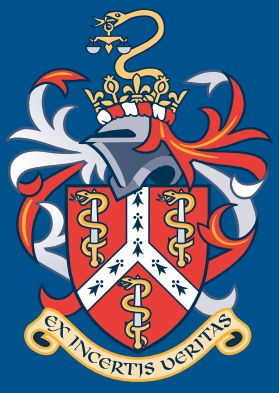

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Detainees with substance use disorders in police custody:

Guidelines for clinical management (fifth edition)

A working group report by:
- The Royal College of Psychiatrists, and
- The Faculty of Forensic and Legal Medicine

March 2020

Contents

Foreword

Since the last edition of these guidelines there have been significant changes in the trends and prevalence of drug and alcohol problems, and in the delivery of care to those with substance use disorders. There has also been an increase in the development of guidelines and evidence-based reports, including updated reports from the National Institute for Health and Care Excellence (NICE) and the UK Drug misuse and dependence guidelines on clinical management (Orange Guidelines).

These guidelines (the *Blue Guidelines*) contribute to this body of knowledge, adding to the armamentarium of evidence available to professionals, and are directed more specifically to a police custody context. Many detainees who have substance misuse problems, both drug and alcohol, may have multiple comorbidities in both physical and mental health; the recognition, and safe and effective treatment, of their substance use disorders are crucial.

Those with substance use disorders who are in police custody are entitled to the same high quality and effective treatment, delivered by healthcare professionals with the appropriate competencies, as the rest of the population. Accurate assessment of associated morbidities, including the degree and severity of dependence, and of the need for medical intervention, is essential, because both intoxication and withdrawal can put detainees at risk of medical, psychiatric and even legal complications.

Previous editions of these guidelines were produced by a Joint Working Group chaired by Professor Hamid Ghodse, comprising representatives of the Association of Forensic Physicians (previously the Association of Police Surgeons), relevant colleges and faculties, the Department of Health, and the Home Office. This expert Working Group has now revised the *Guidelines*, providing updated evidence to the numerous professionals and police who are involved in the care of detainees with alcohol and substance misuse/dependence.

The *Guidelines* recognise that the assessment and treatment of people with substance use disorders in police custody present healthcare professionals with particular challenges that require certain skills and experience to ensure appropriate and safe management. They stress the importance of good communication, of working closely with custody officers, and of the shared responsibility for the safety and care of detainees. In particular, they stress the importance of:

- full participation of competent and skilled healthcare professionals (doctors, nurses and paramedics) in all aspects and at all stages of the healthcare of detainees with substance misuse/dependence
- providing advice to custody officers and others involved with detainees with substance use disorders
- comprehensive contemporaneous records
- appropriate sharing of information in accordance with the law and the General Medical Council's (or equivalent) advice on professional confidentiality

All interventions delivered with the interests of the detainee as paramount. We believe that these guidelines will be of great value to all practitioners in helping and supporting detainees, as well as useful for teaching purposes for medical, nursing, paramedic and third sector staff, and the police. We congratulate the Working Group on its hard work in preparing them.

Professor Wendy Burn
President of the Royal College of Psychiatrists

Dr Margaret Stark
President of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London

As Professor Hamid Ghodse has chaired all of the previous editions of these guidelines and contributed so much to them, we would like to dedicate this edition in his memory.

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Preface

Those with alcohol and other substance use disorders should be treated with high quality, effective and safe care whatever their particular circumstances. These guidelines highlight the changes in the nature and extent of alcohol and other substance use disorders, and evidence the new developments in treatment and care, as well as the changes in UK policies and strategies. They offer a compassionate and effective response to those individuals who have substance use disorders, and often present in police custody with other mental health and physical health difficulties.

Throughout the *Guidelines* it is made clear that the treatment of alcohol and other substance use disorders in police custodial settings should be in line with safe and effective practice. The criminal justice system should offer those affected an opportunity for the identification of problems, with referral to appropriate services, at all stages of the custodial journey, if released, or transferred to court or to prison custody. The overriding principle of care for detainees who have substance use disorders and who are in custody must be their safety and the treatment of suffering that occurs as a result of substance intoxication or withdrawal. When care is delivered to a high standard, the correct balance will be achieved between different factors such as the need for due process in proceedings to safeguard civil rights, treatment needs, and other humanitarian requirements as well as enforcement objectives.

Since the last edition of the *Guidelines* there have been a number of initiatives and developments in services for those with substance use disorders in the criminal justice system, in support of treatment and prevention. These include changes in service delivery in police custody settings, with a greater presence and contribution by other healthcare professionals working closely with doctors. It is essential that all of these healthcare professionals have the appropriate knowledge, skills and attitudes, and obtain the required competencies to provide quality care to detainees with substance use disorders. All clinicians working within police custody must have access to senior clinical support within a strong clinical governance framework.

Like previous editions, this edition has been developed through meetings of a Working Group whose members included healthcare and public health professionals, and representatives from Royal Colleges and police, involved in the care of detainees in police custody. It has been a privilege to chair this expert group and thanks are given to all for their tremendous efforts and professionalism. In particular, many thanks to Dr Margaret Stark, President of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London, who has been key to the quality and development of these Guidelines.

The efforts of the Royal College of Psychiatrists, the Faculty of Forensic and Legal Medicine and other Royal Colleges in the production of the Guidelines are greatly appreciated. The support of Public Health England for their guidance has been of great value.

Eilish Gilvarry
December 2019

Prefaces to past editions

Preface to the fourth edition

Addicted individuals should always be cared for and treated without being stigmatised, whatever their particular circumstances. For those individuals who become casualties of substance misuse and are in police custody, these guidelines offer a humane response, with provision for care and treatment. They are flexible tools designed to accommodate changes in the nature and extent of substance misuse in the community, as well as changes in national policy and strategy, together with new developments in the care and management of substance-dependent individuals.

Throughout these guidelines it is made clear that the treatment of substance misuse should be in line with sound medical practice and should not be used as an instrument to establish or maintain control. The criminal justice system should offer substance misusers an opportunity for treatment and recovery. The overriding principle of care for offenders who are substance misusers and who are in custody must be their safety and the treatment of suffering that occurs as a result of substance intoxication or withdrawal. When care is delivered to a high standard, the correct balance will be achieved between different factors such as the need for due process in proceedings to safeguard civil rights, treatment needs and other humanitarian requirements as well as enforcement objectives.

Since the third edition of the *Guidelines*, there have been a number of initiatives and developments in services for substance misusers and in the criminal justice system in support of treatment and prevention. There has been a greater presence and contribution by other healthcare professionals working closely with doctors. The fourth edition has responded to these developments and I am sure that future editions will demonstrate similar responsiveness.

Previous editions of the *Guidelines* were very well received by all those who have been dealing with detainees in police custody.

Like previous editions, this one has been developed through meetings of a working group whose members included representatives from various health professionals involved in the care of the detainees in police custody. They demonstrated tremendous dedication and hard work. Once again, the efforts and enthusiasm of Dr Margaret Stark (a Past President of the Association of Forensic Physicians) and the Founding Academic Dean of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London have been inspiring and key to the quality of the *Guidelines*. The administrative support of Alex Crowe warrants special acknowledgement. The efforts of the publishing department of the Royal College of Psychiatrists in the production of the *Guidelines* are greatly appreciated. The support of the Department of Health, particularly Dr Mark Prunty, both for invaluable contribution to the text as well as for the dissemination of the *Guidelines* is acknowledged.

Hamid Ghodse
May 2011

Preface to the third edition

Since the second edition of the *Guidelines* there have been a number of initiative developments in services for substance misusers and in the clinical justice system in support of treatment and prevention. Although the outcome of some of these initiatives is not yet clear, there is now a greater emphasis on diverting those in conflict with the law from custodial sentences towards treatment. Previous editions of these guidelines were very well received by all those who have been dealing with detainees in police custody.

This latest edition has taken account of those individuals who, subsequent to custody by the police, are sentenced to prison and those individuals with mental disability whose substance misuse brings them in conflict with the law.

Like previous editions, this one has been developed through a limited number of meetings of a working group whose members demonstrated tremendous dedication and hard work. Once again the efforts and enthusiasm of Dr Margaret Stark (the Past President of the Association of Forensic Physicians) have been inspiring and key to the quality of the *Guidelines*. The unfailing and skilful administrative support of Candace Gillies-Wright warrants special acknowledgement

The efforts of the publishing department of the Royal College of Psychiatrists in the production of the *Guidelines* is greatly appreciated. The support of the Department of Health, particularly Dr Mark Prunty, both for invaluable contribution to the text as well as for the dissemination of the *Guidelines* is acknowledged.

Hamid Ghodse
March 2006

Preface to the second edition

The constant changes in different aspects of substance use problems and the associated responses necessitate the revision of previous texts of these guidelines. The Association of Police Surgeons recognised this need and suggested that the Royal College of Psychiatrists and the Chairman of the Working Group for the first edition should undertake this task. There was a short delay until the general guidelines on clinical management (Drug Misuse and Dependence: Guidelines on Clinical Management) had been published. Those guidelines refer to doctors who are involved in the management of individuals in police custody and therefore made the need for revision more pressing.

As the first edition of the *Guidelines* had been very well received, it seemed appropriate to update them by revision rather than by wholesale rewriting, and the Working Group adopted a similar approach to this task as that used on the previous occasion. A limited number of meetings were planned, and the consultation process was conducted speedily but thoroughly. Alcohol has been included in these revised guidelines, and sections on fitness to be interviewed and reliability of confession have been extended. The wholehearted participation and generous contributions of all members of the Working Party must be acknowledged with gratitude. Dr Margaret Stark's work as rapporteur

and the efforts of Gill Gibbons of the Royal College of Psychiatrists, as an administrator *par excellence*, warrant special mention, as do the encouragement and support of Dr Knight of the Association of Police Surgeons and the contribution of Dr Guy Norfolk.

It only remains to emphasise that the principles articulated in the preface to the first edition about the nature and purpose of the *Guidelines* remain unchanged and are the benchmark for the second edition. The Working Group would appreciate feedback from all those who use the *Guidelines* so that the suggestions and amendments can be incorporated into future revisions.

Hamid Ghodse
February 2000

Preface to the first edition

The development of this document was initiated by the Association of Police Surgeons, and the process of achieving consensus across the medical profession got off to a good start with an excellent conference organised by forensic physicians in 1993. It owes much to the dedication and hard work of a number of forensic physicians, particularly Dr Margaret Stark, and to the untiring efforts of the President of the Association of Police Surgeons, Dr Ralph Lawrence. Wide-ranging discussion among forensic physicians attending the diploma courses in addictive behaviour at St George's Hospital Medical School also formed a valuable contribution.

It should be emphasised that this document was not devised as a set of instructions to be applied in every situation; rather, it is intended as an umbrella, briefly describing the general principles of management of individuals detained in custody and suffering from problems of substance misuse. The *Guidelines*, therefore, do not necessarily cover every situation which may arise, and, where its recommendations are insufficiently detailed or specific, the doctor in charge is advised to consult standard textbooks or seek specialist advice. This is of particular importance where children are involved, when reference should always be made to child psychiatrists. It should also be stressed that the document is not meant to define immutable regulations or the standard required for excellence. As its name implies, it only offers guidelines, and the principles that it endorses indicate good and adequate standards of care.

Finally, it should be noted that the *Guidelines* have received the approval of the Association of Police Surgeons, the Royal College of Psychiatrists, the Faculty of Accident and Emergency Medicine and the Association for Accident and Emergency Medicine. The Working Group would like to thank the Royal College of Psychiatrists for having sponsored the Group, and for having provided the necessary administrative support.

Hamid Ghodse
1994

1. Introduction

1.1 Overview

The substantial prevalence of drug (illicit, prescribed and over the counter) and alcohol use and misuse in detainees in police custody necessitates standardised and excellent practice, based on evidence and clinical consensus. Guidelines support this standardisation of practice in the assessment and acute management of detainees in police custody. All healthcare professionals (HCPs) working in the field of forensic and legal medicine need to be aware of these updated guidelines, intended to supplement and amplify the Department of Health's Drug Misuse and Dependence UK Guidelines on Clinical Management[1] and the NICE guidance on alcohol.[2]

These guidelines pay particular attention to the assessment and acute management of those with alcohol and drug problems in the unique setting of police custody. HCPs should use the *Guidelines* and other evidence in making clinical decisions; these decisions will vary with the specific needs and circumstances of individual detainees. The guidelines are not meant to be rigid protocols though practitioners are expected to be familiar with this guidance, and to consider the recommendations and advice when making clinical decisions and providing effective treatments.

Treatment and care for those in the criminal justice system (CJS) should aim to be excellent, safe, effective, and broadly equivalent to that in the community. In addition, for those in police cells screening of any drug and/or alcohol misuse/dependence and mental and physical health issues should be an opportunity to further assess, treat urgently if required, and appropriately refer to services.

Commissioners and providers of community treatment services and of health care in the CJS should support systems for rapid clinical communication at times of entry and departure, to aid support around release and for continuity of any prescribing required.

Transitions to, from, and between, criminal justice settings such as police custody to courts, prisons and then release, create a potential for interruption of medication and heighten risk of deaths from overdose.[3] The strong evidence for the level of these preventable deaths/risks places a clear responsibility on all clinical assessments, services and treatment providers, in the community and in settings such as police cells, to ensure there are effective channels of communication.

1 Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management Accessed 8/11/2019

2 NICE. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical guideline [CG115] February 2011 https://www.nice.org.uk/guidance/cg115 Accessed 8/11/2019

3 Sordo L., Barrio G., Bravo MJ., Iciar Indave B., Degenhardt L., Wiessing L., Ferri M., Roberto Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies BMJ 2017;357:j1550 https://www.bmj.com/content/357/bmj.j1550 Accessed 8/11/2019

It is important for safe management of alcohol and drug misuse/dependence in police custody that staff are competent to provide a comprehensive assessment, or review/re-assessment, to adequately manage drug and alcohol intoxication and withdrawal along with any associated issues of physical and mental health difficulties (see Appendix A).

1.2 The working group

This is the fifth iteration of these guidelines, first published in 1994, then 1999, 2006 and 2011. In 2017, the Royal College of Psychiatrists and the Faculty of Forensic and Legal Medicine of the Royal College of Physicians convened a working group to update the *Guidelines*. The group brought together individuals with a wide range of expertise, and knowledge of guidelines in the alcohol and drug field; they included representation from the Royal College of General Practitioners, the Royal College of Emergency Medicine, the National Police Chiefs Council, the UK Association of Nurses and Paramedics, Public Health England, and the Royal Pharmaceutical Society. The group considered a wide range of updated evidence, particularly the UK Clinical Guidelines published in 2017, and considered this within the context of police custody with the recent changes in legislation, policing and clinical service delivery – for example, the introduction of liaison and diversion services.

