



Guidelines

Management of Pregnant Drug and/or Alcohol-Dependent Patients in Custody

The medico-legal guidelines and recommendations published by the Faculty are for general information only. Appropriate specific advice should be sought from your medical defence organisation or professional association. The Faculty has one or more senior representatives of the MDOs on its Board, but for the avoidance of doubt, endorsement of the medico-legal guidelines or recommendations published by the Faculty has not been sought from any of the medical defence organisations.

General Considerations

The possibility of pregnancy should be borne in mind for all women of reproductive age seen in custody - particularly those receiving medication or abusing/misusing substances. Absent or infrequent menstruation is not uncommon in this group and the woman may be unaware that she is pregnant.

Pregnancy should therefore always be excluded in the course of the medical assessment by the taking of a history, a routine urine pregnancy test and/or abdominal palpation as appropriate.

Drug and/or alcohol-dependent patients confirmed to be pregnant

In all cases it is necessary to make a thorough antenatal assessment to establish maternal and fetal wellbeing, substance misuse issues, and the current custodial context.

These are **all** high-risk pregnancies in terms of obstetric complications including pre-term delivery, and are associated with poor feto-maternal outcomes.

Accessing Urgent Specialist Assessment:

- Women may or may not be known to the substance misuse treatment services.
- They may or may not be known to the local maternity services.

Individuals not known to treatment services or not accessing antenatal care should be transferred to the local obstetric services.

Urgent obstetric assessment is necessary and may lead to admission for stabilisation of substance misuse treatment in conjunction with the substance misuse treatment services.

This is most appropriately done in collaboration with the obstetric and midwifery services. Transfer to an Emergency Department is rarely appropriate.

Once assessed, it may then be appropriate for them to be returned to custody.

The following should also be borne in mind:

- Some women will not have managed to access antenatal care due to a chaotic lifestyle.
- Some will be actively avoiding antenatal care and misleading professionals due to fears about child safeguarding procedures.
- Some women may have caring responsibilities for other children or vulnerable adults at risk, for whom child safeguarding referral or referral to vulnerable adult services may be needed.

Providing care to the pregnant patient and attending to her medical needs linked to substance abuse must take priority. This may often be compatible with the patient remaining in custody over a short period to time if adequate monitoring is available, depending on the gestational age.

A mental health and risk assessment is recommended given the potential for self-harm – both accidental and deliberate.

The local obstetric services and should be notified of the circumstances of your contact with the patient and your management. You should also be aware of any specialist midwifery services for substance misusers in your area and liaise with them.

Women in custody currently in treatment for both drug/alcohol abuse and receiving antenatal care:

Antenatal assessment by the forensic practitioner must include the following:

- Obstetric history – prior history of miscarriage or premature delivery. These may indicate increased risks if withdrawal symptoms are allowed to develop.

- Social history – existing children, home circumstances, partner, Children and Young People Service (CYPS) involvement.
- Estimated Date of Delivery.
- Assessment of uterine size relative to dates.
- Blood pressure and urinalysis for proteinuria.
- Auscultation of fetal heart, ideally with a fetal Doppler.
- Specific enquiry about fetal movements (Excessive fetal movement may indicate withdrawal symptoms; reduced movements may indicate fetal compromise - both require specialist opinion).
- Specific enquiry about uterine tightening and abdominal pain. Withdrawal can result in increased uterine irritability.
- Specific enquiry about domestic violence.

Substance misuse assessment must include:

- Detailed history of recent (last 10 days) drug and alcohol use, including quantities, route of administration, and time of last use.
- Contact details for local services accessed by the patient.
- Recent efforts to reduce use of specific drugs or alcohol, because of the potential for reduced tolerance and for adverse effects on the fetus.
- Details of all prescribed and non-prescribed medication, times last taken for each and missed doses.
- Name of prescriber and when last seen.
- Details of pharmacy and dispensing arrangements.
- Examination and observation for signs of intoxication or withdrawal.
- Examination of any injecting sites (DVT is a major risk factor in this group).

