst racialised, gender and sexual minority families.

		that strategy with a focus on prevention, and early intervention through the lens of a life course approach for mental health conditions. It is however important that the updated guidance explicitly cites other guidance relating to some mental health conditions not listed in this draft guidance. In particular, co-morbid issues such as drug dependency, the broader range of violence experienced by some women in 16 racialized communities, and the intersection of these issues with mental health. In addition to how the issue of stigma plays into women affected by perinatal mental health problems and accessing timely care/support/treatment.	Other references to stigma are made throughout the guideline.
General	**SMc**	Within the guideline there is no direct comment on collaborative working with Obstetrics (and other specialists including Neonatal colleagues) I wonder whether a comment on who may encompass the MDT and the importance of collaboration from pre pregnancy right through to postnatal and planning any future pregnancy (eg there may be need for GP, midwife, Obs, health visitor, sexual and reproductive health team for more complex discussion on contraception both pre pregnancy and postnatal etc.., plans for scans, OGTT and other Obstetric input and labour and postnatal care planning/risk assessment as an MDT. Neonatal team also need to be aware of medications given risk of withdrawal and small risk of persistent pulmonary hypertension with eg SSRIs (although note this is not specifically mentioned as a risk	The following sentence has been added to section 3 Care planning: Relevant healthcare professionals include maternity providers (eg community midwife, obstetrician, specialist midwife), mental health professionals (eg adult mental health or perinatal mental health team), health visiting, primary care and voluntary sector professionals where appropriate. Other professionals may also be relevant to involve depending on the package of care provided, availability of services and individualised assessment of need for mother/birthing parent and unborn baby. Section 3.7 on general principles of pharmacological therapy includes advice on neonatal monitoring.

		within the guideline but is something we are mindful of where I work and do try and inform our neonatal colleagues in case of any issues) and any other relevant medication or history. I wonder if there could even be a comment made in page 19/20 around this	
General	**LF**	• Whether the recommendations in the guideline are feasible and implementable in Scotland - There may be limited capacity to roll out the guideline due to workforce issues • Suggestions for supporting implementation of the recommendations.- • Education to upskill staff and support roll out for the guideline to the wider workforce would be beneficial – NHS, SW, Third sector etc. • Links could be made to existing resources i.e., on Turas Learn. Some resources on Turas Learn are essential for the maternity care workforce and could be identified and used better in the resource. • Link to embedding trauma informed care. • Documentation platform (Badgernet) requires to be aligned with recommendations to support effective implementation & national application of recording of collaborative care plan.	NES training and the National Trauma Training Programme have been highlighted in the implementation section. Badgernet are aware of the toolkit's production and it is intended that they will include a link. To be discussed with MCN

		• National forum to share learning • Presentation, structure, language and content of the background information. Toolkit could be more user friendly and easier to navigate Toolkit would be enhanced had it a service user, and professional user sections Section 1: Introduction 1.3 Remit of guidance – this should include infant as well as fathers, non-birthing parents and parents. The needs of the infant cannot be separated Links with key policy and agendas could be stronger. For example, there could include more on, substance misuse and ADHD. These are high risk groups that require more support and should have greater prominence within the guideline. I.e. See – Supporting women reducing harm.: Supporting Women, Reducing Harm – Perinatal Mental Health Network Scotland This should be implemented in collaboration with National Trauma Training Programme. Trauma informed care should be thread throughout guidelines as a priority policy in Scotland and Maternity a key priority area (important to recognise trauma experiences across the various trauma events – birth related). • Policies etc that should be referred to in the PNMH Guideline and toolkit:	The toolkit has been edited and will be assessed by the Plain Language Commission. There are separate sections for the service user and professional user. This has been made clearer in the introductory text. The focus of the guideline is on the mother and the related impact on infant. This is stated in the introduction. The purpose of the guideline is to present evidence-based recommendations not link to government policy, but the introduction does highlight key documents. The Supporting women, Reducing Harm report has been added to section 1.6.4: Substance misuse.

		• Supporting Women, Reducing Harm: https://www.pmhn.scot.nhs.uk/supporting-women-reducing-harm/ (care provision varied across Scotland – key recommendations) • UNICEF Baby Friendly Standards should be included and referred to in the standard – this is adopted by all NHS Boards in Scotland UNICEF Baby Friendly Standards: https://www.unicef.org.uk/babyfriendly/about/standards/ • National Trauma Training Programme: https://transformingpsychologicaltrauma.scot/ Trauma informed practice – National Trauma Training Programme needs to be referred to throughout Turas Learn National Trauma Training Programme: https://learn.nes.nhs.scot/37896 (New 3-year plan due for publication). 1.3.2 Target users of the guideline. Recognised that list could be massive however key missing personnel include sonographers, addiction teams PNMH is relevant to all working with pregnant women and with families with young infants 1.4.3 Focused mostly on birth trauma – need to emphasise the wider impact of trauma on psychological wellbeing in line with the NTTP. Ideally this has own section or this section starts with the wider trauma to address recent reports on maternity services lack of	1.3.2 It is not possible to produce an exhaustive list but this has been reworded to be more general. 1.4.3 The focus is on birth trauma not wider trauma, so this is out of scope. 1.7.1/2 – now in section 1.6 Individuals would be managed in the same way while pregnant so the advice is relevant.

		NTTP and TI practice (possibly link to WCYPF NES report https://learn.nes.nhs.scot/60198 1.7.1 ADHD – NICE guideline is referred to; however it does not contain anything specific to pregnancy 1.7.2 Autism Spectrum Disorder – SIGN 145 referred to, however does not contain anything specific to pregnancy	
General	**MMHA**	The introduction mentions that professionals should be alert to signs of abuse and neglect towards infants and notes the statistical links between this and underlying challenges such as domestic abuse. Although the same section notes the findings on maternal suicide from the recent MBRRACE report, the guidelines do not currently acknowledge the information from MBRRACE regarding domestic abuse towards women and the very strong links to mental ill health and suicide. MBRRACE found that domestic abuse was documented in 33% of the suicides studied (and 70% of deaths related to substance misuse). We also know that the records of many women who have lost their lives to suicide do not include information about whether they were a victim of domestic abuse, so we don't know the true number, which is likely to be higher.	Sect 1.5.1 covers intimate partner violence.

		The Scotland Parent and Infant Mental Health Programme Board delivery plan refers directly to expectations that medical professionals will respond to domestic abuse and trauma. (https://www.gov.scot/publications/perinatal-infant-mental-health-programme-boad-delivery-plan-2019-20/) Given the prevalence and risks associated with mental health and domestic abuse, and the risk that women face a double disadvantage of two heavily stigmatised difficulties, we recommend clearer information on how best practice can be implemented. In January 2023, MMHA published a briefing on the links between domestic abuse and perinatal mental ill health. This includes a variety of recommendations to help improve outcomes for mothers and infants experiencing abuse. Some of these recommendations are relevant to sections of the guidelines and have been detailed below.	
1.1	**KM**	"Highest incidence is amongst mothers of infants 0–3 months (26.7 per 100 person years)." – could this be clarified – is it 26.7 cases? Perhaps this is purposefully brief but the focus on prevalence is antenatally. There is a lot of postnatal data available too. A few take homes which might be helpful? – pregnancy is not protective against mental disorder but most	The statistic has been removed. Unlike the original SIGN guideline which was a longer review process and involved a full review of the published evidence base, this guideline has not involved a full review of the epidemiological evidence base and the information in the introduction is aimed as an overview

		disorders do not increase in frequency, apart from OCD. In contrast, postpartum is a high risk time for women to relapse and develop new mental disorders. Depression and anxiety disorders are the commonest complication of pregnancy in high income countries. I remember the previous guideline was really helpful on broad principles and epidemiology.	
1.1.2 (now 1.1.3)	**KB**	Service Provision – the 2017-2027 wellbeing strategy is now being replaced by the Mental Health and Wellbeing strategy. This has been introduced due to the impact of COVID-19 affecting the delivery of the 2017-27 strategy. This strategy is an indefinite strategy.	The new mental health and wellbeing strategy has been added.
1.1.2 (now 1.1.3)	**MCS**	To address the educational needs of a newly developing and expanding workforce NHS Education Scotland (NES) National Education Scotland, the managed clinical network, and PIMHS have coproduced a perinatal curricular framework, with a training plan covering third sector to specialist services, including perinatal and infant mental health. 17,18. Think it would be good to reference instead the two NES pages most relevant, so they would be : Perinatal Mental Health https://www.nes.scot.nhs.uk/our-work/perinatal-and-infant-mental-health/ and Infant Mental Health https://www.nes.scot.nhs.uk/our-work/infant-mental-health/	These have been cited.
1.1.2 (now 1.1.3)	**EMH**	The Third Sector is an essential provider of Specialist Perinatal Mental Health Services, dedicated the highest clinical standards and aligned to the Infant Pledge,	The voluntary sector offers valuable services, however the focus of the guideline is to provide evidence-based recommendations for therapies. Service design is

		Keeping the Promise and the Women and Families Maternal Mental Health Pledge. Understand that this is a statutory sector document. It would be good to see the formal acknowledgement of the significant contribution from the non-statutory third sector contribute to Perinatal Mental Health. And how vital our role is in supporting our NHS Colleagues to achieve the service provision needs in Scotland. Regarding collaboration between our sectors in the provision of perinatal mental health services; there is no seamless link between us and statutory health services. despite the progress made there remains no long term funding for the delivery of perinatal counselling in for organisation like CrossReach, despite our proven track record over decades, working with such a wide range of distress levels and with such consistently positive results. What does sustainability of statutory, community and third sector provision look like?	outside the remit, however, considerations for better links between statutory and third sector services has been added to the implementation section.
1.2	**KM**	"The Pledge ensured that lived experience was not only at the heart of new and expanding services and that a holistic family approach would be sustained by informing outcome measures for service delivery" – I think the and before "that" should be a but.	The 'and' has been changed to 'but'.

		"...though a life model from preconception to the end of life. (Scottish Government 2023 still to be published)" – though should be through	
1.2	**KB**	typo in guideline 7 and 8 (repetition)	Thank you. Typos are checked prior to publication.
1.2	**MG**	point 4 and 6 - this would be better worded as 'your perinatal mental health' than 'your maternal mental health' as not everyone will have 'maternal mental health'.	This has been changed to the direct quote from the Pledge, using the first person.
1.2	**EMH**	Point 5. Guidelines document refers to *'rapid' access to talking therapies during pregnancy and postnatal period* - I am curious as to why there is no further guidance on this in terms of timelines - we currently place expectant parents to the top of the waiting list and so we are aligned to this principle by doing so however what about best practice /acceptable time boundary for cases where NHS (Health Visitor) refer into Crossreach a moderate/severe case (not pregnant) and not known to be moderate/severe until we do the assessment - worst case scenario this could be 3 months waiting……would be good to get their guidance on these cases/their role in keeping in contact with such cases until such time as the parent enters therapy? How is this being managed what does this mean? We in the 3rd sector are not receiving new/consistent funding to ensure rapid access..... to our counselling services.	Point 5 is a direct quote from the woman's pledge. Until there is more specific evidence we can't state timescales. Until then this is an issue for implementation. A sentence to consider how statutory and third sector organisations align has been added to the implementation section.
1.3	**KM**	"anxiety disorders, including generalised anxiety disorder, obsessive compulsive disorder (OCD), psychological birth trauma and PTSD"- ICD-11 separates these disorders out – OCD and PTSD no	The organisation and categorisation of disorders for this guideline is in keeping with the methodology and wording followed by the original COPE guideline, in which recommendations were grouped under these

		longer fall under “anxiety disorders”. I think they should have their own separate bullet points. I also think that “psychological birth trauma” isn’t a disorder and shouldn’t be clumped in this way. I think it could be combined with PTSD in a bullet point or have its own one. “and on some areas of the UK services are extended to 24 months.” – on should be in. I also think it would be worth noting that parent infant relationship teams see families for longer – up until the child’s third birthday.	themes and not according to ICD-11 classification. An explanation of this and signposting to ICD-11 has been added to section 1.3.1 On changed to ‘in’. This is covered by the signposting to the care pathways which have been added to section 1.1.3.
1.3	**MG**	Last paragraph, fathers and birth partners should also say non-birthing parents. Could chestfeeding be included alongside breastfeeding?	A paragraph explain terminology used and what it encompasses has been added to section 1.1.2.
1.3	**EMH**	Perinatal Period up to 36 months post pregnancy at Crossreach	The following sentence has been added: Other services such as infant mental health and third sector services may work with woman and their families within different time frames.
1.3.1	**MCS**	There seems a missed opportunity to think about the mother-infant relationship but also the wider family system as a whole. You rightly highlight the need to think about fathers and non-birthing parents/partners but don’t mention with wider family system. As well as using this as an opportunity to highlight infants, it could also highlight the impact on older siblings too.	This guideline was based on the COPE guideline. Review of the evidence base relating to wider family interventions and older siblings was not included as part of this guideline review. The introduction highlights the importance of a family approach to care planning including family-focussed care and family-based interventions. Mother-infant relationships are included as part of the review.

1.3.1	**KB**	We would suggest that the scope of the review and guidelines are expanded to support the mental health needs of fathers, partners, and non-birthing parents, beyond signposting. See Me recently published evidence based good practice guidelines and a literature review on PNIMH stigma in MHSs (carried out by MHF for See Me). The evidence based good practice guidelines emphasise that a whole family approach is key to providing comprehensive mental health support within PNIMHs. See Me's literature review emphasised partners experiences of stigma and exclusion from PNIMH services. This includes feeling like the 'invisible parent' excluded from services (especially for LGBTQ+ partners). Other Barriers include: emotional responses to mother's admission to hospital, not recognising or misattributing symptoms, feeling a need to 'stay strong' for the mother and not seeking help until crisis point. Further the report highlighted partners feeling they are not legitimate service users as they would be 'stealing' their partner's limited time with healthcare professionals. These findings suggest that self stigma may impact the effectiveness of sign posting under these guidelines and should be expanded to deliver a whole family approach.	We cannot provide a pathway of care for dads when services are not able to provide this care at the moment. We have cited GIRFEC which captures principles for whole family wellbeing. We have also included additional signposting to support for dads in section 2.
1.3.1	**ZD**	Please consider here revising to "fathers, other non-birthing parents and partners" consistent with approaches used elsewhere, which are intended to parental role of all non-birthing parents; this includes the	The terminology used and an explanation of the approach taken to inclusion has been added as section 1.1.2

		NHS good practice guide (https://www.england.nhs.uk/mental-health/perinatal/perinatal-mental-health-resources/involving-and-supporting-partners-and-other-family-members-in-specialist-perinatal-mental-health-services-good-practice-guide/) and the linked evidence synthesis on perinatal mental health assessment (https://www.frontiersin.org/articles/10.3389/fpsyt.2020.585479/full).	
1.3.2	**KB**	We would also add unpaid carers to this list.	The section has been updated to reflect more general groups as it is not possible to produce an exhaustive list.
1.3.2	**EMH**	No mention of not for profit/third sector perinatal specialists including perinatal counsellors/psychotherapists.	The section has been updated to reflect more general groups as it is not possible to produce an exhaustive list.
1.3.2	**MCS**	Specialist MBU's and perinatal mental health units are mentioned but not MNPI teams or infant mental health teams – I think it would be important to include these services in the target audience also given the referral pathways in Scotland.	The section has been updated to reflect more general groups as it is not possible to produce an exhaustive list.
1.3.2	**EMH**	There is no reference to either Psychotherapists or Counsellors in terms of the target audience of this document - it refers to psychologists in there and nursery nurses J or have I missed something?	The section has been updated to reflect more general groups as it is not possible to produce an exhaustive list.
1.3.3	**--**	In 1.3.3 the term 'neurodiverse' is used, there's some debate over neurodiverse vs neurodivergent which may be worth considering if it has not been already - e.g. https://dart.ed.ac.uk/neurodiverse-or-neurodivergent/	Changed to neurodivergent.