1.3 The scope of the problem

The link between drug misuse and crime is well established. However the causal relationship between drug misuse and offending is more complex. Most offenders who misuse drugs begin committing crime before their use becomes problematic, but their offending often escalates to keep up with the rising cost of their drug use.

The National Drug Treatment Monitoring System (NDTMS)[4] consistently reports that approximately a quarter of all referrals into treatment are generated via criminal justice sources. The criminal justice system is increasingly used as a setting to offer treatment or act as a gateway or access point. Clinicians will therefore increasingly be required to deliver treatment within criminal justice settings and may encounter individuals referred from various points in the system, i.e. police custody, courts, probation, and prisons. Clinicians need to understand the nature of these arrangements and where their involvement lies.

The Crime Survey for England and Wales (CSEW) 2018/9 reported that 9.4% of adults aged 16-59 had used illicit drugs in the last year with 3.7% having used a Class A drug.[5] This is lower than a decade ago – 10.1% in the 2006/07 survey. Overall there is stability in the use of traditional drugs but a rise in the use of novel psychoactive substances (NPS). Use of NPS in the last year appears to be concentrated among young adults aged 16 to 24; 1.2% had used a NPS in the last year.[5] Cannabis remains the illicit drug most

4 https://www.ndtms.net/ Accessed 8/11/2019

5 Home Office. Drug Misuse: Findings from the 2018/19 Crime Survey for England and Wales Statistical Bulletin 21/19, September 2019 https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2018-to-2019-csew Accessed 21/11/2019

commonly used by young people, though the trend is towards multiple drug use and use of alcohol. Intoxication in the setting of police custody presents particular challenges in terms of fitness for detention and fitness for interview.

Detainees with substance use disorders may present with poor physical and mental health, both directly and indirectly related to problematic use/dependence. Of concern are the increased rates of drug related deaths in community settings in the UK, with significant increases in the last few years.[6]

With regard to deaths in police custody, a review of the international evidence[7] reported that natural causes were the most common cause of deaths in police custody in England and Wales during the ten year period 2004/05 to 2014/15, accounting for 51% of deaths in this period. Drugs and/or alcohol also featured as causes in around half of deaths (49%). An even higher proportion of deaths identified drugs or alcohol (82%) as an associated factor. However it is important to recognise and treat withdrawal, especially in relation to opiates[8,9,10] and alcohol, to prevent deaths in custody.[11]

1.4 Changing provision of general forensic medical services

Since the publication of the fourth edition of the *Guidelines* there have been changes in the provision of general forensic medicine (GFM) services throughout the UK. The traditional model of a doctor-only service – using forensic physicians (FPs) – has largely been replaced by multidisciplinary/professional teams working in the custodial environment, comprising doctors, nurses and paramedics. These teams are increasingly supported by criminal justice liaison and diversion/mental health services. GFM services have recently been jointly commissioned by the police and NHS commissioners. Many health care professionals work embedded within large custody centres, whilst other remain mobile. Some police services still operate (at the time of writing) the traditional FP model in the Isle of Man, Jersey, and Guernsey. In Scotland, forensic healthcare is provided via the NHS territorial boards.

The Home Office Circular in 2003[12] introduced the role of the healthcare professional (HCP), referring to a clinically qualified person who is working within the scope of practice as determined by their relevant professional body, and who is registered with

6 Deaths related to drug poisoning in England and Wales: (2018) registrations https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations Accessed 21/11/2019

7 Lindon G. & Roe S. (2017) Deaths in police custody: A review of the international evidence. Research Report 95. Home Office https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655710/Deaths_in_police_custody_A_review_of_the_international_evidence.pdf Accessed 8/11/2019

8 McGlinchey and Others v. The United Kingdom, ECHR (2003)

9 Darke S. Larney S. Farrell M. Editorial. Yes, people can die from opiate withdrawal. Addiction 2016: 112; 199-200

10 Stark MM & Payne-James JJ. People can die from opiate withdrawal. Med.Sci.Law 2017: 52(2); 103

11 IPCC. *Learning the Lessons Bulletin* (12 February 2011) http://webarchive.nationalarchives.gov.uk/20170914114208/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-12-general-issues-february-2011 Accessed 8/11/2019

12 Policing & Crime Reduction Group (2003) Healthcare Professionals in Custody Suites – Guidance to Supplement Revisions to the Codes of Practice under the Police and Criminal Evidence Act 1984 (Home Office Circular 020/2003). Home Office

that body as competent to practise. For doctors this is the General Medical Council (GMC); for nurses the Nursing and Midwifery Council (NMC); and for paramedics the Health and Care Professions Council (HCPC). The circular contains guiding principles on recruitment and management, professional independence, clinical supervision, clinical governance, and confidentiality and disclosure in relation to individual records and treatment. All HCPs working in the custody environment must be appropriately trained and work within the scope of their professional competency and according to recommended clinical guidelines.

The Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London (FFLM) was formally established in 2006 to:

- promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine in all its classes

- develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

— (www.fflm.ac.uk)

In March 2009 the then Home Secretary of the UK Government stated:

> Guidance as to the level of professional and clinical qualification required for doctors or nurses is issued by the [FFLM] … Responsibility for recruitment of healthcare professionals is a matter for individual chief police officers, and it is for each police force to make a decision on an individual basis against this guidance … The FFLM will have an opinion as to what duties should, or should not, be performed by staff at each level in each professional role. There is no mandatory guidance from the police service.[13]

The FFLM, working with the UK Association of Forensic Nurses and Paramedics (UKAFN) and the College of Paramedics have produced Quality Standards for all HCPs working in the field of GFM.[14] These standards cover recruitment, initial training and induction support, workplace-based supervision, and continuing professional development, and they outline a service level standard. The service level standard includes access to expert advice from an experienced forensic physician with the FFLM Membership examination. The FFLM continues to work to establish forensic and legal medicine as a distinct specialty that requires an appropriate career path. There is still a need for minimum standards and equivalence of training.[15]

HCPs working in the custody environment must have specialty-specific training, including annual Immediate Life Support and Safeguarding training at the level recommended

13 http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090318/text/90318w0006.htm Accessed 8/11/2019

14 FFLM. Quality Standards in Forensic Medicine (GFM and SOM) April 2019 https://fflm.ac.uk/publications/fflm-quality-standards-in-forensic-medicine/ & Quality Standards for Nurses and Paramedics (GFM) April 2019 https://fflm.ac.uk/publications/fflm-quality-standards-for-nurses-and-paramedics-general-forensic-medicine-gfm/ Accessed 8/11/2019

15 Stark MM. & Norfolk GA. Training in clinical forensic medicine in the UK - Perceptions of current regulatory standards. Journal of Forensic and Legal Medicine 2011; 18: 264-275

by the Intercollegiate Document (Level 3).[16] HCPs should be working towards the relevant postgraduate qualifications for their discipline.[17] There have also been National Occupational Standards for HCPs working in police custody since 2007.[18]

The Police and Criminal Evidence Act 1984 (PACE) Code of Practice C sets out the statutory framework for custodial care and the rights and entitlements of a detainee in police custody.[19] The College of Policing publishes Authorised Professional Practice (APP) which is the official source of professional practice on policing.[20]

Her Majesty's Inspectorate of Prisons and Her Majesty's Inspectorate of Constabulary have also published criteria for assessing the treatment of and conditions for detainees in police custody.[21] Their expectations include that detainees have access to competent health care professionals who meet their physical health, mental health and substance use needs in a timely way.

It is essential that robust clinical governance procedures are developed and maintained for the provision of GFM services which include training in the area of substance misuse and mental health, and ensuring that individual practitioners have the competencies for the role that they are required to perform, with clear protocols as to who to refer to and when (see Appendix A).

There is no longer a national Drug Intervention Programme (DIP).[22] Individual police forces have the discretion to opt in or out of legacy DIP powers including testing on arrest, required assessments and restrictions on bail. Consequently, the implementation of these provisions varies from area to area. HCPs should be aware of whether there is access to Criminal Justice Integrated Team (CJIT) workers who are members of a multi-disciplinary team providing support, advice, and brief and structured interventions to individuals with substance use disorders within the criminal justice system.

1.5 The rights of detainees

Individuals in police stations are entitled to the same standard of medical care as any other member of the public. HCPs need to give careful attention to the issue of the informed consent of a detainee to any examination. Detainees have the right to have prescribed medication continued while in custody, as long as it is clinically safe to do so. Detainees should be informed of the outcome of the assessment and the consequent clinical decisions.

16 https://www.rcn.org.uk/professional-development/publications/pub-007366 Accessed 25/11/2019
17 Stark MM. Advice on obtaining qualifications in clinical forensic medicine. FFLM, January 2018 https://fflm.ac.uk/wp-content/uploads/2018/08/Advice-on-obtaining-qualifications-in-clinical-forensic-medicine-Dr-M-Stark-Jan-2018.pdf Accessed 25/11/2019
18 https://www.ukstandards.org.uk/Pages/results.aspx?k=Police%20custody Accessed 13/03/2019
19 Home Office. Code C Revised. Code of Practice for the detention, treatment and questioning of persons by Police Officers. August 2019 https://www.gov.uk/government/publications/pace-code-c-2019 Accessed 21/11/2019
20 https://www.app.college.police.uk/about-app/ Accessed 8/11/2019
21 HM Inspectorate of Prisons and HM Inspectorate of Constabulary and Fire & Rescue Services. Expectations for Police Custody. Criteria for assessing the treatment of and conditions for detainees in police custody. 2018 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/05/Police-Expectations-2018.pdf Accessed 8/11/2019
22 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/118069/DIP-Operational-Handbook.pdf Accessed 8/11/2019

1.6 Clinical safety of detainees

The overriding consideration of the attending HCP must be the clinical safety and well-being of the detainee.

Detainees should be assessed for signs of intoxication and/or withdrawal with prompt attention being paid to any acute medical needs. It should be remembered that the onset of signs of overdose with certain substances (for example, methadone or other substances swallowed immediately before arrest in order to escape detection, see Section 4.3) may not be immediately obvious and may occur later.

Instructions should be given to the custody staff that intoxicated detainees should be visited and roused at least every half-hour and have their condition assessed as in Appendix B. The purpose of recording a person's responses when attempting to rouse them using this procedure is to enable any change in their level of consciousness to be noted and clinical treatment arranged if appropriate. If the custody staff have any concerns regarding the level of consciousness of an intoxicated detainee, they should be advised to obtain urgent medical attention.

Assessment of the detainee's mental state is also an essential part of risk management, especially in respect of self-harm.

Although treatment to limit or prevent the withdrawal syndrome may seem desirable (see section 3), before such treatment is initiated the HCP must be satisfied that the detainee is not under the influence of any other substance, including alcohol, that might significantly alter the action of the prescribed medication, thus making it unsafe. HCPs must be alert to the dangers of administering and/or over-prescribing substitute drugs.

The prescribed dose of a drug may not accurately indicate the true amount taken per day; for example, part of the prescribed medication may be given to others who misuse drugs, and drugs from illicit sources may be used in addition to prescribed drugs. Before any medication is administered in police custody these possibilities must be reviewed and additional safeguards (such as the provision of smaller, divided doses) should be considered, to reduce any risk.

1.7 Detainees' expectations

Suitable treatment may not necessarily involve the prescribing of a substitute for the drug of dependence, although this may be the case. Detainees should be helped to understand that a prescription is not always necessary or useful, but that effective drugs will be prescribed if appropriate. The treatment requested by a detainee with a substance use disorder may be different from the treatment that the HCP judges to be appropriate.

2. Principles of clinical management

2.1 History and examination

2.1.1 Liaison with custody staff

Recent changes to the provision of healthcare in police custody mean that nowadays the HCP is often contacted by a call centre and not directly by the custody team. It is important for HCPs to be able to triage their workload and attend the cases with the most urgent clinical need. Many service providers record telephone conversations between the HCP and custody staff, which provides a record of advice given. If calls are not recorded then a written account should be made of any advice given.[23]

On arrival at a custody centre, early and effective liaison with the police custody officer is essential and can yield relevant information, particularly about the circumstances of the arrest, the behaviour of the detainee on arrest, whether any physical restraint was used, the extent to which the detainee has been searched, and whether any substances were found.

The custody officer may already have valuable information about the detainee's medical condition and needs, and may also be able to provide details of any risk assessment that has been conducted.[24] The HCP should ask the custody officer how long the person is likely to be detained and if, and when, he or she is likely to be interviewed, if the information is currently available.

