NICE National Institute for Health and Care Excellence

NICE guideline

Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors

Clinical guideline
Published: 22 September 2010

www.nice.org.uk/guidance/cg110

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is the basis of QS22.

Overview

This guideline covers antenatal care for all pregnant women with complex social factors (particularly alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20, domestic abuse). It offers advice on improving access to care, maintaining contact with antenatal carers, and additional information and support for these women.

NICE has also produced a guideline on antenatal care.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Pregnant women who need additional support to use antenatal services, their families and carers

Introduction

The NICE guideline on antenatal care outlines the care that women should be offered during pregnancy. However, pregnant women with complex social factors may have additional needs. This guideline sets out what healthcare professionals as individuals, and antenatal services as a whole, can do to address these needs and improve pregnancy outcomes in this group of women.

The guideline has been developed in collaboration with the Social Care Institute for Excellence. It is for professional groups who are routinely involved in the care of pregnant women, including midwives, GPs and primary care professionals who may encounter pregnant women with complex social factors in the course of their professional duties. It is also for those who are responsible for commissioning and planning healthcare and social services. In addition, the guideline will be of relevance to professionals working in social services and education/childcare settings, for example school nurses, substance misuse service workers, reception centre workers and domestic abuse support workers.

The guideline applies to all pregnant women with complex social factors and contains a number of recommendations on standards of care for this population as a whole. However, 4 groups of women were identified as exemplars:

- women who misuse substances (alcohol and/or drugs)
- women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English
- young women aged under 20
- women who experience domestic abuse.

Because there are differences in the barriers to care and particular needs of these four groups, specific recommendations have been made for each group.

The guideline describes how access to care can be improved, how contact with antenatal carers can be maintained, the additional support and consultations that are required and the additional information that should be offered to pregnant women with complex social factors.

Specific issues that are addressed in the guideline include:

- the most appropriate healthcare setting for antenatal care provision
- practice models for overcoming barriers and facilitating access, including access to interpreting services and all necessary care
- ways of communicating information to women so that they can make appropriate choices
- optimisation of resources.

In addition to the recommendations in this guideline, the principles of woman-centred care and informed decision making outlined in the NICE guideline on antenatal care, specifically recommendations on the provision of antenatal information and individualised care, are of particular relevance to women with complex social factors.

Key priorities for implementation

General recommendations

The recommendations in this section apply to all pregnant women covered in this guideline.

Service organisation

- In order to inform mapping of their local population to guide service provision, commissioners should ensure that the following are recorded:
  - The number of women presenting for antenatal care with any complex social factor. Examples of complex social factors in pregnancy include: poverty; homelessness; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; domestic abuse. Complex social factors may vary, in both type and prevalence, across different local populations
  - The number of women within each complex social factor grouping identified locally.
- Commissioners should ensure that the following are recorded separately for each complex social factor grouping:
  - The number of women who:
    - attend for booking by 10, 12+6 and 20 weeks.
    - attend for the recommended number of antenatal appointments, in line with national guidance, see NICE's guideline on antenatal care.
    - experience, or have babies who experience, mortality or significant morbidity. Significant morbidity is morbidity that has a lasting impact on either the woman or the child.
  - The number of appointments each woman attends.
  - The number of scheduled appointments each woman does not attend.

- Commissioners should ensure that women with complex social factors presenting for antenatal care are asked about their satisfaction with the services provided; and the women's responses are:
  - recorded and monitored
  - used to guide service development.

Care provision

- Consider initiating a multi-agency needs assessment, including safeguarding issues so that the woman has a coordinated care plan. See Information sharing advice for safeguarding practitioners, Information sharing to protect vulnerable children and families and Multi Agency Risk Assessment Conference.
- Respect the woman's right to confidentiality and sensitively discuss her fears in a non-judgemental manner.
- Tell the woman why and when information about her pregnancy may need to be shared with other agencies.

Information and support for women

- For women who do not have a booking appointment at the first contact with any healthcare professional:
  - discuss the need for antenatal care
  - offer the woman a booking appointment in the first trimester, ideally before 10 weeks if she wishes to continue the pregnancy, **or** offer referral to sexual health services if she is considering termination of the pregnancy.
- In order to facilitate discussion of sensitive issues, provide each woman with a one-to-one consultation, without her partner, a family member or a legal guardian present, on at least one occasion.