1.3.3	**KB**	We strongly encourage engagement with lived experience and emphasise the need for their involvement in the co-creation of this document. It may be useful to publish the characteristics of lived experience engagement to ensure that diverse voices have shaped the guidelines. (The link provided later in this chapter does not show the equality evidence). By meaningfully engaging with people with lived experience, organisations can more effectively meet the needs of the people they are supporting. Lived experience voices are invaluable in highlighting experiences of stigma and discrimination within healthcare when co-designing solutions, which can help tackle systemic issues. We suggest referring to Health and Social Care Alliance Scotland's report titled "Engaging people with lived experience: best practice, challenges, and opportunities" as good practice guidelines for ensuring meaningful engagement in the re-design of PNIMH services. This will ensure the guidelines take an intersectional approach to perinatal and infant mental health support. For example in See Me's perinatal literature review, women from a range of ethnic minority backgrounds emphasised overcoming cultural expectations and strong social imperatives such as sharing personal worries outside the family circle and challenging the 'Strong-Black-Women' stereotype.	The guideline development group included three representatives with lived experience. This is detailed in section 10.2. SIGN also consulted relevant organisations and ran a focus group to gather views. These are detailed in section 1.3.3 People with lived experience and voluntary organisations were invited to comment on the draft guideline. The equality impact assessment will be published alongside the final version of the guideline. Service re-design was not part of the evidence-based review and therefore no specific recommendations are included. Reference to the SeeMe report has been added to section 1.5: sociocultural considerations. Medication: This guideline highlights the importance of having discussions with women about their personal preferences relating to their treatment including medication and identifying the risks and benefits and other key considerations. The guideline highlights the importance of taking into consideration sociocultural and religious beliefs in the introduction. Perinatal mental health services serve diverse communities in Scotland, which may have distinct cultural or religious beliefs and traditions relating to pregnancy, childbirth and the early postpartum period as well as child

		Section 1.5 – A theme within our literature review is consistent with the clinical guidelines findings that women stop use of medications during pregnancy/breastfeeding with 'reluctance to take medication' uncovered as a key theme. We support presenting women/birthing parents with the relevant information through considering medication risks and benefits. The literature review produced by See Me highlights the impact of healthcare professionals failing to discuss treatment options/preferences with women. This magnified birthing parents feelings of having no control over their lives and their treatment resulting in lowered engagement. A key theme within the review was 'neglecting to discuss treatment options' as a missed opportunity to support women. We would suggest a process of shared decision making, beyond discussion of risks and benefits of treatment to ensure that the treatment selected is patient-led. Practitioners should ensure language and terminology is accessible and inclusive and further consult with service users on decisions about which treatments to use, wherever possible. Section 1.6 (pg. 8) – We support the acknowledgement of delivery of an anti- racist approach to mental healthcare. We would flag that in order to achieve this, diverse lived experience voices must be fully included in the co-creation of this approach.	rearing, with a need for services to provide culturally informed and competent care that respects and works collaboratively with diverse parents and their families. The toolkit is compatible for use with translation tools. We have also signposted in the toolkit to leaflets and videos that are available in other languages. Section 1.5 covers cultural considerations. A reference has been added to the See Me report on stigma.

		We would flag that considerations such as translators and written health information available in different languages should be key. Barriers to accessing mental health care support include, not understanding the current system or difficulty understanding the information provided through healthcare. See Me's literature review highlighted that immigrant mothers can be reluctant to seek help or be diagnosed with a perinatal mental health condition, this can be centred around concerns that immigration status or chance of employment may be negatively affected if a diagnosis is on their record. Access to health is a human right and mental health stigma and discrimination act as barriers to this. Adhering to the recommendations placed within the Coalition for Racial Equality and Rights Anti Racist Policy report will amplify the effectiveness of these standards, creating a more inclusive approach. Further, investment into staff training to ensure cultural competency may also tackle barriers to access. The Mental Health and Social Care Directorate's (2021) assessment stated that staff's lack of awareness of cultural considerations could be a barrier to use of those services by some religious or other groups.	

1.3.3	**ZD**	p4 paragraph 1 – check if this also concerns other non-birthing parents (not only fathers), i.e. in recognition of non-male non-birthing parents being parents (not simply birth partners).	This reflects the themes gathered from voluntary organisations when defining the remit of the guideline. The voluntary organisations had experience with a diverse range of people seeking help. The primary focus of the guideline is however support for women/birthing parents, as described in section 1.3.1.
1.4	**KM**	1.4 Re definitions – use of term childbirth. How about "end of pregnancy" – would a miscarriage be termed childbirth?	This guideline focusses on the management of perinatal mental illness and did not focus on interventions specific to pregnancy loss or miscarriage. (NICE guidelines can be referred to (CG192))
1.4.2	**MG**	This paragraph omits birthing people who are not women, whilst not referencing research only conducted with women.	The terminology section has been revised. The evidence base relating to gestational parents and birthing parents that do not identify as women is very limited and it is unclear whether or not findings apply equally to the different groups,. As a result there are limitations in the evidence base presented, however the importance of including diverse parents is acknowledged in the introduction.
1.4.3	**MS**	Clear introduction and helpful outlining of different conditions which I imagine will be very informative for non-mental health professionals who play a key role in the perinatal period e.g. midwives. In section 1.4.3 it is stated that there is recognition that stillbirth is linked to increased risk of PTSD. Within the National Bereavement Care Pathways Scotland that are currently being implemented nationally one of the standards relates to bereaved parents being offered	Thank you for your comment These guidelines followed the COPE evidence based guideline and as such it is not within our scope to expand this beyond the remit and methodology that was followed. SIGN encourages professionals to

		emotional support and specialist mental health support. I wonder if this point in the guidance could be expanded to link with the NBCP and offer guidance/signposting on what this specialist mental health support looks like within the perinatal period.	consider implementation of the guidelines in their relevant field of work, where applicable.
1.4.3	**KM**	Anxiety disorders – see comment re ICD-11 structure. Aligning with ICD-11 will make guideline more future-proof.	The organisation and categorisation of disorders for this guideline is in keeping with the methodology and wording followed by the original COPE guideline, in which recommendations were grouped under these themes and not according to ICD-11 classification. An explanation of this and signposting to ICD-11 has been added to section 1.3.1
1.4.3	**MCS**	When talking about prevalence studies it is highlighted that prevalence rates increase from 3- 18.5% in high risk groups and mention women who experience serious complications during childbirth as an example of a high risk group, however, I wonder if it's worth expanding this a little and giving a further example that also highlights women who have experienced a previous traumatic experience as a high risk group, particularly given the current focus of trauma-informed care – might be an opportunity to bring this in within the introductory section a bit more? It is also important to note that it is the perception of having been unsafe or uncared for that predicts trauma independently of the medical complexity of the birth. 'While only a small number of women reach the full diagnostic criteria for PTSD, others experience birth	Trauma-informed care is mentioned in the introduction and the trauma section. The following sentence has been added: The term psychological birth trauma captures a wider definition of experience, outside of a specific clinical disorder such as PTSD and recognises that psychological birth trauma is related to number of factors including experience of care rather than medical complexity of childbirth

		trauma where they are affected by partial symptomology which can have a considerable impact on their quality of life'. Agree fully but wonder if this could be expanded with a further sentence highlighting the point that those who don't reach full diagnostic criteria for PTSD may still benefit from additional support.	
1.4.3	**FF**	A further comment is under the trauma section this appears to be mainly focussed on birth trauma and PTSD emanating from this. Although complex trauma has been briefly mentioned it feels disproportionate to the volume of women that we see with complex trauma, CSA and other interpersonal traumas and the impact of this on navigating the challenges of pregnancy, birth and having a baby as well as reactivating their own traumas and grief and as an indicator for developing other co-morbid mh conditions	This guideline followed the evidence-based review undertaken by COPE. There is a limited evidence base relating to complex trauma in the perinatal period. The recommendations in this guideline followed the methodology undertaken by COPE and it is outwith the scope of this guideline to expand this further.
1.4.4	**KM**	"Prevalence rates for depression vary between the antenatal and postnatal periods, ranging from between 5–33% and 10–15%. 26,37" – what does this mean? Which prevalence applies to when? Isn't depression even more common postpartum than in pregnancy? Perhaps flag here that perhaps contrary to expectation, antenatal depression is associated with poorer outcomes for child than postnatal depression.	The rates are a cited directly from the studies. The sentence has been changed to: Prevalence rates for depression vary between the antenatal and postnatal periods, with international studies reporting rates ranging from between 5–33% and 10–15% respectively. Evidence around the association of antenatal depression on outcomes for the child is not conclusive and would be too detailed to discuss in this introduction, which is intended as an overview of prevalence.

1.4.4	**KM**	"The risks of relapse for women or birth parents with a pre-existing bipolar affective disorder vary according to their subtype of the disorder." – would birthing be clearer? Sounds like this could apply to non-gestational partners too. Bit unclear having schizoaffective disorder mentioned under bipolar heading – and it duplicates what comes later "For a small group of women, experience of a first episode of a major psychiatric illness in the early postpartum period (0–14 days) that requires support from specialist services, may herald later onset of bipolar affective disorder." – I found this confusing. How about instead "For the small group of women who have a first psychiatric contact within 14 days of delivery, about 1 in 6 will later go on to be diagnosed with bipolar disorder – about four fold higher than women who have a first psychiatric contact at other times" "Cohort data suggests that women with schizophrenia, however, may be at higher risk of adverse obstetric and neonatal outcomes, highlighting the importance of care co-ordination and care planning" – this is also true for bipolar. If going to mention one should mention both?	This has been changed to birthing throughout the guideline. The sentence is saying that bipolar is one of the two conditions to be aware of as having the greatest risk of developing psychosis. Prefer to leave this as it is. Reworded to: For a small group of women, experiencing an episode of a major psychiatric illness (requiring specialist support) for the first time in the first 14 days postpartum may lead to later onset of bipolar affective disorder. The advice for multidisciplinary care planning has been moved from here to the general introduction to section 1.4.5.

1.4.6	**KM**	Borderline personality disorder (BPD) is a complex psychiatric disorder marked by severe affective instability and poor interpersonal functioning. " – I think this should be updated to additionally include ICD-11 nomenclature – personality disorder with borderline pattern specifier. Also really should mention complex PTSD here as this is the direction of diagnostic shift. I also wonder if there is a kinder way to phrase the symptom description. Difficulties in interpersonal functioning perhaps? Perhaps mention somewhere that the stress of pregnancy and parenthood are particularly challenging as parenting role models are often lacking and attachment difficulties present? Should probably also mention the high prevalence of childhood sexual abuse and how this plays into anxiety around birth and the need for trauma-informed birth planning.	An explanation for the terminology used, along with signposting to ICD-11 has been added. The section on borderline personality disorder (section 7) provides further information about relevant considerations, particularly with respect to parenting. This is covered by the sentence in section 1.4.3: Post-traumatic stress disorder may be childbirth-related, associated with other stressors, or be present in the context of previous childhood trauma or complex PTSD.
1.4.6	**PB**	The introduction is clear. I particularly liked the definition section detailing the different mental health conditions in the perinatal period. However in 1.4.6 the term 'emotionally unstable personality disorder', or simply 'personality disorder' is often used now instead of the term 'borderline personality disorder (BPD)'. Perhaps this could be referred to.	The guideline uses the definition in the evidence review by COPE. A paragraph has been added to section 1.4.6 to explain this and signpost to terminology for ICD 11.
1.4.7	**KM**	" maternal anaemia, infant feeding difficulties. " missing an and	And has been added.
1.4.8	**LC**	The parent-infant relationship:	This guideline refers to the parent-infant relationship. This review followed the evidence-based review in

		If we are to respect infants as individuals, we must try to address potential future implications of the illness of mothers in tandem with the treatment of their illnesses, wherever possible. Music Therapy has been implemented within one of the two MBUs in Scotland to simultaneously support the bond between mother and baby, and address potential cognitive delay by stimulating baby's mind and communicative abilities. "the usage of lullabies is reported to stimulate early language development, an occurrence that is important particularly because infants of mothers who are depressed	COPE guideline. No significant evidence base was highlighted for music therapies. COPE did not include music therapy as an intervention. As this is not a standard intervention offered in NHS Scotland the guideline group have not conducted an additional evidence review. A sentence has been added to section 4.1: "Other therapies, such as art or music therapies are available, particularly through third sector organisations, but were not included in this evidence review."
1.4.8/1.4.9	**SMc**	It would be good to see patient-infant relationship, perinatal mental illness and infant mental health highlighted as its own heading Maternal suicide page. I'd like to see this have its own heading and not tucked in as a subsection. It's the leading cause of direct maternal death within a year but does not stand out/highlighted in this guideline.	This has its own heading under section 1.4.9 The introduction has been restructured so that suicide as the leading cause of maternal death is included in the first paragraph of section 1.1.1. It has also been given its own section, 1.4.8
1.5 (now 1.7)	**SG**	Point 1:5 – Suggest change wording to say benefits and risks of medications as putting risks first gives impression they are all very unsafe	This sentence has been changed to: Careful consideration relating to the benefits and risks of medication is required during pregnancy and for breastfeeding parents.

1.5 (now 1.7)	**MG**	Suggest chestfeeding parents are added	Chestfeeding has been added to the explanation on terminology in section 1.1.2
1.6 (now 1.5)	**SM**	Mental Health Strategy has now been published	This has been added.
1.6 (now 1.5)	**MCS**	Sociocultural considerations – does touch on culture/religion/racial and gender inequalities but feel that the racialized minority section sits better under the paragraph that talks about maternal morbidity and mortality being higher amongst black women and those from ethnic minority groups. Also feel the section of LGBTQ+ could be strengthened with an example rather than just say that this group needs further attention. Could also include socio-economic disparities which are pronounced in Scotland?	The section has been moved to sit under the between mental health conditions and comorbidities. The first paragraph of the guideline, section 1.1.1 now includes the statement that mortality is highest amongst Black women and those from minority ethnic groups. The evidence base is sparse so we don't think it is feasible to add examples. Scottish disparities are covered earlier in section 1.1.1.
1.6 (now 1.5)	**ZD**	The example barriers that are listed as relevant to the inequalities face by people from minoritised ethnic backgrounds do not adequately acknowledge barriers that operate at different levels (e.g. system level). This is a relevant place to summarise a wider range of barriers and acknowledge the critical role of interpreters (e.g.	Thank you, we have looked at the study and feel the points found in the matrix are covered sufficiently within the context of this clinical guideline.

		NIHR-funded MATRIX study https://www.matrixstudy.org/), in addition to heightened incidence of trauma (e.g. in forced migrants)	
1.6 (now 1.5)	**MG**	Black should be captialised	Amended
1.7.1 (now 1.6.1)	**MG**	This paragraph reads as though more than 5% of the population are now diagnosed with ADHD. This is untrue - prevalence is estimated at 5%, currently considerably less than this percentage are diagnosed, and diagnosis rates have not yet reached 5% despite the increases in young people and adults receiving a diagnosis.	Data is correct as it is presented. We've added more detail to clarify the point.
1.11.2	**SM**	pg 12 all prescriber medical and non medical work within the Royal Pharmaceutical Competency Framework	This has been changed to the following sentence: Non-medical prescribers should ensure that they are familiar with the legislative framework and the Royal Pharmaceutical Society's Competency Framework for all Prescribers.
1.11.2	**IMHDG**	p11 under off-label prescribing, can we amend "doctor" to "doctor or independent prescriber" or just "prescriber"? thus, acknowledging that a lot of non-doctors will be prescribing and this guidance on prescribing off-label also applies to them Is there reference to comorbidity such as disability, Intellectual Disability, sensory impairments, substance use	*Doctor is used here because it is quoting from the advice from the General Medical Council for doctors.* Advice for non medical prescribers has been updated with a link to the Royal Pharmaceutical Society Competency Framework. We have added a section (1.6.2) to highlight that people with intellectual disability may have specific parenting needs, however, this is not covered in this guideline.