2.1.2 History and consent

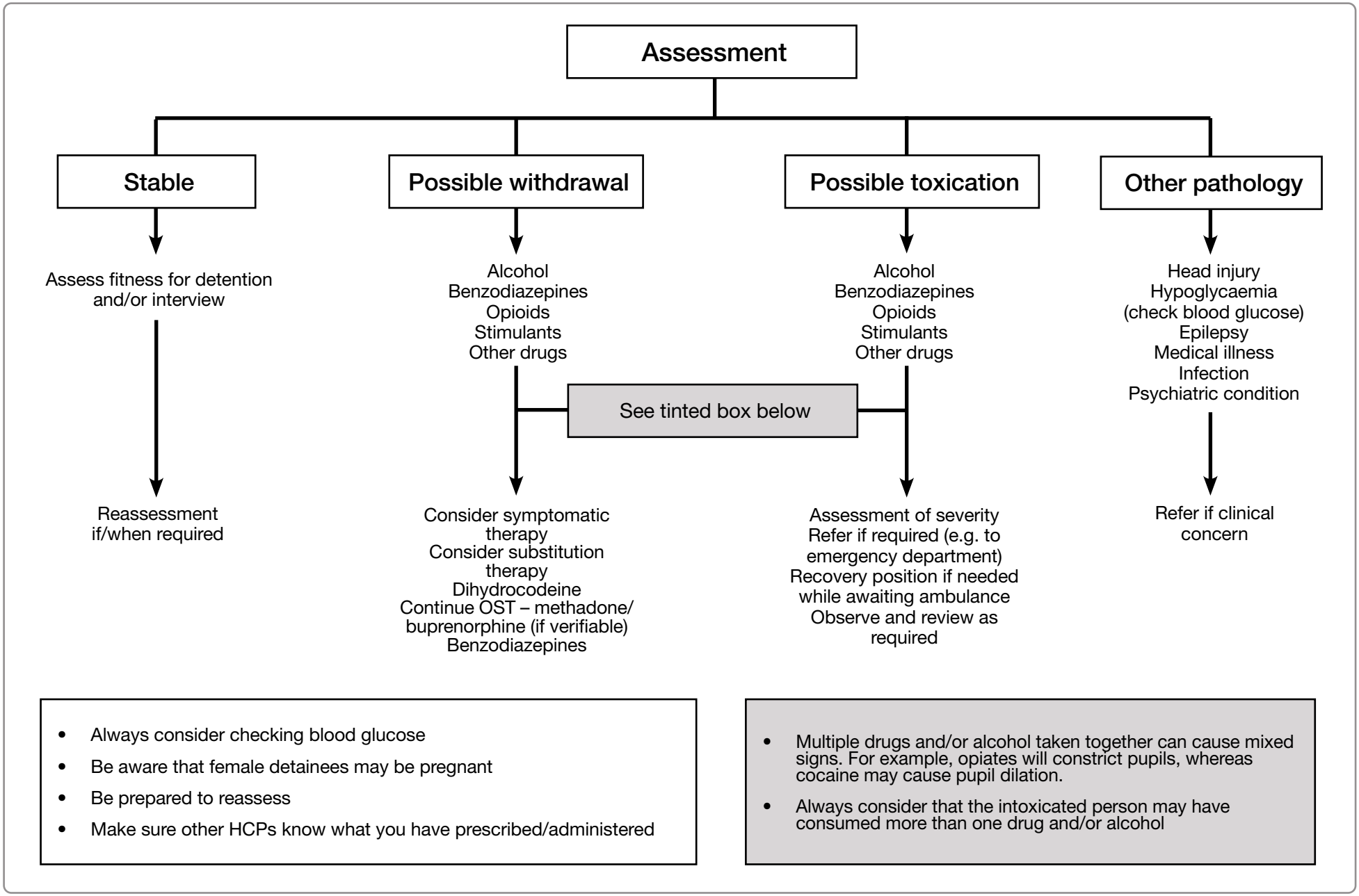
Careful and well-documented history-taking and examination are essential to provide safe and effective care for the detainee and to establish the degree of substance misuse and/or dependence (See Figure 1 – Assessment procedure).

HCPs will have access to the police risk assessment and should review this thoroughly, including the use of force, as well as previous clinical entries on police computer systems such as NICHE (police records management system) and NSPIS (National Strategy for Police Information Systems). The HCP may be able to access the Summary Care

23 FFLM. Telephone advice pro forma (custody) (2018) https://fflm.ac.uk/publications/pro-forma-telephone-advice/ Accessed 8/11/2019

24 McKinnon I & Grubin D. Evidence-Based Risk Assessment Screening in Police Custody: The HELP-PC Study in London, UK. Policing – A Journal of Policy and Practice 2014:8:2;174-182 http://eprint.ncl.ac.uk/file_store/production/197587/E8AEFC0B-A30D-4F04-9EAB-71B06ED5FCCC.pdf Accessed 8/11/2019

Figure 1 – Assessment procedure flowchart



Record (SCR), or other healthcare records, with permission from the detainee or without patient consent in an emergency. Previous clinical notes made by colleagues in hard copy or as computerised records, such as System One, should be reviewed. In Scotland, arrangements have been made to allow access to the NHS computerised emergency care summary (ECS), provided the detainee has permitted this.

All HCPs should explain their role as independent practitioners and as doctors, nurses or paramedics.[25] Consent for the examination should be obtained after an explanation of the nature and purpose of the examination. The HCP must be satisfied that the patient can comprehend and retain the relevant information, believes the information, and can weigh up the pros and cons in order to arrive at a choice.[26]

Consideration should be given to the detainee's capacity to consent. For example, intoxicated detainees or children may not have this capacity (see Section 2.2.5). In a genuine emergency, where there is no possibility of obtaining consent, HCPs have a duty to carry out treatment to safeguard the life and health of the patient in accordance with what would be accepted as appropriate treatment in the patient's best interests in keeping with the doctrine of necessity.

Capacity to consent may also be affected by the presence of mental disorder, including learning (intellectual) disability or other developmental disorder such as autism. If this is suspected, the assistance of an 'appropriate adult' may be required (see Section 2.2.1). If the person is living in a supported setting, it is important to obtain their agreement to inform the carer (e.g. a family member or paid staff) of their detention.

All detainees with substance use disorders, but particularly those from ethnic minorities, are vulnerable as, in addition to possible medical problems associated with substance misuse, they might be charged and convicted of drug offences. There is even greater vulnerability if the detainee is from overseas and has immigration and/or language problems. HCPs may have to examine a person who is a foreign national or whose first language is not English. Police forces often use LanguageLine in these situations and on occasion, especially when assessing mental health, the presence of a qualified interpreter may be required at the police station.

There is now a significant body of evidence regarding the health needs of detainees in police custody,[27,28,29] with mental health problems, including substance use disorders, and physical ailments, often highly prevalent, often requiring both emergency and routine care. Homelessness is associated with multiple complex needs.

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25 FFLM. The role of the Healthcare Professional 2019 https://fflm.ac.uk/wp-content/uploads/2019/02/RoleoftheHCP-Jan-2019.pdf Accessed 8/11/2019

26 *Re C (Adult: Refusal of Treatment)*, [1994] 1 WLR 290 & The Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents Accessed 8/11/2019

27 Rekrut-LapaT., & Lapa A. Health needs of detainees in police custody in England and Wales. Literature review. Journal of Forensic and Legal Medicine 2014:27;69-75

28 Sondhi A., Williams E. Health needs and comorbidity among detainees in contact with healthcare professionals within police custody across the London Metropolitan Police Service area. Journal of Forensic and Legal Medicine 2017 e London Metropolitan Police Service area, Journal of Forensic and Legal Medicine (2017), http://dx.doi.org/10.1016/j.jflm.2017.07.012 Accessed 8/11/2019

29 McKinnon IG., Thomas SDM., Noga HL., Senior J. Police custody healthcare: a review of health morbidity, models of care and innovations within police custody in the UK, with international comparisons. Risk Management and Healthcare Policy 2016:9:213-226

Therefore it is essential that the HCP take a full medical history including:[30]

- presenting symptoms of a physical or mental health problem
- complaint of recent injuries, including use of force during arrest
- past medical history including operations, injuries, (especially significant head injuries) and periods in hospital
- past psychiatric history including periods in hospital, contact with mental health team
- for women, relevant contraception history, cervical screening, menstrual and pregnancy history
- consideration of sexual health and history of sexually transmitted infections (including any partners with HIV or hepatitis B, C)
- oral health problems
- current prescribed medication
- use of non-prescribed medication including over the counter medicines
- cigarette consumption
- allergies or sensitivities, as appropriate.

Regarding the details of past and present drug use, including alcohol, the following information should be obtained:

- type of substance used
- duration of substance use
- quantity taken per day, on an average/typical day and/or amount spent on substances
- frequency of use
- routes of administration (noting any sites of injection)
- sharing of needles and paraphernalia
- amount used in the past 24–48 hours
- the time of the last dose(s).

The detainee should be asked about any history of treatment for misuse and its effectiveness, as well as previous experience of withdrawal symptoms including physical and psychological consequences. It is particularly important to know whether the detainee is currently receiving treatment and medication as part of an opioid substitution detoxification or maintenance programme (OST).

Specific enquiry should be made about the concomitant use of other substances (including those legitimately prescribed and details of the source of supply) and alcohol. This should be an active enquiry, as alcohol dependency is often not recognised or reported by users of other substances. Alcohol withdrawal complicates other presenting symptoms and signs, and carries significant morbidity and mortality if untreated.

It may be difficult to obtain accurate and reliable information as individuals tend to underestimate or even lie about their alcohol consumption. The use of an alcohol screening questionnaire is essential in identifying alcohol problems including Alcohol Use Disorder (AUD). There are a number of tests available but the Alcohol Use Disorders

30 Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management Accessed 8/11/2019

Identification Test (AUDIT)[31] is probably the best screening instrument in this environment. The Severity of Alcohol Dependence Questionnaire (SADQ) may be useful as a measure of the severity of dependence.[32]

2.1.3 Reliability of histories

Studies have shown that those with a substance use disorder who are involved in opioid substitution maintenance programmes are generally honest when reporting recent drug use: the accuracy of self-reported drug use has been reported at over 80%,[33] although there are also reports of exaggeration and underestimation of use.

Frankness on the part of detainees while in custody regarding their history of misuse appears less common. Inconsistent information may be given in an attempt to acquire some perceived secondary gain, and can pose particular risks when a HCP is required to initiate any medication.

Many detainees with a substance use disorder have negative perceptions of their medical management while detained in police custody.[34] Honesty is more likely if the detainee feels confident of a sympathetic hearing and the availability of effective care. HCPs should stress their independence from the police by making it clear that, like any other HCPs, they are concerned about the physical and mental care of their patient. It is essential that HCPs remain non-judgmental and non-confrontational. Detainees have the right to refuse to be examined by a HCP and have the right to be examined by a medical practitioner of their own choice, at their own expense.

2.1.4 Physical examination

Physical examination should involve looking for signs of intoxication, dependence or withdrawal. It should involve an assessment of injection sites in all limbs and inguinal areas, particularly if injecting (or injected in the past) and a general assessment of respiratory, cardiovascular and other body systems, paying attention to any symptoms offered and complaints described. Use of scales can be an adjunct to observation and assessment.

The Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale is commonly used in hospitals to quantify withdrawal symptoms and signs and guide treatment.[35] The use of this assessment has not been validated in the custody environment but repeated examinations may be useful as part of the overall assessment of a detainee.

31 https://www.gov.uk/government/publications/alcohol-use-screening-tests Accessed 8/11/2019
32 https://www.smartcjs.org.uk/wp-content/uploads/2015/07/SADQ.pdf Accessed 8/11/2019
33 Brown, J., Kranzler, H. R. & Del Boca, F. K. (1992) Self-reports by alcohol and drug abuse inpatients: factors affecting reliability and validity. British Journal of Addiction, 87, 1013–1024
34 Gregory, M. Characteristics of drug misusers in custody and their perceptions of medical care. Journal of Forensic and Legal Medicine 2007:14; 2092–2012.
35 Sullivan JT, Sykora K, Schneiderman J, et al. Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). Br J Addict. 1989 Nov; 84(11):1353-7. https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf Accessed 8/11/2019

The Clinical Opiate Withdrawal Scale (COWS) may be of use in the overall assessment of opiate dependent detainees.[36]

A Mental State Examination should always be performed (see Section 2.2.1). The risk of self-harm is increased during withdrawal, when individuals may tend towards impulsive and volatile behaviours. Women are at particularly high risk of self-inflicted death during the early period of prison custody, and self-harm is three times more common among women than men during their prison term.[37]

Assessment of an intoxicated individual whose first language is not English, through an interpreter, poses particular challenges. Mental state examination needs particular care when trying to interpret disorders of speech and thought.

2.1.5 Medical complications of substance use and reducing health risk

Many detainees who have substance use disorders have little or no contact with doctors or other HCPs, therefore chronic conditions, such as diabetes, heart disease and asthma, are poorly managed. It is essential that HCPs use the opportunity to initiate a healthcare intervention, as contact can be transitory and interrupted by events in a detainee's life. Many suffer from self-neglect and malnutrition.

Acute episodes of illness should be treated. Substance misuse may result in medical complications that require assessment and further treatment.

There is a wide range of bacterial infections causing problems in those who inject drugs, including infections with Clostridium novyi, Anthrax, Tetanus, Staphylococcus aureus, Group A streptococci, and Clostridium botulinum.[38] Commonly, there are superficial skin infections at injection sites. Sometimes these develop into a more generalised septicaemia. Bacterial endocarditis also remains a risk for anyone injecting drugs. Cellulitis and abscesses may be seen around injection sites, and septic arthritis may result if deep abscesses extend into joints. There is a higher prevalence of tuberculosis in people who use drugs.

Superficial thrombophlebitis, deep vein thrombosis, pulmonary embolus, and chronic complications of limb swelling, and venous ulcers may result from intravenous drug use. If an injection occurs into an artery, vascular spasm may result in ischaemia and eventually, if prompt treatment is not provided, gangrene and amputation.

36 Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9. https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf Accessed 8/11/2019

37 Horton M, Wright N, Dyer W, Wright-Hughes A, Farrin A, Mohammed Z, Smith J, Heyes T, Gilbody S, Tennant A. Assessing the risk of self-harm in an adult offender population: an incidence cohort study. Health technology assessment (Winchester, England) 10/2014; 18(64):1-152

38 For more information see: Shooting Up: Infections among people who inject drugs in the UK, 2017 An update, November 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756502/Shooting_up_2018.pdf Accessed 8/11/2019

Further to treatment of acute conditions, consideration should be given to:

- encouraging the detainee to see their general practitioner and/or attend hospital clinics to receive the appropriate care for long-term conditions
- referring them to an on-site arrest referral/drug worker
- providing them with information about local agencies involved in counselling and treatment of substance-related problems, such as community drug and alcohol teams, treatment centres and needle exchange schemes
- providing them with information and advice about, and immunisation against, hepatitis B (and possibly hepatitis A)
- checking their tetanus immunisation status if they inject drugs
- providing advice and testing for blood-borne virus infections, hepatitis C and HIV, and referring them for treatment if required
- educating them on the hazards of injecting drugs, particularly with regard to shared injecting equipment
- educating them on the risks of overdose, of multiple use of substances, including alcohol, and of the variable purity of illicit drugs
- advising them regarding the loss of tolerance and risk of fatality following reduction in regular use or a period of abstinence such as may occur following time in prison or residential rehabilitation
- giving them contraception advice, reminders regarding cervical cancer screening, and safer sex advice and, where required, referring them to a sexual health service
- referring them to a dentist if they have oral health problems such as dental caries, tooth erosion, or periodontal disease.

A significant minority of injecting drug users have experienced a broken needle at some time in their injecting career.[39] Central embolisation may occur within a few hours to several days, and can have potentially fatal consequences such as pericarditis, endocarditis and pulmonary abscess. It is recommended that needle fragments be removed as soon as possible to avoid future complications.

39 Norfolk G. A. & Gray S. F. (2003) Intravenous drug users and broken needles – a hidden risk? Addiction, 98, 1163–1166

2.1.6 Near-patient testing

All detainees with a history of current drug misuse should have a multi-drug urine screen. The use of an on-site drug-testing kit in the police station has been found to be helpful in the management of detainees with substance use disorders in police custody.[40] Such tests give qualitative rather than quantitative results and so confirm whether or not a substance has been used rather than the quantity used. HCPs should ensure that they are familiar with the test employed and with its limitations, including false positives and false negatives. The test should only be used with the consent of the detainee and with the clear understanding that this is an aid to clinical management which will remain part of the clinical record.