Pregnant women who misuse substances (alcohol and/or drugs)

Service organisation

- Healthcare commissioners and those responsible for the organisation of local antenatal services should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example:
  - jointly developing care plans across agencies
  - including information about opiate replacement therapy in care plans
  - co-locating services
  - offering women information about the services provided by other agencies.

Training for healthcare staff

- Healthcare professionals should be given training on the social and psychological needs of women who misuse substances.
- Healthcare staff and non-clinical staff such as receptionists should be given training on how to communicate sensitively with women who misuse substances.

Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English

Service organisation

- Those responsible for the organisation of local antenatal services should provide information about pregnancy and antenatal services, including how to find and use antenatal services, in a variety of:
  - formats, such as posters, notices, leaflets, photographs, drawings/diagrams,

online video clips, audio clips and DVDs

- settings, including pharmacies, community centres, faith groups and centres, GP surgeries, family planning clinics, children's centres, reception centres and hostels
- languages.

Young pregnant women aged under 20

Service organisation

- Commissioners should consider commissioning a specialist antenatal service for young women aged under 20, using a flexible model of care tailored to the needs of the local population. Components may include:
  - antenatal care and education in peer groups in a variety of settings, such as GP surgeries, children's centres and schools
  - antenatal education in peer groups offered at the same time as antenatal appointments and at the same location, such as a 'one-stop shop' (where a range of services can be accessed at the same time).

Pregnant women who experience domestic abuse

Service organisation

- Commissioners and those responsible for the organisation of local antenatal services should ensure that a local protocol is written, which:
  - is developed jointly with social care providers, the police and third-sector agencies by a healthcare professional with expertise in the care of women experiencing domestic abuse.
  - includes:
    - clear referral pathways that set out the information and care that should be offered to women
    - the latest government guidance on responding to domestic abuse, see

Domestic abuse: a resource for health professionals

- sources of support for women, including addresses and telephone numbers, such as social services, the police, support groups and women's refuges
- safety information for women
- plans for follow-up care, such as additional appointments or referral to a domestic abuse support worker
- obtaining a telephone number that is agreed with the woman and on which it is safe to contact her
- contact details of other people who should be told that the woman is experiencing domestic abuse, including her GP.

Recommendations

Women have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

In this guideline the following definitions are used.

- Domestic abuse: an incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. It can also include forced marriage, female genital mutilation and 'honour violence'.
- Recent migrants: women who moved to the UK within the previous 12 months.
- Substance misuse (alcohol and/or drugs): regular use of recreational drugs, misuse of over-the-counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile substances (such as solvents or inhalants) to an extent whereby physical dependence or harm is a risk to the woman and/or her unborn baby.

1.1 General recommendations

The recommendations in this section apply to all pregnant women covered in this guideline.

Service organisation

1.1.1 In order to inform mapping of their local population to guide service provision, commissioners should ensure that the following are recorded:

- The number of women presenting for antenatal care with any complex social factor. Examples of complex social factors in pregnancy include: poverty; homelessness; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; domestic abuse. Complex social factors may vary, both in type and prevalence, across different local populations.
- The number of women within each complex social factor grouping identified locally.

1.1.2 Commissioners should ensure that the following are recorded separately for each complex social factor grouping:

- The number of women who:
  - attend for booking by 10, 12+6 and 20 weeks.
  - attend for the recommended number of antenatal appointments, in line with national guidance, see the NICE guideline on antenatal care.
  - experience, or have babies who experience, mortality or significant morbidity. Significant morbidity is morbidity that has a lasting impact on either the woman or the child.
- The number of appointments each woman attends.
- The number of scheduled appointments each woman does not attend.

1.1.3 Commissioners should ensure that women with complex social factors presenting for antenatal care are asked about their satisfaction with the services provided; and the women's responses are:

- recorded and monitored
- used to guide service development.

1.1.4 Commissioners should involve women and their families in determining local needs and how these might be met.

1.1.5 Those responsible for the organisation of local maternity services should enable women to take a copy of their hand-held maternity notes when moving from one area or hospital to another.