			It is hoped that use of the shared decision making toolkit will make the advice more accessible to people with sensory impairment or disability. The advice regarding mental health care is applicable.
Section 3 – Screening and assessment			
General	**FH**	Good.	Thank you
General	**JM**	In general this is well-researched and well written. I am concerned that Eating Disorders are not listed together with other diagnostic categories, given their physical consequences, growing prevalence and potential consequences for future family relationships. It is entirely appropriate to signpost readers to the Eating Disorders SIGN guidance, but this does not mean it can then be virtually ignored in the rest of this document, any more than the existence of guidelines on bipolar disorder allow that to be relegated to a cross reference.	The following sentence has been added to section 2: Pathways or referral to services to support a pregnant woman/birthing parent with comorbidities, such as an eating disorder, should also be considered.
General	**IMHDG**	Comorbidities: Neurodiversity: These may not have been identified or formally diagnosed prior to pregnancy so consideration should be given to screening and assessment of the presenting issues that pre-date pregnancy e.g eating disorders, traits of what looks like OCD, reluctance to leave the house, difficulty managing social groups. It's wise that these guidelines don't attempt to go into ND but the screening for the perinatal mental health	The following sentence has been added to section 2: Pathways or referral to services to support a pregnant woman/birthing parent with comorbidities, such as an eating disorder, should also be considered.

		conditions should be clear if symptoms were consistent pre-pregnancy that there is likely and undiagnosed condition exacerbated by pregnancy.	
General	**TL**	It's reassuring to see how trauma is woven through the screening and assessment process.	Thank you – no action required.
General	**LM**	Cannot identify any factors that would indicate these recommendations are not achievable. Appropriately translated versions will be key	Thank you – no action required.
General	**FF**	Comprehensive	Thank you – no action required.
General	**LIMc**	There are many organizations who have these screening and assessment recommendations in place - to screen, to offer resources, to have a care pathway, etc. There are not really any organizations (besides ours) that offer a full business model on how to institute a Perinatal Mood & Anxiety Disorder comprehensive screening program. A step-by-step guide that ends in creating a screening-specific policy and procedures manual for use. The EPDS screening tool alone may not be enough to assess perinatal depression - it has a large range of sensitivity and specificity so there are many nuances. In addition, anyone who screens positive for depression needs to be given the Mood Disorder Questionnaire (MDQ) for Bipolar Disorder as it often mimics depression; people seek help when they are in a down state and not in a manic state. Providers will find Bipolar Disorder resistant to depression medications such as SSRIs. We have a toolkit of screening tools, what they measure, the sensitivity/specificity of each	The evidence indicates the use of the EPDS tool. Any tool should always be used alongside clinical judgement. Other tools are recommended to pick up anxiety. The following sentence has been added to the introduction: They are not diagnostic and all screening tools should be used along with clinical judgement.

		tool, how many questions it has, and how to score it. Using just the EPDS is going to miss a lot of suffering people. Anxiety is a twin of depression and the EPDS does not pick that up effectively enough to be of clinical significance.	
General	**MMHA**	The MMHA briefing includes the following recommendation relevant to this section: Screening for and assessment of perinatal mental health challenges must incorporate skilled enquiry about experience of domestic abuse, both past and present. Guidelines must routinely and explicitly highlight the need for professionals working with families in the perinatal period to be acutely aware of signs of domestic abuse, coercive control and trauma. This is about always having a lens into the possibility that domestic abuse could be a factor in each case. In addition, there is a need to balance the needs of partners/co-parents and wider family with the risk of inadvertently facilitating abuse, ignoring or missing cases with potentially devastating consequences for women, babies and families. For example, women should be asked about domestic abuse in private, separately to their partner, and this may require professionals to be creative with communication methods, phoning patients back briefly after an appointment or waiting for opportune moments for example. The LARA manual (lara-vp-online-resource.pdf (kcl.ac.uk)) can support professionals' routine inquiry	This is covered in the introduction, and use of the ANRQ.

		and make a significant impact on outcomes for women and babies.	
General	**SMc**	Training in regard to screening and assessment - page 14 'all health professionals providing care in the perinatal period should receive training in patient-centred communication skills, psychosocial assessment and inclusive care' and then goes on to talk about the screening tools. I just wondered if there is a plan for training of Obstetric staff on use of these tools as at each appointment there should be an assessment of wellbeing but especially Obstetric medical staff in general have no training in this. Also, just wondered what the expectation is from this guideline as antenatal clinics are very busy and what the recommendation would be on how to train staff and address this and who would offer clinical supervision to staff on this?	It is for local health boards to determine what supervision is required. Training, and links to the NES training programmes have been highlighted in the implementation section. The following sentences have been added: Before using any screening tool, the clinician must ensure that the tool is validated and that they possess the correct knowledge and skills to provide appropriate ongoing care. NHS Education for Scotland provide publicly-available education for anyone working with women/birthing parents in the perinatal period, and health boards and services should determine their own training needs. Clinical supervision for professionals administering screening tools is recommended and should be implemented as per each organisation's policy.
General	**KB**	See Me's Scottish Mental Illness Stigma Study (SMISS) evaluated experiences of stigma of over 346 participants in Scotland with severe and enduring mental health conditions. Of those who highlighted stigma in mental health care as having some of the biggest impact on their lives: • 87% have experienced unfair treatment when trying to get help for mental	The following sentence has been added, referencing the SMISS report, in section 1.5 sociocultural considerations: Stigma remains a significant barrier to women and families reaching for help and may be increased in some populations such as amongst racialised, gender and sexual minority families.

		health problems • 81% anticipated being treated unfairly when getting help for mental health problems • 80% have stopped withdrawn themselves from getting help for a mental illness See Me's PNIMH literature review build upon these findings, emphasising that fear of losing custody was consistently reported as a barrier to disclosing mental health difficulties, by mothers. This is also the case for substance use. It is important to emphasise that substance use and other forms of mental illness often co-occur, despite the guidance not explicitly covering substance use this is still an important consideration for these guidelines. It is key to also highlight that although, especially the case for substance use, this also presents a barrier for mothers experiencing the forms of mental illness considered in this clinical guidance. We would suggest designing and delivering targeted anti-stigma campaigns, education and training that have been co-produced with people with experience of mental ill health and take into account- context and culture. This will contribute towards creation of delivering	

		Perinatal and Infant Mental Health services that show a good understanding of intersectional stigma. These should also be included within the guidelines to ensure they form the guidance that practitioners and services receive. Further expanding the assessment criteria/tools and providing culturally appropriate training for practitioners is key to overcoming these barriers. For example training to account for cultural differences such as different meanings/ understandings and stigma centring around the word “mental illness”. Participants within a study (Adzajilc, 2022) spoke of mental illness in terms of being a ‘curse’, ‘insanity’ ‘possession of the devil’ and associated it with violence and danger. We would suggest involved diverse lived experience voices for the design, testing and implementation of the assessment criteria/tools to ensure that they meet the needs of diverse groups.	The tools cited have been validated and have translations into other languages. Training and clinical supervision is recommended for those using the tools.
General	**PM**	There is a clear need for universal training for all Health Visitors within Scotland on how best to use the EPDS as a tool in practice. There are guidelines on a pathway but I have seen a variety of ways in which the tool is used (ie handed to the woman, asked verbally in a full	Agree. There are modules on TURAS for training and the NES training programme has been highlighted in the implementation section. The introduction to section 3 also states:

		conversation), with this brings some inequality of care as if the tool is not fully understood and used correctly for analysis and screening, that woman might not get the appropriate referral or support. A national review of the use of EDPS/screening assessments in the perinatal period for all HV's would be beneficial.	Before using any screening tool, the clinician must ensure that the tool is validated and that they possess the correct knowledge and skills to provide appropriate ongoing care. NHS Education for Scotland provide publicly-available education for anyone working with women/birthing parents in the perinatal period, and health boards and services should determine their own training needs. Clinical supervision for professionals administering screening tools is recommended.
General	**AMc**	Fundamentally, referral pathways require review based on the recommendations in this guideline to ensure follow up and support as a consequence to screening in universal services is robust . "Clinical Supervision for professionals administering screening tools is recommended" Who is responsible for providing this supervision across/in each discipline ? I would recommend clinical supervision for maternity is provided by specialist PMH midwife where available. Considerations for other disciplines also require review. Within the badger maternity electronic record system there is scope to ask women/birth parents about emotional wellbeing at each antenatal and postnatal appointment . This can be implemented locally in each board, possibly already being actioned in boards.	Health boards should follow the five pillars national pathways, discussed in section 1.1.3. Who receives and provides clinical supervision is in the remit of local health boards rather than SIGN. The following sentences have been added: Clinical supervision for professionals administering screening tools is recommended and should be implemented as per each organisation's policy. There should be robust pathways for any follow up and support required as a consequence of screening. In Scotland services should follow the five national pathways (see section 1.1.3)

General	**RCM**	Whilst understanding that screening and assessment can identify and offer support to women, rather than diagnostic, It is a big ask for some clinicians - midwives- to determine which tool is appropriate to use and who validates these tools. There might be a risk of preference depending on who has validated the tool. How do midwives decide which tools to use? What level of training might the need in terms of choosing which tool to use? Would there be specific recommendations in the final Guidance? In this context, it would be important to be consistent in the recommendations in terms of the specific tools to be used in screening across the variety of mental health disorders.	Tools should be validated by the researchers. Recommendations have been made for specific tools where there is a supporting evidence base. The other recommendations are based on the consensus of the expert group who developed the COPE guideline, and the expert opinion of the SIGN guideline group, in terms of what is the most appropriate for use in Scotland.
General	**--**	Significant amount of information and advice provided, along with recommended tools and actions to follow. Page 14: “At every antenatal or postnatal visit, enquire about woman’s emotional wellbeing, and the wellbeing of their partner if appropriate”. HV and FN services will already enquire about the woman’s wellbeing, but this needs to be more explicitly rolled out to include partners. Page 15: “Complete the first post-natal screening 6-12 weeks after a birth and repeat at least once in the first postnatal year.” HVs currently undertake an EPDS at 6 and 12 weeks (so twice within the first 12 weeks. This isn’t repeated unless there is a need to re-screen. HV practice may need to be reviewed to reflect this and whether a third screen is required.	Fathers were outside the remit of the guideline, and this is explained in section 1.3.1. However, there is a good practice point to ask about fathers and partners wellbeing and signpost to further support. The following sentence has been added to the introduction to section 2: Screening and support for fathers and non-birthing partners was not part of the remit of this guideline. A directory of organisations that can provide support is available through the Father’s Network Scotland. The recommendation allows for screening at 6 and 12 weeks.

		Section 3.1 is wholly relevant to HV and Family Nurse staff.	
General	**ZD**	The current text reports “At every antenatal or postnatal visit, enquire about women/birth parent’s emotional wellbeing, and the wellbeing of their partner if appropriate.” It would be helpful to provide further information on what this may involve and considerations for processes in appropriately documenting any information shared. The NHS Future Platform has further information on considerations for how this may be done in the context of specialist perinatal mental health services and there is also information from a mixed methods evidence synthesis (https://www.frontiersin.org/articles/10.3389/fpsyt.2020.585479/full), which has been used as a foundational review in the development of the Australian perinatal mental health guidelines.	It is not necessary to use a tool each time, the advice is to check and use clinical judgement at each meeting and use the tool if needed. The introduction explains that the tools can help to facilitate a conversation where there may be barriers such as stigma.
General	**MG**	Second paragraph - 'mother-infant and partner relationship' does not take account of families in which the birthing parent is not a mother, nor of polyamorous families.	A new section, 1.1.2 has been added to explain the terminology used and what it includes.
3.1 (now 2.1)	**MG**	Although women and other birthing parents are mentioned once, most of this guideline refers to women only. I suggest that 'birthing parents' is added to 3.1.1 and 'women' is replaced by 'those' in 3.1.iii and 3.1.iv	Amended to women/birthing parents

3.1 (now 2.1)	**AMc**	Significant change in screening for depressive disorders in the antenatal period - this would require collaboration with electronic maternity records system to initiate this change for midwives which may be lengthy. Midwifery staff training requirements should be considered. Local referral pathways would require review to fit with these recommendations.	Thank you. These points have been highlighted in the implementation section.
3.1 (now 2.1)	**MS**		A point has been added to the implementation section to highlight that there may be training needs around the use of the ANRQ. The following sentences have been added to the introduction to section 2: NHS Education for Scotland provide publicly-available education for anyone working with women/birthing parents in the perinatal period, and health boards and services should determine their own training needs. Clinical supervision for professionals administering screening tools is recommended and should be implemented as per each organisation's policy.
3.2 (now 2.2)	**RL**	NCT has been collaborating with the MAP research study for the past three years as a parent and public involvement partner. MAP (Methods for Assessing Perinatal Anxiety) is a programme of research that aims to identify the most effective, acceptable, and feasible method for assessing anxiety in women during pregnancy and after birth and is funded by the NIHR. MAP has submitted separate detailed feedback based	At the moment there is a lack of robust published evidence to determine which tool can be recommended so we prefer to retain the recommendation from COPE. We have taken out the list of other tools and reworded to: As part of the clinical assessment, use anxiety items from the EPDS or other validated tools that include

		on evidence from the study and other literature assessing the effectiveness of screening tools for perinatal anxiety. NCT support MAP's submission and would encourage the guidelines to include their valuable input and expertise in the field of perinatal anxiety. NCT would like to see the study evidence regarding the acceptability of anxiety screening tools for pregnant and postnatal women reflected in the guidelines..	anxiety items and relevant items in structured psychosocial assessment tools. We have also included a research recommendation for validation studies of the Stirling Antenatal Anxiety Scale. It is hoped that published evidence will be available to revisit this recommendation when the guideline is considered for update in 3 years' time.
3.2 (now 2.2)	**AMc**	Screening for anxiety disorders - There is no recommendation provided in regards to the follow up and consequence of screening for anxiety in this guideline . This conflicts page 14 where its states "there should be robust pathways for any follow up and support required as a consequence of screening - leaving this to local arrangement I don't feel will benefit patients. Stirling antenatal anxiety scale is another tool that could be considered for anxiety disorder screening. I'm surprised to not see any reference to the work of MAP in this document?	A reference to the five pathways has been added to the introduction to section 3 and refers back to the more detailed information in section 1.1.3. There is insufficient published data to recommend the Stirling tool. It has been included in the recommendations for further research.
3.3 (now 2.3)	**AMc**	Screening for trauma - Concern in relation to the 3 months time frame provided when most services are already seeing patients before this recommendation - Most will see from 6 weeks . What implications will this recommendation have for current practice ? Note that on the research page this is highlighted as requiring further research.	This is highlighted for further research due to the differences between the advice in COPE (3 months) and NICE (1 month). Neither recommendation is based on robust evidence from the perinatal population. We feel that the 3 month referral is appropriate as it allows for natural healing. Referral at 1 month could add pressure to waiting lists and cause delays to treatment. We added the good practice point around watchful waiting and earlier referral if there is

		Use of city birth trauma scale - It is not clear who would be utilising this tool to screen for birth trauma, nor when it should be used. This will come with consequences for training, clinical supervision, documentation.	rapid deterioration, to allow for earlier referral if needed. Primary care team who are treating women in the perinatal period would use the scale, It is a self explanatory tool.
3.3 (now 2.3)	**--**	Page 16: use of the City Birth Trauma Screening Tool. The guideline doesn't clearly state who would be responsible for undertaking this. The guideline suggests waiting for three months after the use of the screening tool before a referral should be considered: the inference is that it would be the health visitor or family nurse who would complete this, which has training and competency implications.	Primary care team who are treating women in the perinatal period would use the scale, It is a self explanatory tool. Advice around training and competency needs is covered in the introduction to section 3.
3.3 (now 2.3)	**MS**	3.3xlii which health professionals would be undertaking screening using the City Birth Trauma Screening Tool. If this is midwives, health visitors, GP's and FNPs then further training is required to implement this	The primary care team would be using it. It is a self explanatory tool.
3.3 (now 2.3)	**PMH**	Is there a rationale for the 3 month time period?	We feel that the 3 month referral is appropriate as it allows for natural healing. Referral at 1 month could add pressure to waiting lists and cause delays to treatment. We added the good practice point around watchful waiting and earlier referral if there is rapid deterioration, to allow for earlier referral if needed.
3.3 (now 2.3)	**MCS**	Although it suggests that 3 months was a reasonable time to wait for a PTSD referral, it doesn't acknowledge that good supportive conversations within those first three months (e.g. birth reflections clinics) can lessen the risk	We have amended the statement in the explanatory text to include good supportive communication as well as monitoring.