False-positive screens are the result of cross-reactivity to the antibody in the enzyme-mediated immunoassay tests, due to specific medications, or to direct binding to the antibody through inadvertent ingestion of opiates (e.g. poppy seeds).

Currently access to onsite drug testing in police custody is variable. Detainees may be tested for heroin and cocaine, following arrest for 'trigger offences', using oral fluid. The result of this test may be useful in the overall assessment of a detainee and prior to providing treatment in the form of substitution therapy. The time limits for drug detection in oral fluid samples is between 24–48 hours, indicating recent drug use. Urine samples, if available, have the advantage of indicating drug use over the previous several days.

2.2 Special groups

2.2.1 Detainees with mental disorder and substance use disorders

Under the Codes of Practice of PACE (C1.4)[41] if at any time an officer has any reason to suspect that a person of any age may be vulnerable, in the absence of any clear evidence to dispel that suspicion, that person shall be treated as such for the purposes of this Code.

'Vulnerable' (Code 1.13(d)) applies to any person who, because of a mental health condition or mental disorder:

- *may have difficulty understanding or communicating effectively about the full implications for them of any procedures and processes connected with*
  - *their arrest and detention; or (as the case may be)*
  - *their voluntary attendance at a police station or their presence elsewhere for the purpose of a voluntary interview; and*
  - *the exercise of their rights and entitlements*

- *does not appear to understand the significance of what they are told, of questions they are asked or of their replies;*

40 Stark, M. M., Norfolk, G. A., Rogers, D. J., et al (2002) The validity of self-reported substance misuse amongst detained persons in police custody. Journal of Clinical Forensic Medicine, 9, 25–26.

41 Home Office. Code C Revised. Code of Practice for the detention, treatment and questioning of persons by Police Officers. August 2019 https://www.gov.uk/government/publications/pace-code-c-2019 Accessed 8/11/2019

- *appears to be particularly prone to:*
- *becoming confused and unclear about their position;*
- *providing unreliable, misleading or incriminating information without knowing or wishing to do so;*
- *accepting or acting on suggestions from others without consciously knowing or wishing to do so;*
- *readily agreeing to suggestions or proposals without any protest or question.*

Mental disorder is defined as any disorder or disability of the mind.[42] A history of use of substances alone is not an indication that an appropriate adult needs to be present. The decision is one for the custody sergeant, but HCPs may be asked for advice.

Therefore it is essential that HCPs working in the custodial environment are skilled in performing a mental state examination (see Table 2.1) and, where appropriate and requested, an assessment under the Mental Health Act (a pro forma[43] may assist).

Table 2.1 Mental State Examination	
Appearance	Self-care, clothing Motor e.g. restlessness, over-activity, or retardation Level of consciousness
Behaviour	Disinhibition, withdrawn, aggressive, Attitude to examiner – hostile, cooperative, friendly
Speech	Form and content of speech – talkative, pressure of speech, retardation, mute Presence of thought disorder, flight of ideas
Mood/affect	Objective and subjective Depression, anxiety, elation, hopelessness
Thoughts/perceptions	Hallucinations Delusions
Cognition	Orientation, Concentration attention Memory – short and long term
Insight	Understanding and acceptance of situation
Other considerations: Biological symptoms Self-harm and suicidal ideation Harm to others	Sleep, appetite, energy levels History of self-harm, type of self-harm, current Thoughts, intention, protective factors, plans Thoughts, intent, previous harm to others

The assessment of mental state is important for the general care of the detainee as there may be depression, psychosis, or other psychiatric conditions, requiring treatment, or support

42 Mental Health Act 2007 http://www.legislation.gov.uk/ukpga/2007/12/contents Accessed 8/11/2019
43 FFLM. Mental Health Act assessment April 2017 https://fflm.ac.uk/wp-content/uploads/2017/05/Mental-Health-Act-Assessment-pro-forma-Prof-Ian-Wall-April-2017.pdf Accessed 8/11/2019

from an appropriate adult (see below).[44] When assessing the mental state of an individual, the HCP will need to decide whether to obtain the opinion of a psychiatrist, and if so, when.

Examination of mental state is particularly important medico-legally because if drug (for example, amphetamines, cocaine, or cannabis) or alcohol use gives rise to a psychotic state, this may have implications for the offence or affect fitness for interview (see Section 4.1).

Comorbidity of severe mental illness and substance use disorders is common; for example a diagnosis of schizophrenia may coexist with a diagnosis of drug dependence. Drug use can cause rapid worsening of mental state even in stabilised psychotic illness. Substance misuse may be associated with a psychotic state through a number of mechanisms. Intoxication may mimic psychosis, which may be triggered by stimulants[45] and cannabis.[46,47] A psychotic state may arise that persists beyond the elimination of the drug. Withdrawal states such as those seen with alcohol or benzodiazepines may result in vivid hallucinations and clouding of consciousness.

Substance use disorders may also be associated with other psychiatric conditions, including affective disorders, such as depression, that can result in acts of self-harm, suicide and aggressive behaviour. This is a particular problem following stimulant withdrawal.

Detainees with psychiatric conditions, including attention-deficit hyperactivity disorder (ADHD), who have been prescribed stimulants or any other medication should have this continued in custody.

Risk of suicide and self-harm

Research has shown that episodes of self-harm typically occur soon after arrest[48] and that particular risk factors include histories of self-harm, psychiatric illness,[49] and addiction.[50] The risk in a custodial setting is higher in women.

A risk assessment should be made as part of the mental state assessment. If referral to an emergency department (ED) is not necessary (for acute treatment of self-injury or self-poisoning), any consideration of urgent referral to secondary mental health services should be based on a risk and needs assessment. This would include the social and psychological aspects of self-harm; mental health and social needs; hopelessness; and suicidal intent.

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44 R v Aspinall (Paul James) (1999) MHLR 12 The failure to follow the requirements to have an appropriate adult in the interview of a mentally disordered suspect meant that, despite his apparent lucidity in interview, it was unfair to admit it in evidence.

45 Ghodse, A. H. & Kreek, M. (1998) Resurgence of amphetamine-type stimulants. Current Opinion in Psychiatry, 11, 245–247.

46 Mathers, D. C. & Ghodse, A. H. (1992) Cannabis and psychotic illness. British Journal of Psychiatry, 161, 648–653.

47 Ghodse, A. H. (1986) Cannabis psychosis. British Journal of Addiction, 81, 473–478

48 Ingram, A., Johnson G. & Heyes, I. (1997) Self-harm and Suicide by Detained Persons: A Study. Police Research Award Scheme Paper. Home Office Police Research Group.

49 Norfolk, G. A. (1998) Deaths in police custody during 1994: a retrospective analysis. Journal of Clinical Forensic Medicine, 5, 49–54.

50 Oyefeso, A., Ghodse, A. H., Clancy, C., et al (1999) Suicide among drug addicts in the UK. British Journal of Psychiatry, 175, 277–282.

Where such assessments highlight a risk of self-harm, the HCP should inform the custody officer and provide them (within the bounds of patient confidentiality[51]) with sufficient information to allow the custody officer to give the necessary care to the detainee and to meaningfully communicate risk to others. Detailed assessments should be undertaken of detainees who express a clear intention of self-harm, with attention given to any evidence of previous acts of self-harm. The HCP should ensure that the detainee is kept under the appropriate level of observation (see Appendix C) whilst awaiting formal psychiatric assessment.

In recent years there have been concerns regarding the rise in apparent suicides following police contact.[52] HCPs are increasingly being asked by police to perform a pre-release risk assessment. It is therefore particularly important to remember that the risk of suicide and self-harm increases with substance misuse.

Factors associated with an act of self-harm that indicate a high risk for suicide are:

- a medically serious act of self-harm
- the writing of a suicide note
- precautions having been taken against being found
- a stated wish to die
- a belief that the act would have proved fatal
- an expressed regret that the act failed
- a previous episode of self-harm
- depression and psychoses
- substance misuse
- co-morbidity
- impulsive and aggressive personality traits
- loneliness and lack of a social network.

Risk is dynamic and assessment should be ongoing. The HCP needs to offer advice and options to support the detainee's welfare on release. An adult who is charged may be refused bail and kept in custody if the custody officer has reasonable grounds to believe detention is necessary for their own protection.[53]

Mental Health Acts (MHA)

Compulsory admission to hospital under the Mental Health Act 1983 (England and Wales) as amended in 2007, the Mental Health (Northern Ireland) Order 1986, or the Mental Health (Care and Treatment) (Scotland) Act 2003 may be justified for a detainee with a substance use disorder who has a mental disorder, including mental disorders precipitated by, or associated with, substance misuse. Substance use and dependence alone are not, however, sufficient grounds. It may be necessary to repeat an assessment of a detainee under influence of alcohol or drugs (unless in a very

51 GMC Confidentiality: good practice in handling patient information April 2017. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality Accessed 8/11/2019

52 IOPC 2016 Deaths during of following police contact: Statistics for England and Wales 2018/19 https://police-conduct.gov.uk/sites/default/files/Documents/statistics/deaths_during_following_police_contact_201819.pdf Accessed 8/11/2019

53 Authorised Professional Practice (APP) 2018 Detention and Custody Risk Assessment Section 4 Release from custody. https://www.app.college.police.uk/app-content/detention-and-custody-2/risk-assessment/#risk-of-suicide-and-self-harm Accessed 8/11/2019

disturbed/urgent situation) to decide whether a formal Mental Health Act assessment is required.

A patient may be compulsorily admitted under the Acts where certain criteria have been met, including where detention is necessary in the interests of their own health or safety or for the protection of other people.

Police stations have been used as a place of safety (POS) for assessments under section 136 of the Mental Health Act. Following changes to the Act in 2017[54] this is no longer appropriate, and hospital places of safety should be used except in exceptional circumstances, where the adult poses an imminent risk of serious injury or death to themselves or another person. In this case the police officer must consult an appropriate doctor, nurse, or AMHP (Approved Mental Health Professional). Furthermore a HCP must be present on site throughout the detention and perform checks every half hour. This requirement is not ideal as not all HCPs are embedded in police custody, and even where they are there would not be sufficient time for this role. Police stations are never to be used for a person under 18 years of age. A patient may be moved from one place of safety to another such as a hospital, for example if physical treatment is needed, or community-based POS.

Liaison with local psychiatric services

There has been an increase in Criminal Justice Liaison and Diversion Services (CJLDS) in both police stations and courts in recent years. The mental health professional, when present on site, is available to give advice and help access mental health services and drug and alcohol treatment services. The aim is to improve appropriate intervention for those in mental health crisis presenting to the police. Assessment may also inform suitable sentencing/diversion options.

Local arrangements for liaison between the police, HCPs and psychiatric services vary widely. Whatever local arrangements apply, there must be effective communication at an individual and policy level between the parties involved.

Detainees with substance-related problems who are transferred to general hospitals for physical treatment often have associated psychiatric problems which may need treatment in their own right. It is important that the HCP communicates clearly with the psychiatric services as well as with the medical and surgical teams.

Psychiatric liaison services provide assessment and management of mental health crises in the hospital emergency department; this includes drug and alcohol management. Crisis resolution and home-based treatment service (CRHT) will also provide this function in some areas.

54 The Mental Health Act 1983 (Place of Safety) Regulations 2017 http://www.legislation.gov.uk/uksi/2017/1036/contents/made Accessed 8/11/2019

Appropriate adults (AA)

In England and Wales and Northern Ireland, if a person in police detention is a juvenile, i.e. is or appears to be under the age of 18, or is vulnerable (see Section 2.2), then the custody officer must inform an 'appropriate adult' and ask that adult to come to the police station to see the person.

The appropriate adult is often the person's parent or guardian, or a social worker. However, where there are no other suitable candidates available, it can be any responsible adult aged 18 years or over who is not: a police officer; employed by the police; under the direction or control of the chief officer of a police force; or a person who provides services under contractual arrangements.

If there is evidence of mental disorder, as defined by the respective Mental Health Acts, then an appropriate adult will be required as set out in Code of Practice C issued under the Police and Criminal Evidence Act 1984.[41] The PACE Code applies in England, Wales and Northern Ireland.

A key purpose of the appropriate adult is to advise the detainee during questioning, to observe whether the interview is being conducted properly and fairly, and to facilitate communication with the detainee. More broadly, the appropriate adult is able to assist and support the detainee to ensure that their rights are respected and that they understand what is happening and why.

It is the duty of the custody officer to decide whether to call an appropriate adult. However, if a HCP should become aware at any stage that a detainee falls into one of the relevant categories, they should ensure that a record is made and confirm with the custody officer that an appropriate adult has been or will be called.

In Scotland, an appropriate adult is a person with prior experience (either in a professional or voluntary capacity) of working with adults who have mental health issues, learning disability, autistic spectrum disorder, dementia and/or acquired brain injury, in relation to overcoming communication issues. In Scotland, recommendations regarding the calling in of an appropriate adult are given in the Scottish Office Police Circular 7/1998.[55]

When a police officer in Scotland wishes to interview a person with a mental disorder who is under the age of 16, careful consideration should be given to having a responsible adult present at that time.

A responsible adult, in the first instance, should be a responsible parent or family member of the person being interviewed, who is not connected to the enquiry. If after making all reasonable attempts, no parent or family member can be found, contact should be made with the local social work department in the relevant local authority. In Scotland, a responsible adult is entirely different to an appropriate adult.

It is recognised that special care and understanding is required when dealing with persons with learning disabilities or a mental disorder. When police officers are required to

55 http://www.sehd.scot.nhs.uk/mels/1998_43.pdf Accessed 8/11/2019

deal with such persons, an appropriate adult should be present. This applies whether the person is a witness, suspect or accused.

An appropriate adult is defined as:

- someone who is not a police officer or employed by the police, who has experience in dealing with a person with a learning disability or a mental disorder and/or

- a relative, guardian or other person responsible for their care or custody; however, whenever possible their use should be avoided due to the relationship with the person with the learning disability

or, failing either of the above, some other responsible adult who is not a police officer or employed by the police.

The role of the appropriate adult is to:

- provide support and reassurance to the person being interviewed
- facilitate communication with the person being interviewed.

Local authorities within the Police Scotland area now follow guidelines regarding the provision of trained appropriate adults which are very similar in content. The lead agency in the operation of the scheme in all the local authority areas is the Social Work Department, who will contact a trained person at the request of a police officer.