Training for healthcare staff

1.1.6 Healthcare professionals should be given training on multi-agency needs assessment and national guidelines on information sharing. See information sharing advice for safeguarding practitioners.

Care provision

1.1.7 Consider initiating a multi-agency needs assessment, including safeguarding issues, so that the woman has a coordinated care plan. See information sharing advice for safeguarding practitioners, information sharing to protect vulnerable children and families and Multi Agency Risk Assessment Conference.

1.1.8 Respect the woman's right to confidentiality and sensitively discuss her fears in a non-judgemental manner.

1.1.9 Tell the woman why and when information about her pregnancy may need to be shared with other agencies.

1.1.10 Ensure that the hand-held maternity notes contain a full record of care received and the results of all antenatal tests.

Information and support for women

1.1.11 For women who do not have a booking appointment at the first contact with any healthcare professional:

- discuss the need for antenatal care
- offer the woman a booking appointment in the first trimester, ideally before 10 weeks if she wishes to continue the pregnancy, **or** offer referral to sexual health services if she is considering termination of the pregnancy.

1.1.12 At the first contact and at the booking appointment, ask the woman to tell her healthcare professional if her address changes, and ensure that she has a telephone number for this purpose.

1.1.13 At the booking appointment, give the woman a telephone number to enable her to contact a healthcare professional outside of normal working hours, for example the telephone number of the hospital triage contact, the labour ward or the birth centre.

1.1.14 In order to facilitate discussion of sensitive issues, provide each woman with a one-to-one consultation, without her partner, a family member or a legal guardian present, on at least one occasion.

1.2 Pregnant women who misuse substances (alcohol and/or drugs)

Pregnant women who misuse substances may be anxious about the attitudes of healthcare staff and the potential role of social services. They may also be overwhelmed by the involvement of multiple agencies. These women need supportive and coordinated care during pregnancy.

1.2.1 Work with social care professionals to overcome barriers to care for women who misuse substances. Particular attention should be paid to:

- integrating care from different services
- ensuring that the attitudes of staff do not prevent women from using services
- addressing women's fears about the involvement of children's services and potential removal of their child, by providing information tailored to their

needs

- addressing women's feelings of guilt about their misuse of substances and the potential effects on their baby.

Service organisation

1.2.2 Healthcare commissioners and those responsible for providing local antenatal services should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care by, for example:

- jointly developing care plans across agencies
- including information about opiate replacement therapy in care plans
- co-locating services
- offering women information about the services provided by other agencies.

1.2.3 Consider ways of ensuring that, for each woman who misuses substances:

- progress is tracked through the relevant agencies involved in her care
- notes from the different agencies involved in her care are combined into a single document
- there is a coordinated care plan.

1.2.4 Offer the woman a named midwife or doctor who has specialised knowledge of, and experience in, the care of women who misuse substances, and provide a direct-line telephone number for the named midwife or doctor.

Training for healthcare staff

1.2.5 Healthcare professionals should be given training on the social and psychological needs of women who misuse substances.

1.2.6 Healthcare staff and non-clinical staff such as receptionists should be given training on how to communicate sensitively with women who misuse substances.

Information and support for women

1.2.7 The first time a woman who misuses substances discloses that she is pregnant, offer her referral to an appropriate substance misuse programme.

1.2.8 Use a variety of methods, for example text messages, to remind women of upcoming and missed appointments.

1.2.9 The named midwife or doctor should tell the woman about relevant additional services (such as drug and alcohol misuse support services) and encourage her to use them according to her individual needs.

1.2.10 Offer the woman information about the potential effects of substance misuse on her unborn baby, and what to expect when the baby is born, for example what medical care the baby may need, where he or she will be cared for and any potential involvement of social services.

1.2.11 Offer information about help with transportation to appointments if needed to support the woman's attendance.

1.3 Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English

Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English, may not make full use of antenatal care services. This may be because of unfamiliarity with the health service or because they find it hard to communicate with healthcare staff.

1.3.1 Healthcare professionals should help support these women's uptake of antenatal care services by:

- using a variety of means to communicate with women
- telling women about antenatal care services and how to use them
- undertaking training in the specific needs of women in these groups.