		of full blown PTSD developing or allow for early identification and timely referral – just talks about watch and wait.	
3.3 (now 2.3)	**EMH**	If post traumatic symptoms persist, does referral to Perinatal Counselling sit here? The statement '*appropriate mental health professionals for further assessment"* is a bit vague. Does this include non-statutory partners, eg CrossReach/ Third Sector	Person-centred counselling does not replace the recommended trauma therapies and there needs to be good governance and supervision in place. Appropriate mental health professional would mean whatever service a board has in place.
3.3 (now 2.3)	**SMc**	Trauma referral - page 16 Advises referral at 3 months from onset of post-traumatic symptoms (earlier referral if rapid deterioration in symptoms) But RCOG green top guideline No: 26 advises: 'Offer women with persistent post-traumatic stress disorder (PTSD) symptoms at 1 month referral to skilled professional as per NICE guideline on PTSD' Why the difference? I think the guideline needs to at the very least comment and address this difference in SIGN and RCOG advice. Also, as an Obstetrician this feels like a long period post-delivery to have concern and also the potential impact this may have on infant bonding could be significant. Also, I would be concerned that my colleagues have	COPE advises 3 months and RCOG follows the NICE advice of 1 month. Neither recommendation is based on robust evidence from the perinatal population. We feel that the 3 month referral is appropriate as it allows for natural healing. Referral at 1 month could add pressure to waiting lists and cause delays to treatment. We added the good practice point around watchful waiting and earlier referral if there is rapid deterioration, to allow for earlier referral if needed. We have added to the explanatory text that good supportive conversations should also take place as well as monitoring. The Birth Trauma screening tool is self explanatory. Advice around training and supervision for tools has been added to the introduction to the section and training issues have been highlighted in the implementation section.

		little knowledge currently of the City Birth Trauma Screening Tool.	
3.3 (now 2.3)	**LF**	Screening for Trauma. In this section trauma is focused on birth trauma, and while this is important there is a missed opportunity to consider trauma more widely and to consider trauma informed ways of working. See the National Trauma Training Programme. Again, no mention of screening for Adverse childhood experiences which is embedded in Badgernet and practiced across Scotland. Also linked with the TI national agenda. • National Trauma Training Programme: https://transformingpsychologicaltrauma.scot/ • Turas Learn National Trauma Training Programme: https://learn.nes.nhs.scot/37896 • Transforming Psychological Trauma in Maternity Services: https://learn.nes.nhs.scot/60198 The City Birth Trauma Screening Tool is recommended, we believe that there are better tools and that the City Birth Trauma Screening Tool is not the best tool available to explore trauma. Give example The Antenatal Risk Questionnaire (ANRQ) is recommended. This is an Australian tool and it's relevance and applicability in the Scottish context is questioned. This tool is too specific for wider screening and appears to be tailored for the psychologists /	Wider trauma is outside the remit of the guideline. We have signposted to the National Trauma Training Programme in the Implementation section. The recommendation to use ANRQ for assessing psychosocial risk is evidence based. We have added a point to the implementation section that training in the use of ANRQ is required. The tools recommended are based on the evidence review conducted by COPE. ANRQ and the City Birth Trauma Tool have been added to the toolkit. Badgernet are aware of the toolkit and plan to link to it, however, it is not a platform used universally across Scotland.

		psychiatrists rather than the universal workforce – i.e., midwives, general practitioners etc. Furthermore, all tools recommended should be incorporated and in alignment with resources on BADGERNET The needs of the infant is given very little consideration in this section. Assessment of the infant should be an integral part of the assessment process. Perinatal and infant mental health are intertwined. The principles of GIRFEC should be more explicit and embedded throughout.	Assessment of mother-infant interaction is addressed in section 2.8.
3.4 (now 2.4)	**LF**	Assessment of breast feeding - reference should be made to breast feeding advisor. Each NHS Board has a specialist bf pathways and BF Advisor	This is outside the remit as it applies to any women having difficulties with feeding rather than those specifically with a mental health condition.
3.4 (now 2.4)	**AMc**	Screening for postpartum psychosis/predicting severe mental illness - No comments to add . All feasible implementation to practice in Scotland and very likely already being actioned in health boards.	Thank you
3.5 (now 2.5)	**MG**	Refers only to women. Recommend other birthing parents are included in this section unless there is evidence that they do not experience BPD	Amended to women/birthing parents
3.4 (now 2.4)	**PMH**	3.4 -s3 - these assessments should be prioritised where possible	Agree – this has been added to the recommendation.

3.6 (now 2.6)	**MG**	Does refer to women/birthing parents, but then uses 'she' and 'herself' throughout. Suggest using 'their' and 'themselves', and including birthing parents networks as well as women's	Changed to she/they
3.6 (now 2.6)	**AMc**	Assessment of risk of suicide - Who is a recommended professional to complete a safety plan?	The professional who identified the risk should complete the safety plan.
3.6 (now 2.6)	**--**	Page 17, Section 3.6 Assessment of risk of suicide: this is a helpful bullet-pointed section on safety planning and is something that could be shared with staff to utilise and also to discuss within clinical supervision.	Thank you
3.6 (now 2.6)	**MCS**	See below have highlighted relevant NHS Education for Scotland resources from Scottish national programme:- If a mother/birth parent is at risk of suicide it is helpful to have a safety plan in place to support them. Developing a safety plan involves assisting the woman to identify: NES skilled level resources go over development of safety plans, I would suggest the learning bytes 2, 3 and 4 are of relevance https://learn.nes.nhs.scot/55471 Learning Byte 2 https://learn.nes.nhs.scot/38199 Learning Byte 3 https://learn.nes.nhs.scot/41022 Learning Byte 4 https://learn.nes.nhs.scot/39315 • warning signs that she may be at risk of imminent suicide (eg feeling trapped, worthless or hopeless) Also covered in above resources and informed level	Reference has been made to the NES training programmes in the implementation section. We would prefer not include specific links as they may change. The red flags are direct from the MMBRACE report and the guideline is targeted at health and social care professionals. The toolkit provides advice for mothers/birthing partners and their partners based on the recommendations, translated into plain language.

		resources. We also define what are risk factors as opposed to warning signs. • actions to protect herself and the infant • internal coping strategies that decrease the level of risk – Also covered in above resources • people within the woman's network who can assist in times of need- covered in safety plan materials • health professionals and agencies that can be contacted for help.23 j GPP When a woman/birth parent is identified as at risk of suicide, manage immediate risk, arrange for urgent mental health assessment and consider support and treatment options. S4 GPP- As above Refer to the MBRACCE-UK red flag signs for severe maternal mental illness to identify women/birth parents who require urgent senior psychiatric assessment, for example: • recent significant change in mental state or emergence of new symptoms • new thoughts or acts of violent self-harm – I know this comes from the Red Flags but wonder about the language of this and how staff distinguish violent? Is this person centrered? • new and persistent expressions of incompetency as a mother or estrangement from the infant • severe difficulties with sleeping.	

3.7 (now 2.7)	**SM**	The ANRQ is not currently used in Scotland and impact implementation needs to be acknowledged	Added to implementation section
3.7 (now 2.7)	**AMc**	Assessment of psychosocial factors - Significant change for health professionals recommended - there are similarities noted in some of the questions for which staff will be undertaking at present in current practice. The layout of recommendations in regards to screening from a maternity perspective becomes overwhelming very quickly - this could likely be condensed and addressed digitally to achieve better buy in. Midwives should be consulted directly on the proposed screening recommendations given the significant impact to practice.	The toolkit includes the recommendations, by section for healthcare professionals, along with access to some of the screening tools. Midwives have been involved in the development of the guideline and the consultation. A representative from the Royal College of Midwives is on the editorial team.
3.7 (now 2.7)	**MS**	Use of ANRQ - Which health professionals would be using this tool and what referral pathways would it lead to? If midwives are potentially offering EPDS, City Birth Trauma Screening and ANRQ in addition to the modified Whooley questions routinely asked at booking this represents a significant increase in the volume of screening and therefore training needs, supervision and referral pathways amidst a backdrop of an already very full schedule of midwifery care and mandatory training requirements which may impact on how effectively the screening could be offered.	A list of people likely to carry out screening has been added to the introduction to section 2. Use of the ANRQ has been highlighted as a training need in the implementation section. We are not recommending use of Whooley – the tools recommended in the guideline would replace that.

3.7 (now 2.7)	**MCS**	The need for training on how to use screening tools is highlighted but could also emphasise that they can be useful to initiate discussions about perinatal mental health, I think they also need to highlight more that a compassionate, non-judgemental approach to care is required when such measures are being introduced and that a clear rationale is presented as to why these measures are being used. Also helpful to include something on the need to respond to scores on sensitive questions in a helpful way that elicits more information as opposed to closing off further conversations. I am not familiar with the Antenatal Risk Questionnaire - it looks to be an Australian instrument. How does this fit with the Scottish Context in terms of the screening /assessment tools used by Midwives and Health Visitors in the perinatal period? Should we not be promoting joining up with current Scottish practice in this regard?	The guideline is reporting on the evidence base. Handling responses to the sensitive questions in a tool is a training and supervision issue. The use of the ANRQ is evidence based. This is a change and the need for training has been highlighted in the implementation section.
3.8 (now 2.8)	**MCS**	p18 - assessment of mother-infant relationship: no mention of methods for doing so , e.g. including observational tools. Also no mention of need to think about other children.	There was no evidence identified for the methods to be used. Other children come under the wider family that are part of the assessment.
3.8 (now 2.8)	**MG**	Suggest birthing parent/infant interactions are included alongside mother/infant throughout	Amended
3.8 (now 2.8)	**--**	Page 18: “Seek guidance and support from multicultural health workers when assessing mother-infant interaction in migrant, refugee and culturally and linguistically	This has been changed to ‘seek guidance if available’.

		diverse women". This is feasible within urban health boards such as GGC, Lothian and possibly Tayside, but in some of the more rural health boards where the workforce is less diverse, this may be challenging. Additionally, with the dispersal of asylum seekers from Kent, the arrival of Ukrainian Displaced People and the number of refugee families arriving in local authority areas, the demography is changing much more quickly that the workforce and unfortunately multi-cultural supports are not always readily available.	
3.8 (now 2.8)	**SMu**	Parent centred communication skills are identified but how are the communication support needs of parents (especially with neurodivergent needs or a language disorder) to be identified by practitioners and how can they obtain guidance on appropriate adaptations and communication support tools? Speech and Language Therapy are not routinely part of peri-natal mental health teams. Assessment of mother-infant interaction - Speech and Language Therapy would be a valuable ally to MDTs to support this work to maximise child development.	Input from SLT is outside the remit of the guideline, but we would expect HCPs to seek support from specialists if needed. A recommendation for research around the benefits of a wider MDT has been added to section 10.
3.8 (now 2.8)	**NES**	p18. In the section on assessment of mother-infant relationship, there is no mention of possible methods for doing so. There are a range of observational approaches to assessment and intervention that would be worthwhile signposting to.	There is no evidence to provide a steer on the method. The focus of the section is screening rather than diagnostic assessment.

		It might also be important to make some distinction between specialist and diagnostic assessment and observation or thinking about the mother-infant relationship.	
3.8 (now 2.8)	**PMH**	3.8 - Has there been consultation with Parent -Infant Therapists on this section - there is no mention of them on the guideline development group	Infant Mental Health Practitioners were included in the consultation.
3.8 (now 2.8)	**LF**	There is no mention of methods to assess mother infant relationship i.e., no tools recommended. There is an opportunity here to highlight: Baby Friendly Standards and relationship building resources • BFI Standards: https://www.unicef.org.uk/babyfriendly/about/standards/ • BFI Resources: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/relationship-building-resources/ Other tools such as • Lanarkshire Infant Mental Health Team – Observational Indicator Set / https://www.nhslanarkshire.scot.nhs.uk/download/imh-observational-indicator-set-printable/ • Warwick Medical School. Parent Interaction Observation Scale (PIIOS) / https://warwick.ac.uk/fac/sci/med/study/cpd/cpd/piios/	There are no evidence-based tools at present. BADGERNET is not used by every health board.

		There is no mention of BADGERNET and the aligned supporting resources. Again, there is a missed opportunity to link with this in the guideline	
Section 4 Care planning			
General	**NES**	Within this section, there is positive emphasis on endeavouring to keep mum and infant together where possible. Recognition of the importance of the mother/infant relationship could be emphasised more strongly to urge those supporting the dyad during the perinatal period on the importance of holding both in mind. This provides opportunity to highlight importance of infant, alongside maternal mental health to be held up as core in the responsibilities of support staff. In addition, there is no mention of hospitalised infants during the perinatal period and its potential impact on maternal, and infant, mental health. There could be direction to nationally available free resources for mums/parents - Solihull (postnatal) online modules. Within this section, the guideline declares that it does not include specific management of ADHD or ASD during the perinatal period. Instead, it signposts the reader to the respective NICE and SIGN guidelines on those presentations. however, within these presentation specific guidelines, there does not appear to be specific guidance around managing either of these presenting	Thank you for your comment. This guideline followed the review of the evidence base undertaken by COPE. The separate needs of hospitalised infants was outwith the scope of this guideline. The Solihull modules will be added to the toolkit. The guideline followed the review undertaken by COPE. The needs of parents with ADHD and ASD were not included separately and therefore it was outwith the scope of this evidence based guideline to comment on this. Whilst we recognise this is an area

		conditions during pregnancy and perinatal periods. These presentations are currently receiving much more attention, given increasing awareness of prevalence. There was some reference to cautious use of medications in section 4.7 of this SIGN guideline but this was fairly general. It would seem important, not to mention a much-needed opportunity, to include management of these presentations specifically within this document, due to the wide-reaching implications for mother and infant development. With regards to care planning and intervention considerations, NES Early Intervention Framework provides a resource for support providing stakeholders to consider evidence based approaches to meet the mental health needs of infants, children and YP. The link is as follows: https://earlyinterventionframework.nhs.scot/	gaining increasing interest, the evidence remains very limited. This could be an area that would benefit from future research in Scotland. This guideline highlights the importance of a range of interventions including medication and the evidence base relating to this. Many thanks for your comment and information link. This information was not part of the evidence based literature review and therefore it is outwith our scope to include it.
General	**FF**	Comprehensive	Thank you
General	**SMc**	Within the guideline there is no direct comment on collaborative working with Obstetrics (and other specialists including Neonatal colleagues) I wonder whether a comment on who may encompass the MDT and the importance of collaboration from pre pregnancy right through to postnatal and planning any future pregnancy (eg there may be need for GP, midwife, Obs, health visitor, sexual and reproductive	A list of examples of professionals who may be involved has been added to the introduction to the care planning section. See also subsections relating to SSRI, Antipsychotic use - under specific medications relating to additional neonatal monitoring.

		health team for more complex discussion on contraception both pre pregnancy and postnatal etc.., plans for scans, OGTT and other Obstetric input and labour and postnatal care planning/risk assessment as an MDT. Neonatal team also need to be aware of medications given risk of withdrawal and small risk of persistent pulmonary hypertension with eg SSRIs (although note this is not specifically mentioned as a risk within the guideline but is something we are mindful of where I work and do try and inform our neonatal colleagues in case of any issues) and any other relevant medication or history. I wonder if there could even be a comment made in page 19/20 around this	
General	**KB**	We support all the guidelines that are stated, we would suggest reviewing these alongside our best practice guidelines based on research and evidence. We would emphasise that peer support should be emphasised within the SIGN guidelines. Currently the guidance addressed peer support as a care option for depression but not for other mental illnesses. See Me's PNIMH literature review identified that peer support was one of the key themes stated within the evidence based best practice guidance. Evidence revealed that women and their partners often feel isolated through stigma related to perinatal and infant mental illnesses, but that peer support can offer connection, learning and support. Peer support	Review peer support evidence base. Thank you for your comment. The recommendations within these guidelines followed the evidence based review undertaken as part of the COPE guideline. The toolkit signposts to third sector organisations that offer peer support.