2.2.2 Detainees with learning (intellectual) disabilities[56]

Learning (intellectual) disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) and to cope independently (impaired social functioning), which started before adulthood and has a lasting effect on development. This definition encompasses people with a broad range of disabilities.

Misuse of substances is uncommon among people with learning (intellectual) disabilities.[57] Those that do engage in misuse face significant problems. They can be very suggestible and easily caught, and may take the blame for others. Police officers do not routinely screen for, and may not recognise, when individuals have learning disabilities. The suggestibility of such individuals is not well understood and police officers need to ensure adequate legal protection for these vulnerable individuals, as well as adequate support to enable them to cope with the stress of being interviewed.

Many detainees with learning disabilities are known to a care giveror care-giving organisation and/or to a community learning disability team. Their problems are often of a

56 FFLM. Assessment of people with learning difficulties and disabilities in police custody 2017 https://fflm.ac.uk/wp-content/uploads/2018/01/Assessment-Learning-Difficulties-Disabilities-in-Custody-Dr-J-Holmes-Nov-2017.pdf Accessed 8/11/2019

57 Huxley A, Taggart C, Baker G, et al (2007) Substance misuse amongst people with learning disabilities. Learning Disability Today, 7(3), 34–38.

serial and relentless nature, requiring a strategic and multi-agency response. Efforts should be made to contact people who know the detainee and their context, rather than relying on the minimum of an 'appropriate adult'. HCPs need to be aware of the complicating factor of intellectual disability and ensure that appropriate safeguards are put in place to protect the detainee.

2.2.3 Older people with multiple co-morbidity[58,59]

An increasing number of people with substance use disorders in drug treatment in the community are maintained on opioid substitution treatment (OST) into their 50s and beyond, have complex co-morbidities, and are prescribed multiple medicines. Should such a person be arrested and detained, it is important to identify and understand their health needs. As with all detainees in custody, it is important that they have access to effective healthcare and that they will be catered for with dignity and sensitivity.

There are two distinct groups of older people with problem drug use. The first is older people with a long history of substance use persisting into later life, who tend to be polysubstance users, who have a chronic history of using heroin, crack cocaine, tobacco and alcohol. These are 'early-onset users' and are different to a sometimes quite distinct population of 'late-onset users' of substances who may have begun using them regularly only later in life, often following stressful life events or lifestyle changes (for example retirement, marital breakdown, social isolation, increasing morbidity or bereavement).

The early-onset users may well already have experienced significant complications of their drug or alcohol use, which could have implications for their life expectancy and need for other treatments (e.g. a need for hepatitis C treatment). The late-onset users as a group tend to be a larger but a less visible population of older drug users, and typically use prescription or over-the-counter medicines (for example benzodiazepines and opioid-based analgesics), as well as problematic amounts of alcohol. Tobacco and alcohol use cause the greatest degree of harm at a population level in this age group and these issues should also be addressed.

It is important to remember that prescriptions in the over-65s often include polypharmacy where there may be drug interactions and adverse effects. The 'over 65s' are more susceptible to the effects of drugs and alcohol due to a fall in their ratio of body fat to water, reduced capacity to metabolise drugs, other co-morbidities, and increased chances of drug–drug interactions.

Co-morbidity can be a key factor, with age increasing the risk of suffering from chronic pain, insomnia, bereavement, loneliness and mood disorders. In addition, impaired memory, immobility, incontinence, sensory impairment and iatrogenic problems can develop. These physiological and other health changes mean that older people, especially some over 65, can be at greater risk of harm when using even small amounts of alcohol, medications or other substances. Falls, in particular, can have serious consequences in later life.

58 Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

59 Royal College of Psychiatrists. (2018) Our Invisible Addicts. https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr211.aspx Accessed 8/11/2019

Continued injecting drug use in the older population remains a key factor in overdose deaths. The average age of all drug-related deaths which are mainly related to opioids has increased over the last decade; they occur predominantly in adults in their 30s and 40s.

Complications related to a long history of drug and alcohol use include:

- Infection
  - hepatic damage due to hepatitis B or C infection and/or excessive alcohol use
  - HIV infection

- Respiratory
  - chronic obstructive airways disease from smoking tobacco, from inhaling drugs, or from TB

- Cardiovascular
  - increased cardiovascular disease risk due to alcohol, stimulant drugs, smoking and lifestyle
  - venous damage (IV access can be difficult) and/or arterial damage
  - past cardiac valve destruction
  - risk of QTc prolongation when methadone is co-prescribed with a range of medications including antipsychotics, tricyclic antidepressants, citalopram, and erythromycin

- Oral
  - poor dental health

- Mental health
  - impaired mental health (with increased risk of self-harm and suicide)

- Polypharmacy
  - increased risk of falls, sedation, cognitive impairment and road traffic accidents with polypharmacy; prescribing sedating medicines such as benzodiazepines, hypnotics, antipsychotics, antihistamines, anticholinergics or other opioids
  - ongoing risk of overdose
  - risk of drug–drug interactions which may increase or decrease methadone levels and to a lesser extent buprenorphine.

- Other
  - family breakdown/relationship problems
  - mobility problems consequent on groin injecting
  - traumatic injuries due to falls, accidents or assaults
  - impaired immunity
  - increased risk of cancer
  - chronic pain

2.2.4 Pregnant detainees

Sudden cessation of opioid use in a pregnant woman with dependence may be life-threatening for the fetus. The need to safeguard the patient and her pregnancy is paramount. It is important to consider whether a female detainee is pregnant before initiating treatment.

A pregnancy test should be considered and performed with consent after the clinical assessment, on women of child-bearing age who are being assessed for alcohol and/or drug problems/dependence.

Amenorrhoea is associated with substance misuse, so it is not unusual for women to be unaware that they are pregnant. Sensitivity is needed, however, around encouraging this testing for all women as it will not be appropriate in all cases, such as for women who have been diagnosed as infertile, for some trans women who are not able to be pregnant, and for women who have indicated it is not possible because of recently having no relevant sexual activity.[60]

Some women will know that they are pregnant but may not have attended for antenatal care and may be unaware of the gestation of their pregnancy. HCPs should have a high index of suspicion to test and seek consent to test, after explaining the risks. Palpation of the abdomen should be performed as appropriate.

The examining clinician needs to be competent to assess a pregnant detainee and decide whether referral is required to an antenatal clinic, the early pregnancy assessment unit, or labour ward, for a further skilled assessment.

Special care should be taken to ensure that pregnant women who are taking prescribed medication for substance use disorders have this continued while in custody, as they are at high risk in terms of pre-term delivery, obstetric complications, and poor outcomes for both the fetus and the mother. Best practice, when feasible, is to check when the pregnant detainee was last seen in the drug and alcohol services or specialist antenatal clinic, and to check the results of any urine screening tests.

There is a need to avoid both withdrawal and intoxication, therefore stabilisation of a pregnant detainee while in custody may not be possible. Having the facility to auscultate the fetal heart (Pinard/Doppler) is a minimum requirement if a woman is beyond twelve weeks' gestation and detained in custody. HCPs should have a low threshold for early referral to hospital for obstetric assessment and treatment of substance use disorder.

A pregnant woman who shows signs of marked withdrawal and/or intoxication on arrival should be transferred to hospital for assessment and initial stabilisation. Cocaine use carries risks to the fetus, including premature labour and placental abruption, and risks to the mother, especially those from fluctuations in blood pressure.

60 Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

Red flags requiring hospital assessment include:[61]

- 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 which may indicate fetal sedation and/or hypoxia
- Active fetal movements which may indicate a fetus experiencing withdrawal symptoms of irritability
- Uterine tightenings which may indicate uterine irritability due to withdrawal, and pose a risk of miscarriage or premature delivery
- Alcohol withdrawal in pregnancy, which can only be safely managed in a medical setting with access to fetal monitoring
- Drug-dependent patients not currently in treatment, requiring urgent specialist assessment and initiation of treatment by the specialist drug 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, it is 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), and presence of ulcers or abscesses
- Other acute medical problems such as infection, possible DVT, and mental health issues
- Homelessness – patients will rarely achieve or maintain stability whilst homeless
- Nights or weekends when confirmatory information about antenatal care and substance use disorder treatment is unavailable
- When the period of detention is likely to be prolonged e.g. public holidays.

Essential follow-up

There is a duty under adult and child safeguarding guidelines to inform the specialist midwifery services of any contact you have with a pregnant drug- or alcohol-dependent patient. Referral to social services is required, to inform the pre-birth child safeguarding

61 FFLM. Management of Pregnant Drug and/or Alcohol Dependent Patients in Custody 2016

plan.[62] Sharing of information is preferably done with the patient's consent, but child safeguarding concerns are sufficient to allow information sharing without consent.[63] It may be necessary to alert the custody sergeant to establish the safety of other children whilst the woman is in custody. The detainee's GP should be informed, and the key worker from the substance misuse service; both, if possible, with consent of the detainee.

2.2.5 Children (under 18 years of age)[64,65]

It is important to remember that children and young people who have been detained in police custody are more likely in general to have multiple complex needs, including a higher incidence of mental health problems, a history of self-harm, learning and communication difficulties, and a high incidence of experiencing abuse, neglect or trauma.[66]

They are also more likely to have housing needs or experience of being in local authority care, and there may be ongoing child safeguarding concerns. Thus, substance misuse may be only a part of a wider spectrum of difficulties for the young person. Most young people who use substances do not suffer serious harmful consequences, but a significant minority may develop substance dependence, as well as physical and/or psychiatric comorbidity, whether or not they are dependent.

HCPs in the custodial environment need to make a child safeguarding referral[62] if they have concerns that a child or young person is suffering or likely to suffer harm. Being in custody itself may be harmful, and this should be done despite the fact that police routinely share the details of their contact with children and young people with the local authority.[67]

The most commonly used substances in the under-18s are alcohol and cannabis. Prevalence increases with age, and frequency between girls and boys and is about equal. Polydrug use is common with 34% of children aged 11 to 15 years in England taking two or more types of drug.[63] Novel psychoactive substances (NPS) are the second most prevalent group of drugs being used (after cannabis) in this group, with nitrous oxide the most prevalent. The increasing use of NPS, particularly synthetic cannabinoids, presents a real challenge in relation both to its direct effects and to the impact of possible withdrawal symptoms.

Prevalence of alcohol use increases with age, with 1% of children aged 11 years and 24% of children aged 15 years having had a drink in the last week. Mean consumption

62 FFLM. Child safeguarding summary referral 2017 https://fflm.ac.uk/wp-content/uploads/2017/05/Child-Safeguarding-Referral-pro-forma-Dr-Bernadette-Butler-and-Dr-Nicholas-Swift-April-2017.pdf Accessed 8/11/2019

63 FFLM. Child Safeguarding: Information Sharing Guidance for Healthcare Professionals working in Police Custody 2014 https://www.fflm.ac.uk/wp-content/uploads/2015/10/Child-Safeguarding-Information-Sharing-Guidance-for.pdf Accessed 8/11/2019

64 GMC. Protecting children and young people (May 2018)The responsibilities of all doctors. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people Accessed 8/11/2019

65 GMC 0-18 years: guidance for all doctors (May 2018) https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years Accessed 8/11/2019

66 College Of Policing Authorised Professional Practice – Detention and Custody Children and Young Persons. https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/children-and-young-persons/ Accessed 8/11/2019

67 FFLM. Child Safeguarding: Information Sharing Guidance for Healthcare Professionals working in Police Custody 2014 https://www.fflm.ac.uk/wp-content/uploads/2015/10/Child-Safeguarding-Information-Sharing-Guidance-for.pdf Accessed 8/11/2019

is around 10 units although 18% drink over 15 units a week. As binge drinking and occasional drunkenness are more frequent than sustained high levels of consumption, HCPs should enquire about drinking patterns, including frequency and quantities consumed over time. Even though alcohol dependence is rare in young people, a substantial minority show problematic alcohol use, and individuals should be questioned about the impact of alcohol use on their lives, including getting into fights/arguments, getting into trouble with the police, and driving while drunk.

Assessment should include a full substance use and alcohol history plus any details of comorbid psychiatric symptoms. Enquiry as to whether there has been a previous history of self-harm is particularly important, as this may indicate risk of self-harm while in custody. In performing an assessment of a young person consideration should be given to the presence of a chaperone, essential if an intimate examination is required.[68]

Issues regarding consent

In the UK children become adults for medical (therapeutic) purposes at age 16, when they are entitled to consent to their own medical treatment. As with adults, consent will only be valid if an appropriately informed patient, capable of consenting to the particular intervention, gives it voluntarily. Children under the age of 16 may have the capacity to consent to medical treatment if they have sufficient understanding and intelligence to enable them to comprehend fully what is involved in the appropriate intervention. This is sometimes described as being 'Gillick competent', where such a decision in England and Wales is based on case law (Gillick v. West Norfolk & Wisbech Area Health Authority, 1985).

If the child lacks capacity to consent then the person with parental responsibility should be asked for consent. Those with parental responsibility include:

- The mother, who automatically has parental responsibility (unless removed by a court)
- The father, who acquires responsibility if he is married to the mother at the time of the child's birth or anytime thereafter
- An unmarried father, who acquires parental responsibility if he is recorded on the birth certificate of the child from 1 December 2003 in England and Wales, 15 April 2002 in Northern Ireland, and from 4 May 2006 in Scotland
- An unmarried father whose child's birth was registered before the change in legislation but may still have parental responsibility by way of a court-registered Parental Responsibility Agreement with the child's mother, or a Parental Responsibility Order from the courts
- Others with agreement or by court order (e.g. step-parents or adoptive parents).

68 GMC. Intimate examinations and chaperones. (April 2013) https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/intimate-examinations-and-chaperones Accessed 8/11/2019

In the case of 16- and 17-year-olds who lack capacity in England, Wales and Northern Ireland, the person with parental responsibility can consent to investigations and treatment that are in the young person's best interests. In England and Wales treatment can also be provided without parental consent if it is in the young person's best interests, although the view of parents may be important in assessing this. In Northern Ireland treatment can be provided in the young person's best interests if the parents cannot be contacted, although legal advice should be sought for significant interventions that are not deemed an emergency. In Scotland 16- and 17-year-olds who do not have capacity are treated the same as adults without capacity and treatment may be given to safeguard or promote their health.

Parents cannot override the competent consent of a young person to treatment that is considered in their best interests. In Scotland parents cannot authorise treatment if a competent person has refused. In England, Wales and Northern Ireland the law on parents overriding young people's competent refusal is complex. If treatment is thought to be in the young person's best interests, legal advice should be sought, as the parental power to overrule a young person's competent decision is subject to legal challenge.