The essential conditions for a pregnant drug or alcohol dependent patient to remain in custody include:

- Being able to confirm with the prescriber and or dispenser that the patient is currently stable in treatment (i.e. not using illicit drugs or misusing prescribed drugs or alcohol). Inability to access this information out of hours renders continuing detention in custody unsafe.

- Being able to confirm with the midwifery or obstetric services that the woman is accessing adequate antenatal care.
- There is no current acute concern on examination.
- The patient's regular medication can be accessed from the pharmacy.
- Medical review is available at least 12-hourly.

Red Flags requiring hospital assessment

- A pregnant woman who is acutely intoxicated to the point of drowsiness. She is at risk of inhalation and is more likely to have a fetus affected by hypoxia.
- Reduced fetal movements may indicate fetal sedation and/or hypoxia.
- Active fetal movements may indicate a fetus experiencing withdrawal symptoms of irritability.
- Uterine tightenings may indicate uterine irritability due to withdrawal, and poses a risk of miscarriage or premature delivery.
- Alcohol withdrawal in pregnancy can only be safely managed in a medical setting with access to fetal monitoring.
- Drug-dependent patients not currently in treatment require urgent specialist assessment and initiation of treatment by the Substance Misuse Team.
- Patients receiving treatment who have missed medication doses in the previous week.
- Current crack or cocaine use, because of the risk of placental dysfunction, abruption and intrauterine growth retardation.
- Benzodiazepine use. Although frequently prescribed as part of a management plan for substance misuse, they are usually rapidly stopped by prescribers during pregnancy because of potential for fetal harm.
- Symptoms and signs of drug withdrawal.
- Multiple or high risk injection sites (neck or groin), presence of ulcers or abscesses.
- Other acute medical problems such as infection, possible DVT, mental health issues.
- Homelessness – patients will rarely achieve or maintain stability whilst homeless.

Medication issues in custody

- It is not safe to administer methadone from a supply brought in to custody by the patient – whatever the colour of the liquid it is not possible to verify its composition.
- Only a supply collected from the pharmacy in the presence of officers, or with an unbroken pharmacy seal should be administered in custody as prescribed.
- It is rarely appropriate to administer medication within six hours of the individual's arrest. A patient experiencing symptoms or exhibiting signs attributable to withdrawal within six hours is, by definition, not stable in treatment and should be transferred for hospital assessment.

Essential Follow-up

Child Safeguarding issues

Under local Child Safeguarding Procedures you may have a duty to inform the specialist midwifery services of any contact you have with a pregnant drug or alcohol dependent patient.

Whether or not you have any acute child safeguarding concerns a referral to social services is required, to inform the pre-birth child safeguarding plan. Establish if the family is known to the CYPS.

It may be necessary to alert the custody sergeant to establish the safety of other children whilst the woman is in custody/hospital. Enquire if the patient has children, their names, dates of birth, whether they are in her care, and where and by whom they are currently being cared for.

General

The GP has responsibility for ongoing medical care and should be informed as soon as possible of your contact with the patient and any medical treatment given.

Substance misuse

For patients in treatment with the substance misuse services, their key worker or prescriber should be informed of the episode, your contact and medical management.

If you have prescribed or administered medication to patients already in substance misuse treatment, their pharmacist must be informed.

Sharing of information is best done with the patient's consent. In the absence of consent, you may consider that patient safety (e.g. in relation to medical care or controlled drug prescribing) and child safeguarding concerns are sufficient to allow information sharing without consent.

End note

In most medical environments a consultation with a pregnant woman would trigger routine patterns of history taking and examination, and an assessment of the unborn baby.

The non-medical environment of police custody creates pressures that can make an adequate focus on fetomaternal well being difficult. Police cells are not a safe environment for live babies: the same is usually true for unborn babies.

References

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