		workers and volunteers provide valuable real life insights, individualised support, guidance and encouragement based on their own learning and experiences. We suggest an explicit emphasis of this as a valuable resource would be beneficial for those accessing support.	
General	**RCM**	This section is clear in terms of care planning, addressing issues such as the importance of pre-conception planning which can identify women with previously unknown or known mental health problems through infant feeding choices. However, in terms of information provision and advice, there is a need to highlight/focus/describe what is meant by culturally relevant information. A suggestion might be the co-production of relevant information with racialised communities. The benefits of this would be destigmatising pregnancy-related mental health problems within these communities and encouraging access to support and treatment.	This is diverse depending on the person's circumstances, so prefer not to give an example.
General	**IMHDG**	A. Can there be examples of care plans - the Pan London perinatal doc has these. B. Care planning pre and post natally is important. Adult Protection as well as child protection? C. Issues in different recording systems for different professional groups can lead to information bit being shared with the right people.	A. Development of best practice care plans could be part of the implementation of this guideline and we encourage professionals in this area to consider taking this forward to help implement the guidelines. B. Adult protection added: Management of risk to the infant is essential and GIRFEC principles should be followed. If concerns about adult welfare and protection are raised, other

		D. Our Pharmacist (Mental Health) Comments: The rise in pregnancies exposed to medication is acknowledged, the importance that the parent(s) have useful relatable and accurate information to base decisions on is acknowledges but at no point does the guideline consider where this information really comes from in services - such as a pharmacist with mental health knowledge and awareness of the implications of and interpretation of risk data around prescribing in pregnancy. The recent Perinatal MH strategy didn't even mention pharmacists. E. Please can something be done to acknowledge the part that there aren't enough services with funded access to a pharmacist with knowledge of prescribing in perinatal mental health. All considerations of prescribing in this population need to bear this in mind. It's admirable supporting psychological wellbeing of the infant and funding psychologists for that as a potential (proven?) preventative measure, but why isn't pharmacy even acknowledged? F. Guidance needs to reflect the context of the health services we have and we wish to develop, with fewer psychiatrists and more non-medical prescribers, advanced practitioners and the like and the need for developed team skill mix the roles of more than doctors, nurses and psychologists need to be considered.	relevant frameworks should be considered such as those relating to adult support and protection legislation, gender-based violence policy and protocols, as appropriate to the individual situation and assessment of need. C. The guideline references ' • there is effective sharing of information with all services involved and with the woman herself, including voluntary and statutory services. Consent should be obtained where possible' . D the role of pharmacists is highlighted E. this is an evidence based guideline based on the COPE review. It is outwith the scope of this guideline to comment on the resourcing of services such as pharmacists. We would recommend other avenues for raising these issues, such as liaising with the perinatal mental health network in Scotland. F. this guideline includes reference to non-medical prescribers. The prescribing principles section highlights the complex array of factors that need to be taken into consideration (section 3.7)

		It's true that people having babies with mental health problems need information on the risks v benefits of all treatments perinatally; absolutely.. drug treatments used during pregnancy are more common and increasingly more complex, absolutely. information needs to be tailored to the individuals' circumstances including diagnosis, co-morbidity, history, presentation, co-prescribing, neurodiversity, etc To interpret the limited data available, you need to consider a whole complex range of issues around pharmacodynamics, pharmacokinetics and how these change during pregnancy, relative evidence for the indication being treated, any drug interactions including polypharmacy and non-prescribed medicines or illicit It so happens that the health service has an under-acknowledged group of highly trained professionals who can do all this. Who can access and interpret the information that is there and put it into context of the condition being treated, for patient factors and are experts at helping people understand risk information in language that they understand but also contribute to education of and support of wider perinatal teams, and follow up on cases to contribute to the research and knowledge of outcomes; pharmacists with perinatal MH roles. Are they acknowledged or even considered; no. It's a massive oversight.	

		IF it's not recommended or even mentioned in guidelines it doesn't get funding. Please include the valuable contribution that perintal mental health pharmacy services add to the safety of medicines use during the perinatal period for managing mental health conditions so we can get more of them and have equitable access for all parents and their babies. In fact generally SIGN could do with language adjustments to reflect increasing numbers of non-medical prescribers being involved in the care of patients rather than just using "doctor".	
4.1 (now 3.1)	**MG**	Page 19, halfway down suddenly reverts to women only	The terminology has been checked throughout the document. If the term 'woman' alone is used it is from a direct quote form another reference.
4.1 (now 3.1)	**TL**	I really like the way the general principles are worded. It would be good to see the word, Dad used here, along with Partner. It would also be good to acknowledge the importance of the family unit and the value they have in recovery. I wonder in the brief section on breastfeeding, whether it's worth mentioning the valuable peer support that's available from the third sector to support breastfeeding. In general it would be valuable to see the third sector acknowledged for the general support they can give new families. It's our understanding that there is a national	The toolkit is being restructured to give peer support more prominence. Further references to the voluntary and third sector have been added throughout the guideline.

		requirement for NHS boards to be aware of local and national support and it would be good for this to be acknowledged in this document.	
4.1 (now 3.1)	**SMu**	Positive view of linguistic differences (including neurodiversity) alluded to in general principals of care but nature of these and related clinical considerations are not made explicit.	These are too diverse for the guideline to detail. The point is to flag up that these need to be taken into consideration and adaptations or support provided, such as information translated into another language.
4.1 (now 3.1)	**PB**	4.1 states that 'there is effective sharing of information with all services involved and with the woman herself, including voluntary and statutory services. Consent should be obtained where possible.' I think you need to provide more detail about the circumstances where it is appropriate (and where it is not appropriate) to share information when the woman has either not given or refused consent.	It is outwith the scope of this guideline to provide a more detailed recommendation.
4.1 (now 3.1)	**MCS**	ensuring that information and support is adapted according to need including considerations relating to health literacy, sensory impairment, disability and relevant social, cultural and linguistic needs and other vulnerabilities such as digital exclusion, socioeconomic adversity and IPV'. – include specific learning difficulties and neurodiverse presentations. No reference at all within these guidelines about the impact that having a baby in the neonatal unit/prolonged hospital admission can have on mental health in the perinatal period.	We think this point is adequately covered in the original wording. This guideline followed the COPE review of the evidence base and as such no specific recommendations relating to management of mental disorders where a baby is in hospital for a prolonged period of time were made. This may be an area that requires its own separate guidance or review of the evidence base.

4.1 (now 3.1)	**VR**	General principles of care - re. care coordination - mention 'Advance Statements' The Mental Welfare Commission details them here: https://www.mwcscot.org.uk/law-and-rights/advance-statements#:~:text=An%20advance%20statement%20is%20not,health%20or%20social%20care%20professional. They allow people to say what treatments works for them and what they would wish when they are not in capacity at the time to voice information / preference. Given that this SIGN document will offer guidance to people with postpartum psychosis, consideration should be given to the person's views in this way, if they have put in place an Advance Statement.	The following sentence has been added to section 4.5*:* It may also be relevant to consider use of an advanced statement (a personal statement witnessed by a relevant professional stating future preferences relating to care and treatment), the right to which is enshrined in the Mental Health (Care and Treatment) (Scotland) Act 2003.
4.2 (now 3.2)	**JD**	We need to ensure that all staff working with pregnant women have a conversation about developing a close and loving relationship with their unborn baby. This is part of the antenatal conversations BFI standards and encourages women to think, talk, sing, be mindful of and about their baby and the importance of increased oxytocin, calmness and connection. I would like to see a reference to BFI standards here as this is already what midwives, health visitors, family nurses and support staff are working to.	BFI standards are cited in section 3.4
4.2 (now 3.2)	**MS**	xxv In order to support this a national leaflet would be beneficial to ensure equity of access to information across Scotland. This could signpost to the shared decision making toolkit	In the final version of the toolkit the individual information pages will have an option to convert to pdf and print out as standalone leaflets. Spelling amended to fetal.

		page 23 The spelling 'foetal' is used. I suggest that this should be 'fetal' in line with other national guidance	
4.2 (now 3.2)	**LF**	Consideration of the infant should be included and more explicit. The importance of keeping mother and infant together should be given greater emphasis in all care planning i.e. refer to Best Start Policy and BFI standards BFI Standards: https://www.unicef.org.uk/babyfriendly/about/standards/ The best start: five-year plan for maternity and neonatal care – https://www.gov.scot/groups/best-start-implementation-programme-board/ Again, the principles of GIRFEC & TI care should be more explicit and threaded through the whole document. Requirements for a section on developing care plan for those who have experienced trauma and using the TI principles of safety, choice, trust, empowerment and collaboration. This is important to embed TI care in maternity services and a priority area of development within the maternity TI Pathfinder projects. Strong links between ACE's, psychological trauma and mental health. Providing Information and Advice: All staff working with pregnant women have a conversation about developing a close and loving relationship with their unborn baby as part of the antenatal conversations BFI standards. Encouraging women to think, talk, sing, be mindful of	BFI standards are cited in section 3.4

		and about their baby and the importance of increased oxytocin, calmness and connection. There needs to be a reference to BFI standards here as this is already what midwives, health visitors, family nurses and support staff use to provide evidence based, person centred care.	
4.3 (now 3.3)	**LM**	4.3 If preconception planning should start at diagnosis is the expectation this responsibility would lie with the practitioner giving the diagnosis or at point of diagnosis should referral be made to specialist services preconception clinic.	*This is dependent on the condition.* The following sentence has been added to the introduction: Specialist preconceptual review by mental health services is required for women with a history of complex mental illness, particularly where there is a history of postpartum psychosis or bipolar affective disorder.
4.3 (now 3.3)	**MG**	refers only to women. Also, in 4.3, the importance of contraception may not need to be stressed to women who are only having sex with other people who have a vagina, or to be stressed to trans women. Consider amending this statement.	(where relevant) has been added to the bullet point: the use of contraception (where relevant) and any plans for a pregnancy.
4.3 (now 3.3)	**PMH**	Specialist Perinatal teams would offer preconception advice for woman with previous post-partum psychosis, Bipolar Affective Disorder or Schizophrenia.	The introduction has been expanded to say that specialist preceonceptual review is required.
4.4 (now 3.4)	**MG**	4.4 Would this advice apply to those chestfeeding as well?	An explanation on terminology and the use of breastfeeding has been added to a new section 1.1.2.

4.4 (now 3.4)	**VR**	Planning for breast-feeding: Change of tone? 'In the situation where a parent is *unable to, or chooses not to* breastfeed they should be supported to ...' This wording could be made less biased towards the expectation that it is optimum for a mother/parent to breastfeed her baby. In the context of perinatal mental health, the most optimum outcome is rather for the mother/parent to maintain stable mental health and to do so she/they may be advised not to breastfeed (so as to maintain a healthy sleeping pattern, or revert to pre-pregnancy medication). I suggest altering the wording to "*advised not to, chooses not to, or is unable to*'.	Medication options and side effects are discussed with the patient so they can make an informed choice. We think this is appropriately reflected in the current wording, which encourages breastfeeding, if they wish to, and offers support for those who don't.
4.4 (now 3.4)	**LF**	4.4: Planning for breast feeding. This section needs to be developed and expanded upon. • There needs to be reference to Baby Friendly Standard to support breastfeeding i.e. o skin to skin/ the first magical hour o early, effective and frequent expressing (consider antenatal colostrum harvesting if with appropriate medication review) o support with positioning and attachment Baby Friendly Standards: https://www.unicef.org.uk/babyfriendly/about/standards/ • Reference also needs to be made to the breast-feeding pathways and breastfeeding advisor. Each NHS Board has a specialist breastfeeding pathway and breastfeeding advisor. • Need to reference the 2016 Lancet series re health benefits: Victoria C.G. et al (2016) Breastfeeding in the 21st century:	The BFI standards and WHO advice is referenced. The guidance is specific to issues arising due to mental health conditions, rather than specific issues with how to breastfeed. Lancet reference has been changed to the meta-analysis by Victora et al

		epidemiology, mechanisms and lifelong effect. Lancet 387: 10017:475-490 Current reference to Lancet 2023 is about marketing. • “Mothers/birth parents should be made aware of the benefits of breastfeeding and supported to do so exclusively for the first six months, if they wish” This statement does not reflect current guidance from WHO and UNICEF. i.e. Use exclusive breastfeeding for the first six months and beyond (WHO) o WHO and UNICEF recommend: □ early initiation of breastfeeding within 1 hour of birth □ exclusive breastfeeding for the first 6 months of life □ introduction of nutritionally adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond.	We think the statement to exclusively breastfeed is in line with WHO and UNICEF and is appropriate.
4.4 (now 3.4)	**JD**	This needs to be added to providing information and advice section. Need to reference the 2016 Lancet series re health benefits: Victora C.G. et al (2016) Breastfeeding in the 21st century: epidemiology, mechanisms and lifelong effect. Lancet 387: 10017:475-490 Current reference to Lancet 2023 is about marketing. Use exclusive breastfeeding for the first six months and beyond WHO reference There needs to be reference to BFI standards to support	BFI standards are referenced. Lancet reference has been changed. This advice is general advice on breastfeeding which should be available for anyone. The focus of the guideline is the differing or specific needs of those with a mental health condition.

		breastfeeding: skin to skin/golden hour early, effective and frequent expressing (consider antenatal colostrum harvesting if with appropriate medication review) support with positioning and attachment responsive breastfeeding maximising breastmilk to fully support maternal choices providing information about local and national support Refer to specialist infant feeding pathway in local NHS Board for further breatsfeeding support Where a mother does not choose to breastfeed support to responsively bottle feed must be given. Add in cleaning and sterilising of feeding equipment, safe preparation of formula milk, first infant formula for first year of life and limiting feeding to parents and main care givers.	
4.5 (now 3.5)	**JD**	4.5 and beyond: Need to add in: Opportunities for prolonged skin to skin contact to increase oxytocin and mothering and parental attachment and attunement throughout all of the care experiences	We have added: • support for the mother-infant relationship • support in the postnatal period to cover these points without becoming too detailed.

		Opportunites for talking, singing, Bookbug in Mother Baby units, baby massage as part of relationship building.	
4.5 (now 3.5)	**PMH**	Headline "Planning care for woman/birth parents with severe mental illness" differs from the previous SIGN and Australian Guidelines.	We think this title is more succinct.
4.5 (now 3.5)	**KB**	typo – “involved in their care take into” account “the complexity of…”	Account added, thank you.
4.5 (now 3.5)	**PB**	There is a paragraph which says: Other antenatal considerations highlighted by COPE include education regarding nutrition, monitoring gestational weight gain and providing other healthy lifestyle interventions such as cessation of smoking, alcohol and illicit substances.' Could there be a Good Practice Point relating to this? Many people use cannabis to help their mental health. Some specific guidance / recommendations or good practice points around specifically asking women about use of cannabis or illicit drugs and why they should stop, would be useful.	This is out of scope – it is general good practice in maternity.
4.6 (now 3.6)	**FH**	Typo in 4.6 week's gestation should be weeks' gestation	Amended, thank you.
4.6 (now 3.6)	**MG**	reads as though only women can be admitted to MBU - I am unclear if this is accurate?	Amended to women/birthing parent.

4.6 (now 3.6)	**PMH**	woman requiring MBU admission should be the primary carer for the baby and risks for other babies manageable in the ward setting.	This sentence has been added to section 3.6
4.6 (now 3.6)	**VR**	MBU and right for admission under the Mental Health Act - is this a realistic promise / expectation to give, given number of MBU beds and geographical span?	Yes, it's enshrined in the Act
4.7 (now 3.7)	**VR**	4.7 2nd bullet point re 'if they wish to breastfeed...' Most do wish to, not least because the NHS mantra is that 'breast is best' and there is enormous pressure to do so, not least from hospital staff. Can the choice not to breastfeed be given more official support, e.g. by changing the wording: 'Mothers / parents may choose not to breastfeed (for example, regulating sleep may help the stability of their mental health), and they should be supported in this. If they wish to breastfeed...' When my twins were born and one could not latch on, my partner had to intervene to find a consultant who could overrule nursing staff on the ward to allow me to give my crying hungry baby a bottle. I was not having a bipolar episode at the time. The pressure is enormous to breastfeed. You are made to feel that you are not doing your best for the baby if you do not breastfeed. Given the huge pressures (hormonal, sleep, medication, change, possible birth trauma) on the body and mind of the mother/birth parent already, the breastfeeding pressure needs to be relativised.	This has been changed to: Infant feeding preference • Take into consideration infant feeding preference. • For parents wishing to breastfeed discussions regarding the safety of drugs in breast feeding should occur as early as possible in pregnancy to avoid the need to alter treatment later.
4.7	**PB**	Use of pharmacological treatments:	Outside scope – evidence on OTC was not reviewed.