Forensic examinations

Although not decided in law, it may seem reasonable to assume that young people aged 16 or 17 have the capacity to consent to a forensic examination just as they do to a therapeutic examination.

However, in addition to gaining consent from the juvenile, when a forensic examination is going to be carried out on a child younger than 18 it is best practice to inform and obtain the consent of a person with parental responsibility whenever reasonably practicable. Obtaining such consent is essential if the child is not Gillick competent. Likewise, in Scotland it would be considered best practice to involve an individual with parental responsibility even if the mature minor appears to have the capacity for a therapeutic process in terms of the Age of Legal Capacity (Scotland) Act 1991.

HCPs need to be aware that there are additional procedural considerations regarding forensic examinations of juveniles – those under the age of 18 years. The police are required to follow certain rules to ensure that evidence obtained from those under 18 years of age in custody is legally admissible in court.

The rules regarding obtaining intimate samples (see Section 4.4) from a detained person require 'appropriate consent' for the intimate sample evidence to be admissible.

'Appropriate consent' is defined in Section 65 of PACE as meaning:

- *in relation to a person who has attained the age of 18 years, the consent of that person*
- *in relation to a person who has not attained that age but has attained the age of 14 years, the consent of that person and of their parent or guardian; and*
- *in relation to a person who has not attained the age of 14 years, the consent of their parent or guardian.*

Where the consent of a parent or guardian is required, it is not necessary for that person to be at the police station to give that consent. However, where the consent of the juvenile is required, it must be obtained in the presence of an appropriate adult, who may be the parent or guardian or some other suitable person over the age of 18 years.

The decision as to which other forensic examinations require the presence of an appropriate adult when consent is obtained from a juvenile is essentially a matter for the police and not the HCP.

2.3 Administration of medication in police stations

The overriding consideration of the attending HCP must be the clinical safety and wellbeing of the patient. The FFLM and Royal Pharmaceutical Society have developed recommendations to ensure the safe and secure administration of medication in police custody.[69] HCPs working in this environment must be fully aware of these recommendations.

HCPs will have access to certain medicines for treating a detainee. These may be provided by police, or outsourced providers; provided by the HCP; previously prescribed to the patient and brought in on arrest or by a relative or friend; previously prescribed and collected from a supervising pharmacy (OST) (see Appendix D); and/or collected by police via a private prescription (see Appendix E). Arrangements will vary as to how medication is obtained, and it is important that HCPs are aware of local procedures.

It is essential that authorised medication is given in a timely manner and for the expected duration of detention or until a further clinical review is required. Medication may be prescribed or provided using Administration Protocols (APs) and Patient Group Directions (PGDs).

The PACE Code of Practice for the detention, treatment and questioning of persons by police officers (Code C) also provides guidance on the administration of medication.[18] This legislation applies to England, Wales and Northern Ireland. Paragraph 9.9 of the Code states:

If a detainee is required to take or apply any medication in compliance with clinical directions prescribed before their detention, the custody officer must consult the appropriate healthcare professional before the use of the medication. […] the custody officer is responsible for the safekeeping of any medication and for making sure that the detainee is given the opportunity to take or apply prescribed or approved medication.

69 FFLM. Recommendations – Safe and Secure Administration of Medication in Police Custody, 2016 https://www.fflm.ac.uk Accessed 8/11/2019

Paragraph 9.10 of the Code gives guidance in relation to controlled drugs, stating:

No police officer may administer or supervise the self-administration of medically prescribed controlled drugs of the types and forms listed in the Misuse of Drugs Regulations 2001, Schedule 1, 2 or 3. A detainee may only self-administer such drugs under the personal supervision of the registered medical practitioner authorising their use or other appropriate healthcare professional.

This includes, for example, methadone, buprenorphine, Suboxone, temazepam, phenobarbitone, methylphenidate, morphine, and tramadol.

The custody officer can distribute drugs listed in Schedule 4 (e.g. diazepam) or 5 (e.g. dihydrocodeine) for self-administration if they have consulted the appropriate HCP authorising their use. This may be done by telephone (*where medications are already prescribed to the detainee*) as forensic physicians may give verbal orders where this is in a patient's 'best interest' and there is minimal risk. It is essential that the medication is checked as belonging to the detainee and that the details on the label match the contents. Both parties must be satisfied that self-administration will not expose the detainee, police officer or anyone else to the risk of harm or injury.

It remains good practice to advise police staff that, if they have any concerns regarding the drug to be administered, they should have no hesitation in telephoning the HCP to discuss those concerns and whether a visit is required.

The police should ensure that the treatment recommended by the HCP is properly self-administered by the detainee and documented, and that all ingestion of medication is supervised.

No police officer should measure out doses of methadone or any other medicines. Intravenous medication for treatment of substance use disorders is generally inappropriate in this setting and should be avoided. If OST is required, oral formulations should be given. There is no recognised indication for prescribing amphetamines, cocaine or injectable benzodiazepines for the treatment of dependence in police custody.

National Health Service prescriptions must not be issued for individuals detained in police custody (Home Office Circular 17/1950) unless the service is provided by the NHS; medicines should be prescribed on a private prescription paid by the police.

If a supply of Schedule 2 and 3 controlled drugs is required for a detainee, HCPs should use the private prescription FP10PCDNC or FP10PCDSS (England), WP10PCD and WP10CDSS (Wales), PCD1 (Northern Ireland) or PPCD91 (Scotland). Generally, all medication in the police station is held by the custody officer on behalf of the detainee, and should be kept in a locked receptacle to prevent unauthorised access.

2.4 Liaison with other agencies

2.4.1 Acute hospital referral

Detainees with substance use disorders may have other medical problems, related or unrelated to substance misuse (for example, a recent head injury), which require hospital treatment. HCPs should ensure concurrent problems are not overlooked because of a history of substance misuse/dependence and should liaise with appropriate colleagues, such as the emergency department (ED), obstetrician, surgical or medical team. Communication should preferably be both oral and confirmed in writing (see Appendix F).

The doctor responsible for the discharge of the patient from hospital should ensure that relevant confidential medical information is transferred with the detainee[70,71] (by letter, copy of electronic discharge summary, or completion of any appropriate forms, e.g. Appendix F). The police should also be given any necessary information to ensure the safe transfer and care of the detainee while in police custody. It is a matter for the custody officer to determine whether further clinical advice should be sought from the HCP on the detainee's return to the custody suite.

2.4.2 Liaison with prison

Remand prisons have specialist nurses with experience in substance use disorders, and a 24-hour healthcare presence. The assessment and treatment of drug and alcohol dependence in this setting tends, therefore, to be more equivalent to that provided in the community rather than the unique short-term environment of police custody, where the period of detention can be restricting to clinicians in maintaining ongoing medication or managing symptoms of withdrawal. Methadone (first line) and, where clinically appropriate, buprenorphine are opioid substitutes for managing opioid withdrawal in prisons.

To inform clinical assessment in prison a record of any consultation provided by a HCP should be made on the police medical record form. If a detainee is transferred to court, and subsequently prison, a copy of the medical record form should be sent with them. Any medication prescribed should be entered on the form with confirmation of the time the medication was dispensed to the detainee. In addition, objective clinical measurements such as pulse rate, blood pressure and size of pupils, and COWS scale, are useful; so too are any initial drug screen test results.

If there is concern that a detainee who is due to be transferred to court may be at risk of suicide or self-harm, the procedure outlined in Section 2.2.1 should be followed. HCPs should (within the bounds of patient confidentiality) provide custody officers with sufficient information to allow them to give necessary care to the detainee and to meaningfully pass on risk warnings. The custody officer will then communicate this suicide or self-harm risk

70 GMC. Good Medical Practice 2014 Section 44 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice Accessed 8/11/2019

71 GMC. Confidentiality: good practice in handling patient information 2018 Sections 26-29 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality Accessed 8/11/2019

warning to escort services, the court and the prison (using the Prisoner Escort Record Form PER). Again, HCPs should ensure that they make a record of any consultation in the police medical record form.

Detainees may arrive in police custody having left a prison only hours previously. Details of the clinical management of a drug or alcohol problem may be sought from the healthcare department of the prison. It is worth noting that all controlled drugs are routinely taken under supervised conditions in all prisons. A criminal justice integrated team from a detainee's home area will also hold information on drug services received by their clients in prison, including in relation to prescribed medication.

3. Management of specific drug problems

3.1 General principles

The increasing likelihood of polysubstance misuse and associated problems, such as drug interactions and dependence on different drugs, should be borne in mind when considering the management of each individual detainee.

There should be a high level of awareness of possible alcohol problems when assessing detainees with other substance use disorders, and a high level of suspicion of co-occurring organic disorder.

Female detainees should be asked about the possibility of pregnancy, as this may influence the choice of treatment (see Section 2.2.4).

Treatment of children with substitution or symptomatic medication should be undertaken with great caution (see Section 2.2.5). Children are less likely to be dependent and are more likely to suffer adverse effects from medicines used more commonly in adult patients. Any medication given for withdrawal symptoms and signs needs to be carefully titrated.

Great caution should be exercised in the medication of elderly patients who present with alcohol and/or opioid dependence, or dependence on prescribed drugs (see Section 2.2.3). Doses of medication required for symptomatic relief are usually less than in adult patients. There is also a greater likelihood of an underlying disease.

Substance misuse, even with some degree of dependence, is not in itself an indication for prescribing a substitute drug if the time in custody is brief. Simple reassurance or the prescription of symptomatic drugs may be helpful and effective in alleviating the detainee's anxiety about possible withdrawal, and in limiting the emergence of withdrawal symptoms.

Once dependence has been diagnosed, sufficient treatment should be provided for the proposed period of detention. There should be a low threshold for frequent clinical reviews in the early stages of treatment.

Decisions about prescribing will need to consider not only the clinical presentation but also the anticipated length of time in custody and whether or not the individual will be returning to the community or is likely to be sent to prison.

Wherever possible (and where clinically appropriate), methadone or buprenorphine treatment should be continued for anyone detained in police custody and already stable on such medication in the community.

It is unacceptable to have a rule to automatically withhold opiate replacement therapy in police custody.

Withholding such treatment from detainees who are compliant with their regime may increase the risk of relapsing or re-offending, and with pregnant detainees there are significant risks to the unborn child.

HCPs should prescribe, or provide under PGD, substitution treatment only if they are sure that it is clinically safe to do so. Even if the HCP is confident and has objective evidence of dependence on prescribed drugs, the HCP should still advise the detainee and the police of the possible side-effects and review as appropriate.

3.2 Opioids

Symptoms and signs of intoxication

Intoxication with opioids can cause a feeling of well-being. Those under their influence may display a euphoric appearance. At times they may appear slightly distant, drowsy or unable to concentrate. Pinpoint or small pupils are a good clinical indication of recent opioid use.

Intoxication with opioids can lead to hypotension, bradycardia, cyanosis, respiratory depression, loss of consciousness and death. Onset may be rapid with parenteral use and delayed several hours with oral use. Close observation and provision of respiratory support are essential, especially when the respiratory rate is slow or irregular. Oxygen should be used if available in suspected cases of opioid overdose.

Naloxone is an opioid antagonist which can be used to reverse the effects of severe opioid intoxication.[72] Rapid reversal of opioid effects may precipitate an abrupt withdrawal syndrome.

Emergency medicine advice suggests supplemental oxygen or bag-valve-mask ventilation where RR < 10/minute or SpO2 < 92% (on air). Where severe opioid intoxication is suspected, an emergency ambulance must be called immediately, and naloxone given:

- *By intramuscular injection,* (into deltoid region or anterolateral thigh) in a non-medical setting, adult 400 micrograms repeated at intervals of 2–3 minutes until consciousness regained, breathing normally and further medical assistance is available. Repeated doses may be required.

- *By intravenous injection,* 400 micrograms; if no response after 1 minute, give 800 micrograms, and if still no response after another 1 minute, repeat dose of 800 micrograms; if still no response, give 2mg (4mg may be required in a seriously poisoned patient), then review diagnosis; further doses may be required if respiratory function deteriorates.

72 https://www.sps.nhs.uk/articles/what-naloxone-doses-should-be-used-in-adults-to-reverse-urgently-the-effects-of-opioids-or-opiates/ Accessed 8/11/2019

Naloxone has a shorter duration of action than many opioids; close monitoring and repeated injections are necessary according to the respiratory rate and depth of coma. Repeated administration of naloxone can be given by continuous intravenous infusion instead and the rate of infusion adjusted according to vital signs.

If naloxone is given in custody the detainee must be transferred to hospital.

Nasal naloxone is now available as Nyxoid®, a single-dose nasal spray containing 1.8mg of naloxone (as hydrochloride) in a 0.1 ml solution (two nasal sprays are included in the carton).[73] It is indicated for emergency administration for known or suspected opioid overdose in adults and adolescents aged 14 years and over, and there should be a response within 2-3 minutes of administration.

Symptoms and signs of withdrawal

The severity of opioid withdrawal symptoms is influenced by psychological factors and is not only directly related to the quantity of drugs previously consumed. The environment in a police cell is likely to exacerbate these symptoms. Observable or measurable signs of opioid withdrawal include those shown in Table 3.1.

Table 3.1 Symptoms and signs of withdrawal

Symptoms	Signs
Sweating	Dilated pupils
Running nose and eyes	Gooseflesh
Yawning	Flushing
Feeling hot and cold	Sweating
Anorexia and abdominal cramps	Lachrymation and rhinorrhea
Nausea, vomiting, diarrhoea	Tachycardia, hypertension
Tremor	Increased bowel sounds
Restlessness and insomnia	–
Anxiety and agitation	–
Generalised aches and weakness	–
Coughing and sneezing	–

The start of withdrawal symptoms will vary with different opioid drugs. On average, the symptoms of heroin withdrawal start within 8 hours, progress to a peak and then gradually improve within 48–72 hours.

Withdrawal from methadone usually leads to a less severe but more protracted abstinence syndrome than withdrawal from heroin. When assessing the severity of withdrawal, greater weight should be given to observable signs than to subjective symptoms in this context.

73 See for more information - https://www.nyxoid.com/uk Accessed 8/11/2019

Symptomatic treatment of withdrawal

It is essential that treating HCPs take time to allay any anxiety detainees have about the treatment provided in police custody.

Symptomatic relief of withdrawal symptoms (Table 3.2) can be achieved in the short term without substitution of the drug of dependence. However, for those who are likely to remain in custody (including prison) for a longer period, symptomatic treatment is not as effective as substitution treatment, and may affect fitness to be interviewed.