Service organisation

1.3.2 Commissioners should monitor emergent local needs and plan and adjust services accordingly.

1.3.3 Healthcare professionals should ensure they have accurate information about a woman's current address and contact details during her pregnancy by working with local agencies that provide housing and other services for recent migrants, asylum seekers and refugees, such as asylum centres.

1.3.4 To allow sufficient time for interpretation, commissioners and those responsible for the organisation of local antenatal services should offer flexibility in the number and length of antenatal appointments when interpreting services are used, over and above the appointments outlined in national guidance (see NICE's guideline on antenatal care).

1.3.5 Those responsible for the organisation of local antenatal services should provide information about pregnancy and antenatal services, including how to find and use antenatal services, in a variety of:

- formats, such as posters, notices, leaflets, photographs, drawings/diagrams, online video clips, audio clips and DVDs
- settings, including pharmacies, community centres, faith groups and centres, GP surgeries, family planning clinics, children's centres, reception centres and hostels
- languages.

Training for healthcare staff

1.3.6 Healthcare professionals should be given training on:

- the specific health needs of women who are recent migrants, asylum seekers or refugees, such as needs arising from female genital mutilation or HIV
- the specific social, religious and psychological needs of women in these groups
- the most recent government policies on access and entitlement to care for recent migrants, asylum seekers and refugees (see the Department of Health and Social Care and Maternity Action).

Information and support for women

1.3.7 Offer the woman information on access and entitlement to healthcare.

1.3.8 At the booking appointment discuss with the woman the importance of keeping her hand-held maternity record with her at all times.

1.3.9 Avoid making assumptions based on a woman's culture, ethnic origin or religious beliefs.

Communication with women who have difficulty reading or speaking English

1.3.10 Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman's family, her legal guardian or her partner) who can communicate with her in her preferred language.

1.3.11 When giving spoken information, ask the woman about her understanding of what she has been told to ensure she has understood it correctly.

1.4 Young pregnant women aged under 20

Young pregnant women aged under 20 may feel uncomfortable using antenatal care services in which the majority of service users are in older age groups. They may be reluctant to recognise their pregnancy or inhibited by embarrassment and fear of parental reaction. They may also have practical problems such as difficulty getting to and from antenatal appointments.

1.4.1 Healthcare professionals should encourage young women aged under 20 to use antenatal care services by:

- offering age-appropriate services
- being aware that the young woman may be dealing with other social problems
- offering information about help with transportation to and from appointments
- offering antenatal care for young women in the community
- providing opportunities for the partner/father of the baby to be involved in the young woman's antenatal care, with her agreement.

Service organisation

1.4.2 Commissioners should work in partnership with local education authorities and third-sector agencies to improve access to, and continuing contact with, antenatal care services for young women aged under 20.

1.4.3 Commissioners should consider commissioning a specialist antenatal service for young women aged under 20, using a flexible model of care tailored to the needs of the local population. Components may include:

- antenatal care and education in peer groups in a variety of settings, such as GP surgeries, children's centres and schools
- antenatal education in peer groups offered at the same time as antenatal appointments and at the same location, such as a 'one-stop shop' (where a

range of services can be accessed at the same time).

1.4.4 Offer the young woman aged under 20 a named midwife, who should take responsibility for and provide the majority of her antenatal care, and provide a direct-line telephone number for the named midwife.

Training for healthcare staff

1.4.5 Healthcare professionals should be given training to ensure they are knowledgeable about safeguarding responsibilities for both the young woman and her unborn baby, and the most recent government guidance on consent for examination or treatment. (See the Department of Health and Social Care.)

Information and support for women

1.4.6 Offer young women aged under 20 information that is suitable for their age – including information about care services, antenatal peer group education or drop-in sessions, housing benefit and other benefits – in a variety of formats.

1.5 Pregnant women who experience domestic abuse

A woman who is experiencing domestic abuse may have particular difficulties using antenatal care services: for example, the perpetrator of the abuse may try to prevent her from attending appointments. The woman may be afraid that disclosure of the abuse to a healthcare professional will worsen her situation, or anxious about the reaction of the healthcare professional.