(now 3.7)		The focus of this section is on legally prescribed medication. It might be helpful to add a GPP about enquiring around non-prescribed 'over the counter' medication and illicit medication.	
4.7 (now 3.7)	**MS**	w reference is made to ultrasound screening. The timings mentioned do not completely line up with routine timings for this screening (early pregnancy scan routinely offered between 11 and 14 weeks and fetal anomaly scan routinely offered between 18-21 weeks). If there is a recommendation that USS should be offered at a specific gestation e.g. 13 weeks then I suggest that this is made clearer in the guidance	Changed to 11–14 week and 18–21 weeks.
4.7 (now 3.7)	**AMc**	Use of pharmacological treatments - There is a chronic issue with GP prescribing in pregnancy/breastfeeding which requires to be addressed on a national level to allow this aspect of the guideline to be feasible and implementable. This is an essential aspect to the wider perinatal mental health care plan.	Thank you for your comment. It is hoped that the guideline will help to support GPs in prescribing and would encourage training for professionals such as those working in primary care.
4.7 (now 3.7)	**MG**	4.7 Suggest chestfed infants are offered the same protection. Suggest discussion with significant others is at the woman/birthing parent's discretion.	A section, 1.1.2, has been added explaining terminology and what is included.

Section 5 Depression and anxiety disorders			
General	**FH**	Good.	Thank you
General	**RCM**	This section appears to have addressed the range of available treatments for depression and anxiety disorders. There isn't much to add to this by way of a critique on which treatment is right for individual women. However, it is important that the offer of treatment takes into account individual choices by affected women, particularly those from racialised backgrounds where there is some reluctance to accept treatment and the stigma attached to mental health conditions, particularly in childbirth.	The recommendations are based on a review of the evidence and there is little to determine specific individual choices. It is stressed throughout the guideline that an individualised approach to care should be taken. The importance of the impact of stigma has been added to section 1.5.
General	**SA**	See information under 'Screening and Assessment'	Unclear what the comment is in relation to section 5. Please see response in the Screening and assessment section.
General	**MS**	Very clear.	Thank you
General	**AMc**	Appears feasible and implementable - most recommendations likely to be in place in health boards currently. Note - research section highlighted use of sedating antihistamines as requires further research - agree these are often used in practice and further clarity would be beneficial.	Thank you
General	**MG**	Due to the deadline for responses, I am not able to comment on each section. Please read for consistency in the inclusion of birthing parents and	A new paragraph has been added as section 1.1.2 explaining the terminology used and what it

		non-birthing parents (if that is the chosen language), replace 'birth parents', and ensure chestfeeding as well as breastfeeding is included. Please also check for the use of gendered pronouns.	encompasses. Use of gendered pronouns has been checked throughout.
5.1 (now 4.1)	**EMH**	No mention of Perinatal Counselling and Psychotherapy in section	This section is addressing anxiety and depression. This would not be first line treatment for these conditions. The advice provided reflects the COPE evidence base.
5.1 (now 4.1)	**--**	Significant information for supportive interventions, with a variety of accessible different suggested options and clear descriptions for treatments and therapies. Page 24, section 5.1 Psychosocial and psychological therapies: No mention of utilising group therapy and positive effect this has on maternal anxiety and mood via peer support and inclusion	There was not evidence in the COPE review to support a recommendation in this. A call for further research into psychological therapies has been added.
5.1 (now 4.1)	**IMHDG**	Psychology response: Should there be more info on maternal OCD and evidenced based approaches like Exposure and Response Prevention Should there be mention of Behavioural activation and the role of OT Training and supervision of staff if suicidal ideation/ planning identified	The advice for OCD is included under anxiety (see section 1.4.3). The recommendations reflect the evidence identified in the COPE review. This is covered in section 2.6
5.1 (now 4.1)	**LC**	5.1 Psychosocial and Psychological Therapies: There is mention of psychological therapy and CBT but not non-verbal therapies like Arts Therapies. One	Arts therapies were outwith the remit of the COPE guideline and as it is not a mainstream therapy offered

		of the two MBUs in Scotland includes a permanent music therapist in the team and evidence shows that music therapy can provide an alternative way for depressed patients to experience and address their symptoms. (HATTERS FRIEDMAN, S.; KAPLAN, R. S.; ROSENTHAL, M.B.; CONSOLE, P, 2010. Music Therapy in Perinatal Psychiatry: Use of Lullabies for Pregnant and Postpartum Women with Mental Illness Furthermore, focusing only on verbal therapies could exclude marginalised people to whom speaking or speaking English is not readily available.	in services in NHS Scotland it was not prioritised for an additional review by SIGN. A sentence has been added at the end of the section: “Other therapies, such as art or music therapies are available, particularly through third sector organisations, but were not included in this evidence review.” Interpreters are widely used to support people who do not speak English. If someone is unable to speak, they would be supported with other care options rather than a talking therapy.
5.1 (now 4.1)	**MCS**	5.1 I can see that the guideline uses the Australian COPE review to evidence the psychological and psychosocial recommendations. NHS Education for Scotland is about to launch the Matrix website https://www.matrix.nhs.scot/ (Augist '23)and reviewing the evidence for Psychological Interventions and Therapies and Common Mental Health Problems in the Perinatal Period is one of the topic areas fully reviewed. The link for the Matrix website is https://www.matrix.nhs.scot/ and NHS Education for Scotland is keen to provide you with the text for you to see before the launch. We would hope that as this work has been done by Scottish academics and clinicians with the Scottish context in mind that this can be referenced in the guideline.	Additional advice on psychological interventions has been added from the NICE guideline. The following sentence has been added: Further information on psychological therapies and implementation support for services is available from the NHS Education for Scotland website www.matrix.nhs.uk
5.1	**FF**	Limited focus on CBT and IPT for psychological therapies and no mention of role or value of other	Additional advice on psychological interventions has been added from the NICE guideline.

(now 4.1)		evidence based or emerging psychological therapies for depression which is not in keeping with current PT practice. I think it would be helpful to reference these and also cross reference with NES's matrix	A link to the matrix website has been added.
5.1 (now 4.1)	**VR**	EBR re social support group. Very important. Peer and social support groups need to be bolstered, in particular post-pandemic, when many antenatal classes have not resumed. CBR Online CBT is welcome and all very well but it does not help social isolation. While cheaper, it is better for vulnerable new parents to meet with a therapist. That provides an expectation, so that homework is more likely to be done. Also there is social contact and a piece of structure in the day. CBR mothers/parents with postnatal depression could also benefit from peer support. There have been groups, e.g. in Bothwell and Uddingston, pre-2012. Remit of NHS or Third Sector?	Agree. No action required We agree that online CBT may not be the preference for all people, so we added the following sentence to the recommendation: “This needs to be appropriate and acceptable to the service user.” The Scottish Government is investing in peer support groups but it is beyond the remit of the guideline which reflects the evidence base.
5.2 (now 4.2)	**PB**	5.2.1 is mainly about starting a pharmacological therapy for depression. In clinical practice it is sometimes difficult to know what to do when a women is already on an antidepressant (e.g. SSRI) for depression - and who is doing well on that medication (i.e. is not currently depressed) and becomes pregnant. Should the SSRI be stopped, and risk a recurrence of depression - or should the SSRI continue throughout pregnancy? It would be good to	Section 3.7 provides further guidance on the factors to be taken into consider when considering starting and stopping medication. We have added a cross reference to section 3.7, re-iterated the key points in the depression section and made the advice clearer.

		know what the evidence base is and whether any recommendations around this could be made.	
5.2 (now 4.2)	**LF**	"Before prescribing antidepressants to women/birth parents who are breastfeeding, consider the infant's health and gestational age at birth". This requires further explanation, for example, what does this statement mean? Would the practitioner require to assess the suitability of medication whilst mother is breastfeeding. When prescribing anti-depressants guidance should be sought from the following sources: • Drugs in Breastmilk factsheets - The Breastfeeding Network / https://www.breastfeedingnetwork.org.uk/drugs-factsheets/ • Safety in breastfeeding – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice / https://www.sps.nhs.uk/home/guidance/safety-in-breastfeeding/ • Drugs and Lactation Database (LactMed®) - NCBI Bookshelf (nih.gov) / https://www.ncbi.nlm.nih.gov/books/NBK501922/ • Medicines A-Z - NHS (www.nhs.uk) / https://www.nhs.uk/medicines/ • Breastfeeding and Medication – Wendy's Support on Breastfeeding and Medication (breastfeeding-and-medication.co.uk) / https://breastfeeding-and-	Further information has been added to this section. Breastfeeding support will be included in the toolkit.

		medication.co.uk/ A statement should be included to emphasise the need to always support breastfeeding. Yoga, exercise and mindfulness exercise etc are mentioned however this should be introduced and discussed earlier in the guideline as an early intervention and before the person becomes depressed.	There was insufficient evidence to support a recommendation on yoga etc. There is a section in the toolkit for keeping well generally.
5.2 (now 4.2)	**SMc**	Depression/anxiety - pharmacological therapies page 25 I am concerned that there may be a reluctance to prescribe medication for depression given what is documented in considerations prior to prescribing. I'm a little unclear as an Obstetrician why smoking, preterm birth … are listed on the considerations in regard to deciding who to prescribe eg an SSRI too. Given the limited evidence in regard to bleeding and SSRI, the fact that we would consider this in a risk assessment, I would be concerned that a person would not be prescribed an SSRI due to H/O PPH and the limited evidence around increased bleeding in relation to this. This is where collaborative working comes in again and can be discussed with Obstetric team. There is no mention of which SSRIs would generally be recommended first line but there is reference to	The advice on considerations before prescribing in section 4.7 has been updated. Further information has been added to section 4.2, including persistent pulmonary hypertension. We have added more information around considerations for which therapy to use first, which is an individualised decision. The statement on paroxetine has been removed.

		paroxetine and poor neonatal adaptation but not about the potential cardiac risk with this drug. Also no mention specifically about persistent pulmonary hypertension - our neonatal unit would want to know about a person on SSRI. Is it worth specifically stating which SSRIs are recommended as currently only paroxetine mentioned, the one that ideally you wouldn't choose first line (and ideally avoid).	
5.2	**IMHDG**	p24 3rd paragraph; I'd suggest when prescribing a "new" antidepressant treatment that SSRIs should be first line, but when prescribing for relapse of previous antidepressant ideally use what worked before as it's a better chance of working again without trial and error and further worsening of mood.	This section has been updated for further clarification, incorporating a greater explanatory statement including a section on section 5.2.1 'choice of medication': Where there has been poor response to SSRI treatment or benefit from alternative, it may be preferable to choose the medication that the patient has previously responded to, taking into consideration foetal wellbeing and infant feeding preference (eg breastfeeding) and any adjustments required.
Section 6 – Birth trauma			
General	**--**	Sufficient information offered/clear actions to follow. No mention of positive outcomes from use of Birth Reflections for birth trauma and how this minimises need for further treatment/ further decline.	There is insufficient evidence to support a recommendation on Birth Reflections.
General	**MS**	Very clear.	Thank you

General	**CRa**	Comment from Dr M Broom Consultant Obstetric Anaesthetist Glasgow Royal Infirmary Antenatal discussion with an anaesthetist may be useful/recommended, on a case by case basis, particularly where anxieties relate to analgesia, operative delivery and previous complications etc. Consultation may be at an anaesthetic high-risk clinic or as a consult during an obstetric clinic appointment (we often input to SNIPS clinic). In addition, I notice that there are useful links in the Toolkit section. The most useful/relevant link from our side would be to the OAA's LabourPains.org website, where there is a host of useful - officially curated - information for mothers. Here is the link: Labour Pains - Information on pain relief choices during labour www.labourpains.org This site also, very usefully, has multiple translations of information leaflets, by Translators Without Borders.	Agree. This is already in place as good practice. Who it would be helpful for them to meet/what their concerns are could vary. It needs to be individualised for that person. GPP added: Offer women/birthing parents, who have a subsequent pregnancy following a traumatic birth experience, the opportunity to speak with a member of their multidisciplinary team (eg midwife, anaesthetist, obstetrician) prior to and/or post delivery. *To be added to the toolkit*
General	**AMc**	Reference is made to "providing parent-centred, trauma-informed opportunities for review of what happened during the birth shortly afterwards and again at 6 weeks is an important aspect of postnatal care"	This has been kept general to allow it to vary from health board to health board, depending on what size of team a board has. This is an implementation issue rather than a reflection of what the evidence says.

		Interpretation of this statement will vary significantly - I feel expansion on what that looks like and who delivers this would be beneficial as the reality is there will be limited professionals able to review what happened during the birth. (Some areas have models of birth reflections type sessions with midwives, some MNPI services provide birth reflection/afterthoughts with specialist midwives) The recommendations on page 27 appear feasible and implementable in Scotland where NHS Boards have access to perinatal and MNPI services with appropriately trained clinicians. Service capacity of these services must also be considered - Many MNPI services cross Scotland have a very limited cohort of staff and in my experience the majority of birth trauma referrals now come to an MNPI service and this is likely to increase in time. Boards without access to perinatal/MNPI services may need to consider local availability of service provision to achieve this recommendation and some thought in supporting affected boards will be important to prevent barriers of access across Scotland . This could be achieved via local psychological therapies teams if available in that area but a strong recommendation for links with the maternity service should be considered.	

General	**FH**	Probably needs more about the MDT for caring for birthing people in subsequent pregnancies	The following GPP has been added: Offer women/birthing parents, who have a subsequent pregnancy following a traumatic birth experience, the opportunity to speak with a member of their multidisciplinary team (eg midwife, anaesthetist, obstetrician) prior to and/or post delivery.
General	**--**	same response as in section 1: I feel structure and language is appropriate. I wonder whether there needs to be some emphasis /acknowledgement on maternity and neonatal Psychological Interventions (MNPI) work where this is more in relation to adjustment to some aspect of pregnancy or maternity journey that has not gone to plan and parents require psychological intervention re adjustment to this (e.g. adjustment to delivery of a preterm baby), grief and loss work (stillbirth, recurring miscarriage, birth trauma (loss of hoped for birth). The reason I raise this is that there is a spectrum of perinatal mood disorders/ways in which parents are affected and I feel adjustment to situations where the maternity experience is different to that hoped for is vital for health parent infant relationships and for perinatal mood.	We have added detail from COPE that highlights the situations that can trigger trauma.
General	**MG**	Due to the deadline for responses, I am not able to comment on each section. Please read for consistency in the inclusion of birthing parents and non-birthing parents (if that is the chosen language),	A new paragraph has been added as section 1.1.2 explaining the terminology used, what it encompasses, and highlighting the limitations of the evidence on specific groups.

		replace 'birth parents', and ensure chestfeeding as well as breastfeeding is included. Please also check for the use of gendered pronouns. There is (weak) evidence that trans men and non-binary people may be at higher risk of traumatic birth. There is (weak) evidence that lesbian, bisexual and pansexual women may have higher rates of postnatal anxiety.	
General	**RCM**	We are pleased to see Birth Trauma highlighted for action. This is often missed or not addressed despite an increasing number of women who have reported being affected by negative birthing experiences. In considering these recommendations, it may be helpful to offer as standard care to all women, the opportunity to defuse/discuss their labour and birth. Also at an initial booking for subsequent pregnancies. This offer will need to be considered within the context of provision and funding.	The following GPP has been added: For women/birthing parents who have a subsequent pregnancy following a traumatic birth experience, offer an opportunity to discuss any antenatal anxieties relating to the deliver and previous experiences with a member of the multidisciplinary team (eg midwife, anaesthetist, obstetrician).
General	**IMHDG**	Maybe not helpful to describe birth trauma as a severe mental illness. Perhaps use perinatal trauma to cover range of potentially traumatic experiences and also more acknowledgement of past trauma and risk of multiple ACES should there be mention of tokophobia primary and secondary Reference to both EMDR and Trauma focused CBT	The guideline does not refer to birth trauma as a severe mental illness. This has been restructured in section 1.3.1, describing the conditions included. The definition used for birth trauma is in section 1.4.3. A list of situations associated with birth trauma has been added to section 5. An additional section and recommendation on tokophobia has been added to the section on therapies for anxiety.