Table 3.2 Symptomatic treatment of withdrawal

Symptom	Drug	Administration
Vomiting	Metoclopramide	10mg three times daily. Not known to be harmful in pregnancy. Action antagonised by opioid analgesics. Caution, especially in young adults (15-19 yrs), extrapyramidal effects commonly occur.
	Buccal prochlorperazine	3 or 6mg (one or two 3mg tablets) absorbed from buccal cavity twice daily. Useful if unable to retain oral medication.
Abdominal cramps	Mebeverine hydrochloride	135-150mg three times daily, preferably 20 minutes before meals. Antispasmodic, not known to be harmful in pregnancy.
	Hyoscine butylbromide	10-20mg four times daily Smooth muscle relaxant Advised to avoid in pregnancy
Diarrhoea	Loperamide	Loperamide 4mg initially followed by one after each loose stool; maximum 16mg daily. An opiate receptor agonist which acts on the gut to reduce peristalsis, increase intestinal transit time and increase tone of the anal sphincter.
Minor aches and pains	Paracetamol	Paracetamol 500mg x 2 up to four times a day (maximum eight per day).
	NSAID such as ibuprofen	Ibuprofen 200-400mg three to four times daily (max 2.4g daily. Avoid in pregnancy especially third trimester.

The routine use of benzodiazepines for anything other than benzodiazepine or alcohol dependence is not recommended in police custody, as such drugs may affect cognition and therefore fitness to be interviewed. Furthermore, if the detainee is subsequently transferred to prison they may suggest a dependence on benzodiazepines and, as these drugs will appear in the initial urine drug screen test on reception, this may result in a period of unnecessary detoxification and increased risk of overdose.

Consideration of use of substitute drugs for opioid dependence/ authorising continuation of substitute drugs

Any consideration, and then prescription, of opioid medication must be managed by competent staff, and broadly in line with the Clinical Guidelines 2017. The police custody suite environment is a unique environment due to the acute and short-term detention of detainees and the need to manage symptoms acutely and safely. All prescribers should be aware of the increased risk of overdose and death, particularly in those with opioid use, and this especially with concomitant prescribing of other sedative drugs, such as anti-depressants, and use of illicit drugs and alcohol.

A comprehensive history and clinical examination (which includes the keeping of accurate notes) should be conducted to assess dependence and the objective signs of withdrawal and to correlate these with the subjective symptoms complained of by the detainee. Documentation of basic parameters such as pulse, blood pressure and size of pupils are essential, and the use of an opiate withdrawal scale (e.g. COWS) may be beneficial, particularly when a reassessment is performed. Care must be taken to exclude the presence of intoxication by substances, illicit or prescribed (e.g. benzodiazepines/ anti-depressants), and/or alcohol.

Mild opioid withdrawal can be controlled by symptomatic medications, as described above. There will be cases of significant withdrawal symptoms not managed by symptomatic medication, where opioid drugs may be required to control the symptoms and signs.

Caution should be exercised when prescribing OST in the absence of withdrawal signs, or other confirmatory information and confidence about previous consumption.

'Street' heroin varies in purity and consumption cannot be accurately estimated. Therefore, the dose should be carefully titrated against withdrawal symptoms and signs. Hospital admission may be required in certain circumstances. Preventive prescribing on the assumption that someone is dependent is not safe practice and should not be done unless the HCP is confident that a detainee is dependent.

Information from other sources, including the prescriber (general practitioner, drug-dependence clinic) and dispenser (pharmacist), should be obtained if possible. The enquiry should include details of medication prescribed, dosage, duration of treatment, dispensing arrangements and recent urine screening results. If methadone, buprenorphine or, indeed, any other medication is being supervised daily at a pharmacy or clinic, the level of dependence on the prescribed dose cannot automatically be assumed. There may have been missed doses, inadequate supervision, and/or a time lag since the last supervised dose because of a weekend. This information needs to be clarified. The detainee may, of course, be continuing to use illicit substances as well. It should be remembered that even a small amount of opioid may be fatal to a non-dependent individual.

Methadone

Methadone is a synthetic opioid drug, used widely in the treatment of opioid dependence as it has a long duration of action. It is available in liquid, tablet and injectable formulations though currently the liquid form is licensed for the treatment of dependence.

HCPs are reminded that liquid methadone for the treatment of opioid dependence is available in a number of strengths: the usual form is methadone oral solution 1mg/ml, which is typically green, although there is a colour-free mixture; methadone oral concentrate, not commonly used, is available in two strengths: 10mg/ml (blue) and 20mg/ml (brown).

The effect of a dose of methadone depends on the individual's tolerance to opioids, which can develop within two weeks of commencing daily use. Tolerance disappears as quickly as it develops, and loss of tolerance can lead to previously safe doses proving fatal. Care is required when authorising and dispensing previously prescribed methadone to ensure that the correct strength is provided, since any confusion could lead to overdose. If supervision and clarity on dispensing cannot be confirmed, then a most cautious approach must be adopted with titration against withdrawal signs.

Methadone oral solution 1mg/ml may be prescribed and need only be given once daily following stabilisation. Peak concentration is achieved 4 hours after consumption and the drug has a half-life of 10–25 hours after a single dose and 13–55 hours after repeated doses. It is highly lipid-soluble and it takes several repeated doses before tissue reservoirs are full.

As long as it is clinically safe to do so, prescribed methadone, from a community drug/primary care centre, should be continued while in custody, if prescribing and supervised dispensing is verifiable.

Buprenorphine

Buprenorphine is an opioid with agonist and antagonist properties, less of a risk in overdose when taken alone. The tablets are available in 0.4mg, 2mg and 8mg strengths. Buprenorphine with naloxone is available (as 2mg/0.5mg and 8mg/2mg). Apart from sublingual tablets there is increasing availability of different formulations of buprenorphine including freeze-dried wafer formulations; trials are ongoing with depot preparations. The HCP needs to be aware of the possible increased use of these preparations.

Peak concentration is 90–150 minutes, with peak effects 1–4 hours post dose. The duration of action is related to dose – with a low dose of 2–4mg effects last for up to 12 hours, whereas with a higher dose of 16–32mg effects may last for up to 48–72 hours. Buprenorphine is usually administered once a day because of its long duration of action.

As long as it is clinically safe to do so, prescribed buprenorphine from a community drug /primary care centre, should be continued while in custody, if prescribing and supervised dispensing is verifiable.

Self-administration of the drug must be personally supervised by the HCP, who should observe the patient to ensure that the drug has fully dissolved in the mouth. This may take 5–10 minutes. Care should be taken with the concomitant use of other sedating drugs such as benzodiazepines, antipsychotics, and tricyclic antidepressants.

Precipitation of opioid withdrawal can occur in someone commencing buprenorphine who is dependent on large doses of opioids or other opioid analgesics, if this treatment is started when the person is not in withdrawal.

Assessment procedure

On an initial assessment, especially if the detainee is seen soon after arrest, it would be unusual to prescribe any drugs immediately. This cautious approach is taken because the detainee may have recently taken substances (alcohol, over the counter, illicit and prescribed drugs), and the full effects of this ingestion may not yet be obvious.

If there is evidence of intoxication, NO substitution treatment should be given until the intoxication has resolved and withdrawal signs are manifest. Many substances, for example methadone with alcohol, have an additive effect leading to significant morbidity or mortality. Consideration of whether the detainee is fit for detention is then the priority.

It should be remembered that most individuals are not detained in police custody for a long period, and pharmacological treatment in the form of opiate substitute drugs may therefore not be required. However, for those detained for longer periods, previously prescribed substitution opioid treatment should be continued, if in the HCP's judgement it is safe to do so.

The HCP should recommend reassessment after a specific period depending on the history given by the detainee and the clinical findings. Reassessment of a detainee with a history of heroin use/dependence, for example, would be necessary after 6–8 hours, as heroin has a short half-life compared with methadone. Reassessment must be by a HCP with appropriate expertise and the ability to prescribe or administer, under a patient group direction (PGD), any medication identified as necessary.

For those on substitution pharmacological treatment (e.g. methadone/buprenorphine), in the absence of withdrawal signs, confirmation of OST should be sought from other reliable sources before authorising continuation of treatment.

Where a patient's recent compliance with supervised consumption of methadone or buprenorphine medication in the community can be adequately confirmed, that patient's medication can be used to provide continuity of care (by being collected and administered at the community prescribed daily dose). HCPs in police stations should support this continuity of care.

However, knowledge of the prescribed dose of OST does not absolutely accurately indicate actual consumption, as part or all of the dose may be diverted or not taken. Therefore, the HCP needs to know not only the amount prescribed but also whether the detainee is actually taking the drug.

The decision to prescribe OST and supervise self-administration is the responsibility of the forensic physician or other appropriately trained HCP, even when the drug is collected from the usual clinic or pharmacist. If there is doubt about the daily dose, then the dose can be divided and given every 6–12 hours.

Any forensic physician can prescribe substitution drugs (except for diamorphine, dipipanone and cocaine) for the treatment of dependence, and it may be more convenient to arrange for the prescription to be dispensed at a local pharmacy. However, the regular prescribing doctor and the pharmacist or clinic responsible for dispensing should be

informed, to avoid duplicate dispensing should the detainee be released from custody earlier than previously anticipated.

It should be remembered that if a single dose is prescribed and given by the forensic physician/HCP, a detainee may not be able to pick up subsequent days' doses from the pharmacy on release from detention. This will depend on how their regular prescription has been written. For example, if the individual has to collect their prescription twice weekly, unless the prescriber has appended wording that allows the balance to be supplied if the patient misses the collection day, the pharmacist cannot supply a missed instalment on a subsequent collection day. Therefore, the forensic physician should check with the pharmacy when the individual can collect their next dose and, if necessary, write a new prescription to cover any missed instalments or liaise with the original prescriber to ensure continuation of therapy.

Where it is determined with the person in police custody that continuing their supply of controlled medication from their community pharmacy is most appropriate, it is important to understand responsibilities to communicate effectively and to record decisions and actions taken. Further guidance on the mechanics of arranging for such supply to police custody suites in England is contained in 'Access to supervised doses of opioid substitution for people in police custody.'[74]

Managing those not on substitution treatment or where OST cannot be confirmed

If the detainee is not under current treatment or treatment details cannot be verified but they nevertheless have a clear history of opioid dependence, signs of regular drug use, and objective evidence of withdrawal symptoms and signs, then treatment should be given to alleviate the withdrawal syndrome.

The evidence base for management of heroin dependence consistently indicates that where a need for opioid substitution is identified, and where safe induction on to methadone or on to buprenorphine is possible, either drug (methadone or buprenorphine) prescribed is the most appropriate intervention for stabilisation and management of the detainee[75] (see Appendix I).

However, there is limited published evidence to aid choice of opioid substitute to manage dependence and withdrawal symptoms and signs that is specific for the context of police custody. In this context clinicians have to take into account the circumstances for the individual, the possibility of rapid transfer out of the police cells to courts, release or prison, risks associated with transportation of the individual between different custodial settings, and the clinician's ability to review, identify and manage any emerging intoxication or emerging withdrawal associated with treatment with a substitute opioid.

It is essential that for those detainees where it is confirmed that they are currently receiving supervised methadone/buprenorphine substitution therapy, and with all caveats outlined above, this should be continued.

74 Public Health England. Access to supervised doses of opioid substitution for people in police custody 2015 https://psnc.org.uk/sheffield-lpc/wp-content/uploads/sites/79/2013/06/access-to-supervised-opioids-for-people-in-police-custody.pdf Accessed 8/11/2019

75 Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health

For detainees where it is not possible to confirm the OST or they are suffering from opiate withdrawal it is important for clinicians to provide treatment to minimise the emergence of opioid withdrawal in the unique context of police custody.

Though with little research evidence, the common practice of experienced clinicians in police custody is to use non-opioid symptomatic medication or dihydrocodeine.[76,77] Dihydrocodeine tartrate has a short duration of action so need to be given several times a day (every 4–6 hours). These drugs have a half-life of 3.5–4.5 hours and reach a peak concentration after 1.5–2 hours. Dihydrocodeine has perceived safety advantages in short-term use, being a lower potency opioid agonist with a short half-life, with a consequent reduced likelihood of accidental dose accumulation and of overdose.

It must be remembered (as with all substitute opioid prescribing) that these drugs are potentially toxic, and the dose should be titrated against withdrawal symptoms and signs. Dihydrocodeine at a dose of 60–90mg (or sometimes greater) three or four times a day may be required to alleviate and manage withdrawal symptoms and signs. The decision as to the necessity and timing of any reassessment is the HCP's responsibility and should be based on the severity of dependence and other aspects of the clinical examination.

Dihydrocodeine is not licensed for the treatment of opiate withdrawal and should not be routinely used for managing withdrawal in the community. There is however extensive experience of using dihydrocodeine in the unique circumstances of the police custodial environment. It is essential that clinicians working in this setting and using dihydrocodeine off-licence to treat opiate withdrawal have the competencies to do so (see Appendix A).

Regular assessment is essential to ensure that the dose is adequate to avoid withdrawal, adjusting the dose to the observed symptoms and signs. The decision as to the necessity and timing of any reassessment is the responsibility of the HCP and should be based on the severity of dependence and the clinical findings. Adequate relief of withdrawal symptoms is essential in good care and in fitness to be detained and interviewed. All medication provided to the detainee, or left with the police staff for later self-administration by the detainee, needs to be recorded on the clinical notes and police computerised records.

PGDs need to reflect the potential higher doses of dihydrocodeine required in the treatment of opioid dependence to adequately manage withdrawal symptoms and signs. Any HCPs providing medication by PGD must review the detainee prior to providing this treatment:

> HCPs who supply or administer medicines under a PGD can only do so if they belong to one of the approved classes of HCP designated in writing by or on behalf of the authorising person (Human Medicines Regulations 2012) and identified as named individuals. It follows that delegation to another person of all or part of the process stipulated in a PGD (in effect, deputising for another HCP to carry out part of the practice), from the assessment of the patient through to the act of supply or administration, is not allowed.[78]

76 Stark MM., Gregory M. The clinical management of substance misusers in police custody – a survey of current practice. Journal of Clinical Forensic Medicine 2005; 12: 199-204

77 Robertson JR., Raab G., Bruce M., McKenzie JS., Storkey HR. Addressing the efficacy of dihydrocodeine versus methadone as an alternative maintenance treatment for opiate dependence: a randomized controlled trial. Addiction 101, 1752-1759, 2006

78 FFLM. Recommendations – Safe and Secure Administration of Medication in Police Custody, 2016 https://www.fflm.ac.uk/wp-content/uploads/2016/08/Safe-and-Secure-Administration-of-Medication-in-Police-Custody-July-2016.pdf Accessed 8/11/2019

Patients who have been prescribed dihydrocodeine who are due to leave police custody, particularly those transferring to court and to prison, need consideration of the limitations of dihydrocodeine in these circumstances, when its lower potency and short duration of action could contribute to the patient becoming unstable during transfer, and displaying severe symptoms and signs of withdrawal if not adequately or promptly treated.