1.5.1 Women who experience domestic abuse should be supported in their use of antenatal care services by:

- training healthcare professionals in the identification and care of women who experience domestic abuse

- making available information and support tailored to women who experience or are suspected to be experiencing domestic abuse
- providing a more flexible series of appointments if needed
- addressing women's fears about the involvement of children's services by providing information tailored to their needs.

Service organisation

1.5.2 Commissioners and those responsible for the organisation of local antenatal services should ensure that local voluntary and statutory organisations that provide domestic abuse support services recognise the need to provide coordinated care and support for service users during pregnancy. (See also the NICE guideline on domestic violence and abuse: multi-agency working.)

1.5.3 Commissioners and those responsible for the organisation of local antenatal services should ensure that a local protocol is written, which:

- is developed jointly with social care providers, the police and third-sector agencies by a healthcare professional with expertise in the care of women experiencing domestic abuse
- includes:
  - clear referral pathways that set out the information and care that should be offered to women
  - the latest government guidance on responding to domestic abuse (see the Department of Health and Social Care's guidance on domestic abuse: a resource for health professionals)
  - sources of support for women, including addresses and telephone numbers, such as social services, the police, support groups and women's refuges
  - safety information for women
  - plans for follow-up care, such as additional appointments or referral to a

domestic abuse support worker

- obtaining a telephone number that is agreed with the woman and on which it is safe to contact her
- contact details of other people who should be told that the woman is experiencing domestic abuse, including her GP.

1.5.4 Commissioners and those responsible for the organisation of local antenatal services should provide for flexibility in the length and frequency of antenatal appointments, over and above those outlined in national guidance (see NICE's guideline on antenatal care) to allow more time for women to discuss the domestic abuse they are experiencing.

1.5.5 Offer the woman a named midwife, who should take responsibility for and provide the majority of her antenatal care.

Training for healthcare staff

1.5.6 Commissioners of healthcare services and social care services should consider commissioning joint training for health and social care professionals to facilitate greater understanding between the two agencies of each other's roles, and enable healthcare professionals to inform and reassure women who are apprehensive about the involvement of social services.

1.5.7 Healthcare professionals need to be alert to features suggesting domestic abuse and offer women the opportunity to disclose it in an environment in which the woman feels secure. Healthcare professionals should be given training on the care of women known or suspected to be experiencing domestic abuse that includes:

- local protocols
- local resources for both the woman and the healthcare professional
- features suggesting domestic abuse
- how to discuss domestic abuse with women experiencing it

- how to respond to disclosure of domestic abuse.

Information and support for women

1.5.8 Tell the woman that the information she discloses will be kept in a confidential record and will not be included in her hand-held record.

1.5.9 Offer the woman information about other agencies, including third-sector agencies, which provide support for women who experience domestic abuse.

1.5.10 Give the woman a credit card-sized information card that includes local and national helpline numbers.

1.5.11 Consider offering the woman referral to a domestic abuse support worker.

Recommendations for research

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

1 Training for healthcare staff

What training should be provided to improve staff behaviour towards pregnant women with complex social factors?

Why this is important

The evidence reviewed suggests that women facing complex social problems are deterred from attending antenatal appointments, including booking appointments, because of the perceived negative attitude of healthcare staff, including non-clinical staff such as receptionists. It is expected that education and training for staff in order to help them understand the issues faced by women with complex social factors and how their own behaviour can affect these women will reduce negative behaviour and language. A number of training options currently exist that could be used in this context; however, which of these (if any) bring about the anticipated positive changes is not known. Given the resource implications of providing training across the NHS it is important to ascertain the most cost-effective way of providing this.

2 Effect of early booking on obstetric and neonatal outcomes

Does early booking (by 10 weeks, or 12+6 weeks) improve outcomes for pregnant women with complex social problems compared with later booking?

Why this is important

The NICE guideline on antenatal care recommends that the booking appointment should ideally take place before 10 weeks and policy by the Department of Health on maternity

matters: choice, access and continuity of care in a safe service, supports booking by 12 weeks for all women. The main rationale behind these recommendations is to allow women to participate in antenatal screening programmes for haemoglobinopathies and Down's syndrome in a timely fashion, to have their pregnancies accurately dated using ultrasound scan, and to develop a plan of care for the pregnancy which sets out the number of visits required and additional appointments that may need to be made.