		Reference to role of Birth reflections/ listening conversations/ debriefs More assessment of impact on parent infant relationship and other significant relationships	The recommendations reflect the evidence identified in the review by COPE. Assessment of impact on mother infant relationship is covered in section 2.8.
General	**SA**	The inclusion of birth trauma in the SIGN guidelines and recommendation that "women/birth parents should also be screened for birth trauma in the perinatal period" is welcome, as is the SIGN recommendation that measures that follow diagnostic criteria, such as the City Birth Trauma Scale, should be used to assess birth trauma and PTSD. These points are consistent with recommendations from an EU-COST (Co-operation in Science and Technology) funded network of researchers and clinicians from 33 countries specialising in birth trauma and PTSD (Ayers et al., under review). Key recommendations from this group which are relevant to the SIGN guidelines are that: • Routine clinical outcomes should incorporate assessment of parents experiences of care and identification of negative birth experiences in order to evaluate and improve care. • Following an experience of childbirth-related trauma, secondary prevention and treatment of perinatal mental health issues must include the family as a whole and focus on prevention in a subsequent pregnancy and birth. • Principles of trauma-informed care need to be	We think we have covered these points in the recommendations and the policies signposted in sections 1.1.3 and 1.2. We have added a good practice point that women should have the opportunity to discuss concerns with a member of the MDT.

		integrated across all maternity care settings and into clinical training programs. The first of these is a priority for NHS England and the development of a measure to assess parents experiences of maternity care has been initiated by the NIHR Policy Research Programme (see https://www.nihr.ac.uk/documents/policy-research-programme-36-01-02-measuring-the-experience-of-maternity-service-users-development-of-a-maternity-patient-reported-experience-measure-prem/33541. This is therefore likely to be incorporated into NHS practice in a few years. Clinical recommendations in SIGN and NICE for the secondary prevention and treatment of birth trauma and PTSD currently rely heavily on evidence from PTSD treatment in other populations. It would therefore be good if this need for more evidence on secondary prevention and treatment were highlighted in the SIGN guidelines. Ayers S, Horsch A, Garthus-Niegel S, Nieuwenhuijze M, Bogaerts A, Hartmann K, Karlsdottir SI, Oosterman M, Tecirli G, Turner JD, Lalor J on behalf of COST Action CA18211. Traumatic birth and childbirth-related post-traumatic stress disorder: Recommendations for practice, policy and research. Under review.	This has been added as a recommendation for further research

6.1 (now 5.1)	**MCS**	see comments above it would be good to reference the Matrix https://www.matrix.nhs.scot/	The following sentence has been added: Further information on psychological therapies and implementation support for services is available from the NHS Education for Scotland website www.matrix.nhs.uk
6.1 (now 5.1)	**EMH**	Can this be provided by your non statutory specialist perinatal counselling services for high intensity trauma support. Non mention of who provides this across the sectors	These interventions can be provided by any service that has appropriately trained staff, governance and supervision.
6.1 (now 5.1)	**LF**	This section could be developed further and explored and discussed in greater depth. For example: • There is a missed opportunity to include trauma informed practice and to make reference to the National Trauma Training Programme • There is a need to emphasise that birth trauma is the women's perception of their birth experience and not just a medically complicated birth. • Birth trauma was often not recognised in the past but can continue till old age and therefore this needs to be addressed robustly in this section • Birth trauma often linked with an unwell infant, therefore the infant needs to be recognised in this section i.e., infant in nursery – separated from mother; infant death etc.	Reference to the trauma training programme has been added to the implementation section. This has been added to the description in section 1.4.3 and further information has been added to section 5. Post perinatal support is available but the guideline focuses on the perinatal period. This is covered in the care planning section. A list of factors associated with birth trauma has been added to section 5. The recommendations focus on therapies rather than team set up or who delivers them. The trauma programme has been added to the implementation section.

		• There is a need to link in with the maternity neonatal psychologist (MNPI) • A skilled practitioner is needed to review/ debrief the 'traumatic birth' with mother / parents. The National Trauma Training Programme could be referred to make this more explicit. **Should there be a separate section for psychological trauma**	Conditions are addressed under the context of perinatal care rather than condition-specific, so PTSD is covered under anxiety. This is discussed in section 1.4.3.
6.1 (now 5.1)	**LC**	Attending eye movement desensitisation processing therapy may be more difficult for new mums, particularly when there is limited support at home. Arts therapies can offer a non-directive way of exploring trauma and can be delivered in the community, either at local centres on at home. Arts therapies may be more accessible to patients who are not able to access long-term interventions.	We agree but it is recognised as an effective treatment. It is given as an example. CBT could be used instead if it is does not suit an individual. Arts therapies is not referenced in COPE and not widely available so beyond the scope of the guideline. A sentence has been added to section 4.1: Other therapies, such as art or music therapies are available, particularly through third sector organisations, but were not included in this evidence review.
Section 7 – Severe mental illness			
Now section 6			
General	**--**	Adequate details provided/understandable information.	Thank you

General	**LM**	Production of guides (as per COPE) on specific conditions for health professionals (particularly those with less MH expertise) and women and families could be useful	The shared decision toolkit provides additional information on specific conditions.
General	**PMH**	Does a further explanation of "severe mental illness" need to be part of the title?	The title has been changed to Bipolar affective disorder, postpartum psychosis, schizophrenia and related conditions.
General	**LF**	When prescribing anti-depressants guidance should be sought from the following sources: • Drugs in Breastmilk factsheets - The Breastfeeding Network / https://www.breastfeedingnetwork.org.uk/drugs-factsheets/ • Safety in breastfeeding – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice / https://www.sps.nhs.uk/home/guidance/safety-in-breastfeeding/ • Drugs and Lactation Database (LactMed®) - NCBI Bookshelf (nih.gov) / https://www.ncbi.nlm.nih.gov/books/NBK501922/ • Medicines A-Z - NHS (www.nhs.uk) / https://www.nhs.uk/medicines/ • Breastfeeding and Medication – Wendy's Support on Breastfeeding and Medication (breastfeeding-and-medication.co.uk) / https://breastfeeding-and-medication.co.uk/ A statement should be included to emphasise the need to always support breastfeeding	Section 3.7 outlines key prescribing principles Section 3.4 provides advice on the support for breastfeeding. Other resources for breastfeeding support will be added to the toolkit.

General	**RCM**	The RCM has no specific comments to make on the offer or types of treatments for the recommendations. It would be important for women presenting with severe mental illness/who already have a history to have been identified earlier in the antenatal period with care plans and discrete multi-disciplinary support from the relevant agencies and professionals.	Care planning section (Section 3.5) and pre-conceptual planning (3.3) identify the importance of multidisciplinary care planning, including in the preconceptual and antenatal periods.
General	**IMHDG**	Role of adult psychiatric hospitals and MBU Role of crisis and home treatment teams How to support parent infant bond e.g. breastfeeding	Pathways for care are discussed in section 1.1.3, and section 3. Breastfeeding support is discussed in section 3.4
General	**MS**	Very clear	Thank you
General	**MG**	Due to the deadline for responses, I am not able to comment on each section. Please read for consistency in the inclusion of birthing parents and non-birthing parents (if that is the chosen language), replace 'birth parents', and ensure chestfeeding as well as breastfeeding is included. Please also check for the use of gendered pronouns.	A section, 1.1.2 has been added to explain the use of terminology throughout the guideline. Use of gendered pronouns has been checked throughout.
7.1 **(now 7.2)**	**AMc**	Page 28 - "Any baby who was exposed near delivery, or is breastfed, by a mother/birth parents taking antipsychotics should be monitored closely for extrapyramidal and withdrawal symptoms" What does the above look like in terms of monitoring and for duration of monitoring if breastfeeding ? Which professional should lead on this ? Current guidelines in Maternity and Neonatology in most boards are likely to be "gray" in regards to monitoring infants. More robust guidance on this	There was insufficient evidence to support a more detailed recommendation. The wording of the GPP has been revised to ‘individualised multidisciplinary care planning’ An additional GPP has been added to the antipsychotics section: Consider that infants exposed to medication in pregnancy may be at risk of adverse effects and may require additional monitoring after birth. Monitoring

		should be recommended - there is an excellent Pan - London document on guidance on Newborn assessment in relation to perinatal mental health medications which would be an excellent national resource for Scotland if replicated. Lithium - It may be helpful to consider recommendation to involve a specialist perinatal mental health midwife in care planning, where available . The specialist midwife acts as vital link between maternity and mental health services and in particular with lithium use in pregnancy collaboration with MDT is essential . Some specialist midwives prepare advance care planning documents that support complex mental health management.	should be individualised and considered as part of multidisciplinary birth planning taking into consideration the medication dose, polypharmacy, infant feeding and infant vulnerability such as risk of preterm delivery, low birth weight and any obstetric complications
7.1 (now 6.2)	**VR**	'Because antipsychotics have a ... possibly better reproductive safety profile than lamotrigine and lithium, antipsychotics generally form the mainstay of the treatment'. Can this be double-checked please? While I am not a psychiatrist, from recent information I have picked up at a psychoeducation course and webinars, Lithium is being considered the 'gold standard' for bipolar in general (Prof Danny Smith, Edinburgh) and considered to be less risky during pregnancy than thought before (Dr Clare Dolman, KCL; Prof Ian Jones, Cardiff).	The introductory statement to this section has been revised to say that if a woman is already on lithium it may be safer to continue use.
7.2.1	**FH**	Need to make it very clear that advice for high dose folic acid applies for pregabalin as well as carbemazepine/lamotrigine	The GPP has been added: Provide high-dose folic acid (5 mg/day) to all women on anticonvulsant mood stabilisers who are planning

(now 6.3.1)			pregnancy including before any possibility of pregnancy.
7.2.2 (now 6.3.2)	**SMc**	5. Mood stabilisers - page 29/30 - more of a comment As someone who does epilepsy clinic with people on anti-epileptic drugs I may have a different perspective (although in agreement on comments Re: sodium valproate). Mainstay in epilepsy clinic generally lamotrigine and leviteracetam and have some on carbamazepine as well where risks a little higher than the other 2. I guess I feel uncomfortable restricting a person to not getting a medication with mental health problem if there isn't a better fit where risks considered and individualised person care considered and an informed choice by the patient. Do we consider mental health to be lesser than epilepsy/other neurological condition? Obviously if there are better alternatives then that is the route to choose but just wanted to clarify that it should be a balance of risks and informed choice and important to collaborate with Obstetric team and consider the balance against risks of untreated/poorly managed mental health if these drugs are the best fit. Antipsychotics and gestational diabetes - page 29 I think I'd like to see a specific recommendation for OGTT or whatever is agreed nationally.	The guideline highlights the importance of ensuring an individualised approach to weigh up the individual benefits and risks for the specific treatment being considered, including the specific considerations relating to the use of mood stabilisers or anticonvulsants. Further advice has been added about keeping patients on their medication to reduce risk of relapse. The recommendations relating to the use of anticonvulsant therapy in pregnancy include the recommendation in section 6.3: If women/birthing parents commence or continue metabolic-inducing antipsychotic treatment during pregnancy (such as olanzapine, clozapine, quetiapine], consider earlier screening and monitoring for gestational diabetes [as per local protocols). The wording has been clarified to make this recommendation clearer. The guideline refers to the importance of multi-agency and multidisciplinary care planning including maternity colleagues in the Care planning section 3.

		It was discussed at the RCOG annual perinatal mental health meeting December 2022 that now many units are now stating an OGTT should be done for anyone on antipsychotics in pregnancy and therefore I think we need to have clear advice as currently what is written in this draft guideline is quite vague 'consider earlier screening and monitoring for gestational diabetes' Again importance of collaborating with Obstetric team	
7.2.2 (now 6.4.3)	**AMc**	CBR - "if prescribing lamotrigine to a women/birth parent who is breastfeeding, arrange close monitoring of the infant and specialist neonatologist consultation where possible. What would this monitoring advice look like and who would lead on response action where required? In the absence of more robust guidance in regards to breastfeeding monitoring we may find professionals advising against breastfeeding and this will have detrimental impact on breastfeeding rates and benefits for women with additional perinatal mental health needs on a wider public health platform.	Wording revised to 'where needed' rather than 'where possible'. Further information in the section on lamotrigine has been added to explain factors to be taken into consideration.

Section 8 – Borderline personality disorder			
General	**--**	Sufficient information offered/clear actions to follow/professionals would require access to specify training.	Thank you
General	**FH**	Good.	Thank you
General	**FF**	Unsure what a structured formulation means and if this is a psychological formulation this would not be achievable with current psychology resources or necessary for everyone. I think you could argue that in an ideal world this would happen for all disorders and it would be a standard that realistically we could not meet.	'Structured formulation' has been changed to 'shared formulation' to reflect input from MDT rather than just psychology: "Where possible and appropriate, provide perinatal women/birthing parents with borderline personality disorder the opportunity to develop a shared formulation of the impact of pregnancy and parenthood on them, and their symptoms of borderline personality disorder." We agree that is is not always achievable. The GPP states 'where possible and appropriate'.
General	**PB**	The term 'emotionally unstable personality disorder', or simply 'personality disorder' is often used now instead of the term 'borderline personality disorder (BPD)'	We have used the term borderline personality disorder as this was used by COPE and therefore reflects the evidence review underpinning the recommendations. An explanation of this has been added to section 1.4.6 with signposting to the ICD-11 terminology.
General	**LF**	1. This section could be stronger and the links between substance misuse and personality disorder, sexual abuse and personality disorder, and trauma and personality disorder etc	1. This is covered in COPE which is hyperlinked and included in section 1.4.6. We have added 'substance misuse disorders' to the GPP outlining comorbidities: "Where indicated this should facilitate access to individualised support and/or access to structured

		2. Trauma informed care needs to be explained better and links made to the National Trauma Training Programme 3. Consideration needs to be given to staff as some staff may need additional support due to complexity of working with families where the mother / parent has a personality disorder. Note for consideration is that high incidence of substance use with BPD. Guidance currently links to dated guidance which not efficient in providing appropriate care for this priority area of families known to have high social concerns and linked with maternal and neonatal morbidity and mortality. Many have co-morbid mental health and substance use and can be declined from PMHT and psychology. Consideration, are they receiving the appropriate level of support from addiction services? Are these consistent? * Again, consideration on having section for this vulnerable group. *	psychological therapies either specifically designed for borderline personality disorder, or for current comorbid mental health conditions such as substance misuse disorders, anxiety or depression." 2. Further information on trauma has been added to section 6. The trauma programme has been signposted in the implementation section. 3. This is covered in the first GPP saying healthcare professionals should have access to support. 4. Substance use has been added to the GPP. It is outside the remit to extend to a review of the evidence for the range of comorbidities that are experienced.
General	**RCM**	The recommendations in this section should also be specific about identifying those women at risk as per MBRRACE	The increased risk of suicide is highlighted in the first sentence, and the MBRRACE advice is covered in section 2.6.
General	**IMHDG**	What about comorbidity such as substance misuse? section 8 and throughout:	This has been added to the good practice point: "Where indicated this should facilitate access to individualised support and/or access to structured

		Borderline Personality Disorder is a DSM term, in Europe we're supposed to use ICD terminology so the term should be Emotionally Unstable Personality Disorder (EUPD)	psychological therapies either specifically designed for borderline personality disorder, or for current comorbid mental health conditions such as substance misuse disorders, anxiety or depression." Borderline Personality Disorder is the term used by COPE for the evidence review underpinning the recommendations. This explanation, plus signposting to ICD 11 terminology has been added to section 1.4.6.
General	**MS**	Very clear.	Thank you
General	**MG**	Due to the deadline for responses, I am not able to comment on each section. Please read for consistency in the inclusion of birthing parents and non-birthing parents (if that is the chosen language), replace 'birth parents', and ensure chestfeeding as well as breastfeeding is included. Please also check for the use of gendered pronouns.	A section has been added to the introduction explaining our use of terminology and inclusive language (section 1.1.2)
8.1	**LC**	As above, arts therapies can offer a non-directive intervention that may be helpful to some patients for whom speaking is less available.	Arts therapies were not covered in the COPE review, so is out of scope for this guideline. A sentence has been added to section 5.1: "Other therapies, such as art or music therapies are available, particularly through third sector organisations, but were not included in this evidence review."
8.1 and 8.2	**AMc**	All recommendations on page 32 are positive however service provision in each health board is likely to differ. Health boards should review service provision in relation to BPD and perinatal and infant mental health considerations and this should be	This has been added to the implementation section.

		reflective in local perinatal mental health referral pathways	
Section 9 – Implementing the guideline			
General	**JM**	Again please include eating disorders services.	This is outside the remit of the guideline.
General	**--**	Possible challenges could be for funding required to provide enough staffing levels for services.	It is outside the remit of SIGN to make recommendations on funding for services.
General	**SM**	As per previous comment there needs to be consideration of the impact to the educational needs of staff prior to and ongoing supervision administering new tools. How this impacts on electronic systems.	Links to NES training and the need for training in ANRQ have been added to the implementation section.
General	**FH**	Good.	Thank you
General	**EMH**	There is no mention of partnerships with your voluntary sector colleagues who provide specialist perinatal and infant mental health services like CrossReach Counselling.	The following bullet point has been added to section 9: a review of how statutory, community and third sector services align and are funded
General	**LM**	Overall I would be of the opinion that recommendations are feasible and implementable.	Thank you
General	**LF**	• There may be limited capacity to roll out the guideline due to workforce issues • Consideration needs to be given to education and training needs to support effective roll out to the wider workforce – NHS, SW, Third sector etc • Reference and signposting to existing resources is needed. For example, Turas Learn host a variety of resources some of which are essential learning for	The guideline offers recommendations for what the best standard of care can be based on the available evidence. It is outside the role of SIGN to determine funding of services. Links to NES education programmes have been added to section 8, including the trauma programme.

		the maternity care workforce and could be identified and used better throughout • The Scottish way of working and trauma informed principles National Trauma Training Programme need to be embedded throughout • The following links may help to integrate different policies and workstreams better • Transforming Psychological Trauma o https://www.transformingpsychologicaltrauma.scot/ o https://transformingpsychologicaltrauma.scot/media/x54hw43l/nationaltraumatrainingframework.pdf • NHS Education for Scotland (2021) Transforming Psychological Trauma in Maternity Services: NMAHP Project Report https://learn.nes.nhs.scot/60198/women-children-young-people-and-families/2021-maternity-services-report-transforming-psychologica • Supporting Women Reducing Harm Report https://www.pmhn.scot.nhs.uk/wp-content/uploads/2021/09/SUPPORTING-WOMEN-REDUCING-HARM-Report-V1.pdf • Specialist perinatal mental health professionals role definitions and support structures: https://www.pmhn.scot.nhs.uk/wp-	Supporting Women Reducing Harm report has been added to section 1.6.4: Substance misuse.

		content/uploads/2021/06/RD-Clinical-Psychologists_Final.pdf • Infant Mental Health – Developing positive attachments: https://www.nes.scot.nhs.uk/media/x4lmfskd/final_imh_interactive_pdf__3_.pdf • NES Infant Mental Health Page: https://www.nes.scot.nhs.uk/our-work/infant-mental-health/#solihullapproach2	
General	**RCM**	The RCM is supportive of providing the best optimal care for women with perinatal mental health conditions. We are unsure of what that would look like in terms of the staffing levels and the challenges within the maternity services. This is why it is important to consider the resource implications in the context of the national maternity strategy for Scotland and the national maternity workforce tool, and not just the mental health workforce. Implementation of the Guideline should also be aligned with the review/update of the Perinatal Mental Health Training Plan for Scotland. The Perinatal Mental Health curriculum Framework should also be extended or adapted to include training on which validated tool to use for assessment and how to validate the recommended tools. Given the multiple	This point has been added to the implementation section. SIGN have been in contact with NES to make them aware of the recommendations.

		tools in use. Implementation should also focus on the electronic maternity notes and the barriers/difficulties in extracting content. It may be appropriate to ring-fence the resources and focus on leadership to drive the recommendations, particularly in maternity services. A specialist midwife role with access to the executive leadership at the Board level. Implementation should also include plans to address the stigma associated with mental health	These suggestions are outside the role of SIGN This has been added to the implementation section.
General	**MMHA**	The MMHA briefing includes the following recommendation relevant to this section: Given the prevalence and risks associated with mental health and domestic abuse during the perinatal period, it is vital that part of the plan for implementing best practise guidelines such as these includes appropriate training to enable health professionals to identify and respond empathetically to domestic abuse survivors who feel suicidal and connect them to appropriate support.	This is included in the NES training framework which we have signposted.
General	**IMHDG**	Difficult to implement pharmacology recommendations without specialist perinatal Pharmacist roles in teams or regional model. This role was not considered in the DES recommendations.	*It is outside the remit of SIGN to recommend specific roles. The recommendations made are to provide advice for all prescribers involved in perinatal mental health.*

		Importance of supporting staff with supervision, training and reflective practice/ staff support. Would all staff feel comfortable with asking questions about trauma and knowing what to do with this information?	*Signposting to the NES training programmes, including the national trauma training programme, has been added to the implementation section.*
General	**SA**	Guidance and support for implementing perinatal mental health assessment and treatment are important. The MATRIx evidence synthesis project identified key barriers and facilitators to implementing perinatal mental health support and treatment. Findings can be used by services to identify areas they need to avoid or address when changing and/or implementing new initiatives in perinatal mental health (see https://www.matrixstudy.org/ for more information). It therefore might be helpful to incorporate or signpost the MATRIx information into your guidelines. Webb, R., Ford, E. M., Easter, A., Shakespeare, J., Holly, J., Hogg, S., Coates, R., Ayers, S., & The MATRIx study Team. (in press). The MATRIx Models – Conceptual frameworks of barriers and facilitators to perinatal mental health care. British Journal of Psychiatry Open. Webb R, Uddin N, Constantinou G, Ford E, Easter A, Shakespeare J, Hann A, Roberts N, Alderdice F, Sinesi A, Coates R, Hogg S, Ayers S and the MATRIx Study Team. (in press). A Meta-Review of the	*Thank you, the Scottish policies that have been produced to address the barriers highlighted in the matrix information are outlined in section 1.*

		Barriers and Facilitators to Women Accessing Perinatal Mental Health Care. BMJ Open. Webb R, Uddin N, Ford E, Easter A, Shakespeare J, Roberts N, Alderdice F, Coates R, Hogg S, Cheyne H, Ayers S and the MATRIx study team (2021). Barriers and facilitators to implementing perinatal mental health care in health and social care settings: A systematic review. Lancet Psychiatry, 8(6), 521-234.	
General	**MS**	In order to implement the guidance I feel that support with staff training in regard to using the proposed screening tools in pregnancy by non-mental health professionals will be required i.e. what training would be most appropriate and discussion regarding what supervision should be offered during implementation but also on an ongoing basis	The NES training modules have been signposted in section 8, along with a call for training in the use of ANRQ.
General	**AMc**	Given the extensive recommended changes within this guideline that impacts multi professional disciplines, local implementation of this guideline is likely to be a significant challenge. This guideline would benefit from a national approach that provides a basis for effective use at the local level. Screening and assessment in particular are the areas where change is significant. Health boards should consider aligning a lead practitioner/lead service who can review implementation of the guideline.	We hope that the MCN can support a national approach to implementation and encourage services to address the recommendations.

9.3	**RCM**	The audit would be a challenge because of the current issues of extracting data from the maternity e-records. Resolving these issues would meet the expectations for auditing practice and developing best practice initiatives. Consider Peer action research within the communities served with an emphasis on awareness raising and education to address the issue of stigma, especially in racialised communities.	The audit section has been removed. A call for education and awareness raising to reduce stigma has been added to section 8.
9.3	**KB**	We support the use of auditing tools and suggest that accountability and governance is key in implementation of these guidelines to ensure that each NHS board delivers a consistent approach to Infant and Perinatal Mental Health support. For those health boards that are not meeting these standards, we would question what is in place to ensure there is a consistency of care across Scotland (especially for those areas that are socioeconomically deprived). As stated within the guidelines, there are higher rates of mental illness in areas of high poverty - disparity of care should be addressed to minimise the postcode lottery. We would suggest an explicit leadership commitment to practice reform and accountability is required to fulfil this. This should include a focus on addressing stigma and discrimination and its impact. Scrutiny and regulation should include a wide and diverse range of	This is beyond the remit of SIGN. We will discuss support for implementation with the managed clinical network. A call for education and awareness raising to reduce stigma has been added, including input from diverse people with lived experience.

		lived experience voices, expertise and skills in the coproduction, delivery and assessment of services. We also would suggest adding training and development of the workforce into the guidelines. This would equip staff to be able to have open conversations about mental health during the perinatal and infant mental health period. This includes training on use of the assessment tools, anti-discriminatory practice and equality and diversity training. Currently ethnic minority groups flag that they do not receive adequate care in mental health services. Expanding training for staff members is key to bridge this gap (Intercultural Youth Scotland, Speaking our mind, 2021). Providing appropriate training on these guidelines will support staff to identify patient needs and provide support that improves the outcomes for individuals. We would suggest that training, scrutiny and regulation should centre around diverse lived experience voices via co-production. Lived experience voices are invaluable in highlighting experiences of stigma and discrimination within healthcare when codesigning solutions, which can help tackle systemic service delivery issues. The UNCRPD flags that a human rights approach to regulation requires involvement of lived experience in monitoring and evaluating services.	Signposting to the NES training modules has been added.

Section 10			
General	**LN**	Thank you for including the recommendation on research in Occupational Therapy- consideration required for this and how this will be undertaken. Currently limited capacity for this given small number of occupational therapy staff in all health boards and all in clinical posts- consideration of who will lead this research and protected time and capacity for this.	This recommendation has been broadened to incorporate input from others in the multidisciplinary team. It is hoped that researchers with capacity to carry out the studies will pick up the recommendations on gaps in research.
General	**JM**	Please include the need for research on eating disorders in pregnancy and the puerperium.	Because we haven't reviewed the evidence for eating disorders in this guideline we can't include this recommendation. A call for research in the perinatal period is included in SIGN 164: Eating disorders
General	**--**	Impact of COVID-19 on PTSD levels of mothers Post-natal depression in fathers and how best to support this	A paragraph on the impact of COVID-19 has been added to section 1.1 This section is to highlight gaps found in the evidence review for the guideline. These areas were not part of the SIGN remit so cannot be included as research recommendations.
General	**SM**	Bullet point 4 benefits of input from OT not clear where this ties into the guideline, there is a dearth of research on the impact of care provided by perinatal mental health nurses as we work in MDTs should this be inclusive of all disciplines.	This has been broadened to: benefits of input from wider members of the multidisciplinary team, such as occupational therapists, speech and language therapists, and perinatal mental health nurses, in providing an holistic approach to care.

		1.6 indicates more research needed but no recommendation made. Section 3 the Stirling Anxiety Scale was developed from research completed in Scotland there should be a recommendation for further research into the validity to allow informed inclusion / exclusion in future guidelines	An additional point has been added: the experience of gestational or birthing parents who do not identify as women, who experience perinatal mental health conditions, and which therapies best suit their needs. A point has been added for validation studies for the Stirling Antenatal Anxiety Scale.
General	**SMu**	The potential role of Speech and Language Therapy in supporting peri-natal mental health can be clearly seen (supporting communication needs of parents due to co-existing conditions, supporting positive parent-infant interaction, etc.) and is therefore also a professional role deserving of further investigation in this context.	SLT has been added: benefits of input from wider members of the multidisciplinary team, such as occupational therapists, speech and language therapists, and perinatal mental health nurses, in providing an holistic approach to care.
General	**FH**	Good.	Thank you
General	**VR**	How many pregnancies in those with bipolar are unplanned in comparison to the average? As hypersexuality is a symptom of hypomania and mania, the risk of an unplanned pregnancy is higher. The manic or hypomanic person has grandiose ideas and loses a sense of risk. This may lead to suddenly wanting a child or stopping contraception. If unplanned pregnancies are more common in women with bipolar, then further difficulties are: chaotic lives and so little support network; sodium valproate harming the fetus.	Thank you for your comment. This guideline aims to highlight the importance of pre-conceptual planning for women at risk of planned or unplanned pregnancy who have a known mental health conditions such as bipolar affective disorder.

General	**LF**	Further suggestions include • Efficiency of the service provision developed through the PIMH Network • What does the Scottish landscape look like? What could be better? • What is the Lived experience? – is this changing over time? • What could be better • Impact of Trauma informed care on supporting women with mental health.	This would be useful research however this section is to highlight gaps found in the evidence review for the guideline and these are areas that were out of scope of the systematic review.
General	**IMHDG**	The benefits of a perinatal mental health pharmacy service for services providers and users low dose sedating antipsychotics in managing anxiety and distress in pregnancy. esketamine not esketamin Effectiveness of psychological therapies/ approaches group models with women Effectiveness of other therapies such as Compassion Focused Therapy	This was not included in the evidence-based review and therefore the guideline is not able to comment on this. Amended thank you. The following bullet point has been added: benefits of psychological therapies or approaches, in comparison with CBT or IPT, to address depression, anxiety or trauma in women/birthing parents in the perinatal period.

General	**SA**	The recommendations for research on the prevalence of psychological birth trauma and effects of a 3-month waiting period for assessment and/or care for post-traumatic stress symptoms are welcome. However, there are other areas where research is sorely needed to inform practice. Relevant recommendations from the EU-COST funded network specialising in birth trauma and PTSD are that: (1) research is needed on prevention and intervention that could ameliorate or prevent the onset of childbirth-related PTSD; and (2) to determine the economic costs of traumatic birth and PTSD. Research on prevention and intervention is directly relevant to clinical practice and economic costs are a key driver to changing governmental policy and funding allocations. Both these recommendations would therefore be good to incorporate in the SIGN guidelines. Ayers S, Horsch A, Garthus-Niegel S, Nieuwenhuijze M, Bogaerts A, Hartmann K, Karlsdottir SI, Oosterman M, Tecirli G, Turner JD, Lalor J on behalf of COST Action CA18211. Traumatic birth and childbirth-related post-traumatic stress disorder: Recommendations for practice, policy and research. Under review.	This bullet point has been changed to: • studies into secondary prevention and management of people experiencing birth trauma and PTSD, including the benefits and harms of a 3-month 'watch and wait' period before referral for treatment.
General	**AMc**	Agree. no further comments	Thank you

Section 11 Development of the guideline			
General	**MCS**	Development of the Guideline Should there be reference to the Matrix https://www.matrix.nhs.scot/ - Scottish evidence tables and supporting implementation guidance for psychological therapies and interventions.	Signposting to the matrix has been added to sections 4.1 and 5.1
General	**FH**	Good.	Thank you
General	**FF**	Overall looks an excellent piece of work comprehensively covering the main areas but feel around trauma and psychological therapies more thought and reflection of current practice and wider guidelines required	Please refer to our responses to your more specific comments in earlier sections.
General	**LF**	Stakeholder group could have included Infant Mental Health specialist and NTTP. Front line / universal services staff could have been included i.e., staff midwives, health visitor etc– universal rather than specialist staff NHS Education for Scotland staff should have also been involved Consideration needs to be given to the trans community. There is also a need for consistency in the terminology used in all national documents - Needs to be a national guidance and a consistent approach to terminology	The stakeholder group was recruited to be multidisciplinary and geographically representative, while restricting numbers to be an effective working group. The draft was widely circulated and open for comment for anyone to provide input. A paragraph has been added as section 1.1.2 to explain the approach to inclusive language/terminology. Feedback from the focus group of people with lived experience was a preference to use the terms woman/birthing parent throughout.

		The work would be more reader friendly if there was a disclaimer at start i.e., stating the term 'woman' will be used to refer the person giving birth – other terms like birthing person could then be removed.	
General	**RCM**	In deciding what the final recommendations would be, it may be appropriate to be explicit about the asks of the individual organizations, and how professionals should work together seamlessly to effect the changes required to care for and support women with Perinatal Mental Health Problems.	The recommendations reflect the evidence base for best practice. We hope that health services will work to adapt to implement this best practice.