Pregnant women with complex social factors are known to book later, on average, than other women and late booking is known to be associated with poor obstetric and neonatal outcomes (see the report of the Confidential Enquiry into Maternal Deaths in the United Kingdom). It seems likely that facilitating early booking for these women is even more important than for the general population of pregnant women. There is, however, no current evidence that putting measures in place to allow this to happen improves pregnancy outcomes for women with complex social factors and their babies.

3 How can different service models be assessed?

What data should be collected and how should they be collected, and shared, in order to assess the quality of different models of services?

Why this is important

There is a paucity of routinely collected data about the effectiveness of different models of care in relation to demography. Although mortality data are accurately reflected in reports published by the Centre for Maternal and Child Enquiries, morbidity and pregnancy outcomes are not often linked back to pregnancies in women with complex social factors. Most research in the area of social complexity and pregnancy is qualitative, descriptive and non-comparative. In order to evaluate the financial and clinical effectiveness of specialised models of care there is a need for baseline data on these pregnancies and their outcomes in relation to specific models of care.

A national database of routinely collected pregnancy data is needed. The GDG is aware that a national maternity dataset is currently in development and it is hoped that this will ensure that data are collected in a similar format across England and Wales to allow for comparisons of different models of care.

4 Models of service provision

What models of service provision exist in the UK for the four populations addressed in this guideline who experience socially complex pregnancies (women who misuse substances, women who are recent migrants, asylum seekers or refugees or who have difficulty reading or speaking English, young women aged under 20 and women who experience domestic abuse)? How do these models compare, both with each other and with standard care, in terms of outcomes?

Why this is important

The evidence reviewed by the GDG was poor in several respects. Many of the studies were conducted in other parts of the world, and it was not clear whether they would be applicable to the UK. Many of the interventions being studied were multifaceted, and it was not clear from the research which aspect of the intervention led to a change in outcome or whether it would lead to a similar change in the UK. Also, in some instances it was not clear whether a particular intervention, for example a specialist service for teenagers, made any difference to the outcomes being studied.

Developing a clear and detailed map of existing services in the UK for pregnant women with complex social factors, and the effectiveness of these services, would enable a benchmark of good practice to be set that local providers could adapt to suit their own populations and resources. A map of providers, their services and outcomes may also enable commissioners and providers to learn from each other, work together to develop joint services and share information in a way that would lead to continuous improvement in services for these groups of women.

5 Antenatal appointments for women who misuse substances

What methods help and encourage women who misuse substances to maintain contact with antenatal services/attend antenatal appointments? What additional consultations (if any) do women who misuse substances need, over and above the care described in the NICE guideline 'Antenatal care' (NICE clinical guideline 62)?

Why this is important

Women who misuse substances are known to have poorer obstetric and neonatal outcomes than other women. Late booking and poor attendance for antenatal care are known to be associated with poor outcomes and therefore it is important that measures are put in place to encourage these women to attend antenatal care on a regular basis. Some of the evidence examined by the GDG suggested that some interventions could improve attendance for antenatal care, but this evidence was undermined by the use of self-selected comparison groups, so that the effect of the intervention was unclear.

In relation to additional consultations, the GDG was unable to identify any particular intervention that had a positive effect on outcomes, although there was low-quality evidence that additional support seemed to improve outcomes. Much of the evidence was from the US and there was a lack of high-quality UK data.

It seems likely that making it easier for these women to attend antenatal appointments and providing tailored care will improve outcomes, but at present it is not clear how this should be done.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic pages on fertility, pregnancy and childbirth, vulnerable groups, mental health and behavioural conditions, injuries, accidents and wounds, medicines management, community engagement and smoking and tobacco.

For full details of the evidence and the guideline committee's discussions, see the full guideline and appendices. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

Minor changes since publication

October 2018: After a surveillance review, links to other NICE guidance have been updated as needed and new links added in some recommendations. Some terminology has also been updated.

ISBN: 978-1-4731-4570-2