Actions to help mitigate the risks include:

- timing of doses prior to any planned transfer (and possible review prior to transfer)
- giving clear advice to the patient about duration of the effects of their medication
- providing appropriate information to the custody officer
- ensuring the recorded information provided for prison healthcare staff gives clear doses and timing.

Some patients will be released back into the community from police custody after receipt of dihydrocodeine or non-opioid symptomatic treatments for withdrawal. It is important to discuss carefully with these patients the management of their risks and the treatment options available to them. Any information on prescribing (either dihydrocodeine or another opioid) should be communicated to drug services, if the person was already prescribed from the drug service, or if referrals are made, for example to drug services or to the GP.

Tramadol

Tramadol is a widely prescribed analgesic of the 'synthetic opiate' class controlled as a Class C drug under the Misuse of Drugs Act 1971. This drug has become highly abused, causing more deaths in Northern Ireland in 2015 than any other drug.[79] Convulsions, specifically, are common in overdose. Naloxone may have an inconsistent response in suspected overdose with a potential risk of convulsions.

Tramadol is not suitable as a substitute in opioid-dependent patients. Although it is an opioid agonist, tramadol cannot suppress morphine withdrawal symptoms. Tramadol has also been implicated in Serotonin Syndrome when combined with serotonin-boosting antidepressants, such as citalopram, fluoxetine, and monoamine oxidase inhibitors (MAOIs) (see section 3.19).

Fentanyl

Fentanyls have recently and increasingly been implicated in opioid-related deaths.[80] As a medicine fentanyl has analgesic and sedative effects and it is used in the management of severe pain and in anaesthesia. It is available in a number of formulations. Misuse of fentanyl medications is not new but there has been an increase in the availability of illicit fentanyl, and an increasingly diverse range of illicit fentanyl analogues, some very potent.

79 Randall C, Crane J. Tramadol deaths in Northern Ireland: a review of cases from 1996 to 2012. J Forensic Leg Med. 2014 Mar; 23: 32-6.

80 ACMD 2016 Reducing Opioid-related deaths https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf Accessed 8/11/2019

There are different formulations: powders, liquids (in nasal sprays, e-cigs) and tablets. Overdose may result in vomiting, sedation, respiratory depression, and death. The high potency of fentanyl means only a low dose is required for effect. There are increased toxic effects, especially when mixed with other central nervous system depressant drugs, and where there is lack of tolerance. Injection of the contents of the fentanyl medicinal patch may occur.

3.3 Alcohol

Symptoms and signs of intoxication

Alcohol acts as a central nervous system (CNS) depressant. In small doses it affects cortical function but in larger doses it may depress medullary function. The clinical effects of alcohol vary considerably between different individuals, depending on their degree of tolerance.

The diagnosis of alcohol intoxication requires that there must have been recent ingestion of alcohol associated with behavioural or psychological changes and the necessary physical signs, along with the proviso that there are no medical conditions that may account for the condition.

Signs of intoxication:

- disinhibition/labile effect
- sedation
- concentration/attention/memory difficulties
- smell of alcoholic liquor
- tachycardia
- hypertension
- flushing
- nystagmus
- pupil size – may be normal or dilated
- sluggish pupillary reaction to light
- poor co-ordination
- Romberg's positive
- ataxia.

Signs of severe intoxication/overdose:

- alteration in mental state
- hypoglycaemia
- respiratory depression
- CNS depression (coma with pin-point pupils)
- depressed or absent corneal, gag or deep tendon reflexes
- CVS depression.

Severely intoxicated detainees, in particular those who are unable to walk unaided or speak to provide a coherent history, should not be managed in custody and must be transferred to hospital for observation and treatment.

Care should be taken to exclude concurrent medical problems in alcohol-intoxicated detainees, in particular head injuries and hypoglycaemia, which may complicate the picture (see Table 3.3).

Table 3.3 - Differential Diagnosis of Alcohol Intoxication[81]

Differential Diagnosis	Clinical Marker(s)
Other Intoxicants	–
Drugs of abuse Cocaine/Amphetamines-type stimulants Opiates Prescribed medication: benzodiazepines, anti-psychotic medications	Personal history of use Information from police (National computer database) Drug possession/drug paraphernalia identified during police search (e.g. citric acid) Disproportionate mental stimulation Injection marks, excessive sedation Medications found/prescriptions, hospital appointment cards
Infections	History/Examination for source of infection Pyrexia Meningism
Head injury	History of head injury, particularly at time of arrest Visible head injury Localising neurological signs
Metabolic causes Hypoglycaemia Hyperglycaemia / diabetic ketosis Other electrolyte disturbance Hepatic encephalopathy	MEDIC ALERT bracelets Blood glucose measurement Blood glucose measurement/urinalysis for ketonuria Diuretic use, other comorbid conditions (cancer, heart failure etc) Signs of chronic liver disease, ascites
Other Seizures/post-ictal states Acute psychiatric conditions Hypoxia/hypercapnia	– Confusion/disorientation Abnormal mental state examination Pulse oximetry

A breath alcohol measuring device may be a tool to assess the alcohol concentration and facilitate diagnosis and treatment, but any decision regarding whether a suspect who has been drinking alcohol is fit for interview is best made on a full assessment, rather than on arbitrarily defined 'safe' breath alcohol levels.[82]

81 Stark MM., Holmes J. The Alcohol-Intoxicated Person in Custody: Diagnosis, Differential Diagnosis and Management. Acad Forensic Pathol, 2014, 4 (2), 198-205

82 Rogers, D. J., Stark, M M & Howitt, J. B. (1995) The use of an alcometer in clinical forensic practice. Journal of Clinical Forensic Medicine, **2**, 177–183

Symptoms and signs of withdrawal

It is essential that alcohol dependence is recognised in custody; the Alcohol Use Disorders Identification Test (AUDIT)[83] for screening and the Severity of Alcohol Dependence Questionnaire (SADQ) may assist in the diagnosis and measurement of the severity of dependence.[84] In alcohol-dependent individuals, withdrawal symptoms may begin 6–8 hours after the last consumption of alcohol and before the blood alcohol level reaches zero. It should always be remembered that alcohol use may not be disclosed, and that alcohol withdrawal may mimic other withdrawal syndromes.

Table 3.4 Symptoms and signs of alcohol withdrawal

Uncomplicated	Complicated
Agitation Mild tremor Sweating Fever Tachycardia Hypertension	Seizures Hallucinations Confusion Disorientation Aggressive behaviours Delirium tremens

Treatment of withdrawal

Withdrawal from alcohol in police custody can pose a serious threat to the individual's health, with increased mortality related to delirium tremens (DT), both treated and particularly untreated DT. An attempt should be made to assess the degree of dependence and initiate early treatment to avoid the complications of withdrawal, such as convulsions and DT. Detainees at high risk, especially those with a history of severe withdrawal with seizures or previous DT, may require admission to hospital for medically assisted alcohol withdrawal.[85] Those who have severe alcohol use disorder may be at risk of Wernicke's encephalopathy, a triad of confusion, ataxia, and nystagmus that may be irreversible. They require urgent hospital care with parenteral thiamine. A high index of suspicion is required to diagnose Wernicke's encephalopathy as the triad is only present in about 10% of those with the disorder.

Benzodiazepines, for example chlordiazepoxide or diazepam, are the treatments of choice.[86] If the detainee is unable to take oral medication, transfer to a general hospital for parenteral treatment should be arranged.

There are a number of different regimes for detoxification.[85] A symptom-triggered regimen involves treatment tailored to the person's individual needs, determined by the severity of withdrawal signs and symptoms. The patient is regularly assessed and monitored, using clinical experience and questioning/assessment alone, or with the adjunct of a designated questionnaire, such as the CIWA-Ar. Drug treatment (long acting benzodiazepine) is provided if the patient needs it and treatment is withheld if there are no symptoms of withdrawal. Such a regime may not be possible in police custody, even

83 https://www.gov.uk/government/publications/alcohol-use-screening-tests Accessed 8/11/2019
84 https://www.smartcjs.org.uk/wp-content/uploads/2015/07/SADQ.pdf Accessed 8/11/2019
85 https://www.nice.org.uk/guidance/cg100/chapter/recommendations#medically-assisted-alcohol-withdrawal Accessed 8/11/2019
86 Alcohol-use disorders: diagnosis and management of physical complications Clinical guideline [CG100] Published date: June 2010 Last updated: April 2017 https://www.nice.org.uk/guidance/cg100/chapter/recommendations Accessed 8/11/2019

with embedded staff, because of ongoing workload and the careful need for hourly monitoring at commencement of treatment. Usually in this setting if dependence is noted a fixed and adequate dose regime of a long acting benzodiazepine is prescribed, with higher and extra doses given on regular review. If symptoms continue to be severe, or there is onset of severe complications, hospital treatment is required.

3.4 Benzodiazepines

Symptoms and signs of intoxication

Benzodiazepine intoxication presents with inattentiveness, reduced muscle tone and poor coordination, impaired recall, and eventually disorientation and drowsiness. Large doses may be consumed without producing drowsiness in the presence of tolerance, although effects on anxiety and memory may still be significant.

Benzodiazepine overdose

The symptoms of overdose are mainly an intensification of the therapeutic effects (drowsiness, dysarthria, muscle weakness, profound sleep, hypotension, bradycardia, nystagmus, ataxia) or paradoxical excitation. Paradoxical reactions like restlessness, agitation, irritability, aggressiveness, delusion, rages, nightmares, hallucinations, psychoses, inappropriate behaviour and other adverse behavioural effects are known to occur when using benzodiazepines.[87] In most cases of intoxication observation of vital functions is required.

Extreme overdose

Extreme over-dosage may lead to coma, areflexia, cardio-respiratory depression and apnoea, requiring appropriate countermeasures (ventilation, cardiovascular support). Benzodiazepine respiratory depressant effects are more serious in patients with severe chronic obstructive airways disease. Severe effects in overdose also include rhabdomyolysis and hypothermia.

Management of extreme overdose

Maintain a clear airway and adequate ventilation. Monitor level of consciousness, respiratory rate, pulse oximetry and blood pressure in symptomatic patients and arrange for urgent transport to hospital. Flumazenil is not recommended in the pre-hospital care environment of police custody.

87 https://www.medicines.org.uk/emc/product/4522 Accessed 8/11/2019

Benzodiazepine withdrawal syndrome

Sudden cessation of benzodiazepines in dependent individuals can lead to a recognised withdrawal state with anxiety symptoms, disordered perceptions and major complications including psychosis and seizures.

Table 3.3 Benzodiazepine withdrawal syndrome		
Anxiety symptoms	**Disordered perceptions**	**Major complications**
Anxiety Insomnia	Feelings of unreality derealisation depersonalisation	Psychosis
Nausea	Abnormal body sensations (numbing and tingling of extremities)	Epileptiform seizures
Headache	Abnormal sensation of movement	
Sweating	Hypersensitivity to stimuli (light, noise and physical contact)	
Tremor		
Confusion and irritability		

The withdrawal syndrome usually develops within 2 days, and the risk of seizures during short-term detention is low.

In recent years, the regular misuse of very large amounts of benzodiazepines, orally or intravenously, has been more prevalent, especially in combination with opioid and/or alcohol misuse. There are marked similarities to alcohol withdrawal symptoms and signs, and careful history-taking and examination are required. However, the use of benzodiazepines is often in binges, and even if huge doses are taken dependence is not common, and may not need pharmacological treatment.

Clonazepam is a second-line treatment for epilepsy, and detainees may say that they are receiving the drug for this purpose. If possible, the diagnosis of epilepsy should be confirmed before prescribing further clonazepam.

Treatment of withdrawal

Once intoxication has been excluded, and likely dependence has been confirmed benzodiazepine withdrawal can be treated. Treatment is aimed at alleviating symptoms and preventing the major complications of seizure and psychosis.

Although any benzodiazepine will control the withdrawal syndrome, a long-acting one is preferable. Diazepam has several advantages because of its relatively long half-life and availability in many different strengths of tablet. A dose of diazepam 10mg three times a day should be adequate to prevent withdrawal seizures, but uncommonly greater amounts may be required if severe symptoms are evident. If treatment has been given in police custody then the details of that treatment should be communicated on transfer to other healthcare facilities or prison.

An anti-epileptic drug should be considered only if the individual is already receiving such drugs, or if there is a history of seizures due to epilepsy or a structural brain lesion.

3.5 Pregabalin and gabapentin

There have been increasing reports of the misuse of both pregabalin and gabapentin in recent years. Pregabalin has been especially reported as a drug of abuse in Belfast (Northern Ireland) where it has the street name 'Bud' (Budweiser).The Advisory Council for the Misuse of Drugs (ACMD) suggested in 2016 that these drugs be regulated under the Misuse of Drugs Act 1971 and Regulations 2001.[88] From April 2019 gabapentin and pregabalin were reclassified as Schedule 3 controlled drugs under the Misuse of Drugs Regulations 2001, and Class C of the Misuse of Drugs Act 1971. They will be exempted from the safe custody requirements under the Misuse of Drugs (Safe Custody) Regulations 1973.[89]

These drugs are indicated for the treatment of epilepsy, generalized anxiety disorder, for the relief of neuropathic pain, postherpetic neuralgia, diabetic peripheral neuropathy, fibromyalgia, and as an adjunct therapy for partial seizures.

Gabapentin and pregabalin are associated with significant euphoric effects. Individuals misusing them variably describe improved sociability, euphoria, relaxation and a sense of calm. Gabapentin, and especially pregabalin, have the propensity to cause depression of the central nervous system, resulting in drowsiness, sedation, respiratory depression, and at the extreme, death. The majority of related deaths are in those who are also taking opioids.

Pregabalin can be taken orally or 'snorted' and there is anecdotal evidence of pregabalin being mixed with cocaine for such delivery. Both gabapentin and pregabalin have significant adverse effects on the central nervous system, which are additive when used with other centrally acting drugs, particularly opioids. Morphine can increase the bioavailability of gabapentin. Caution is needed when these drugs are co-prescribed because of increased risk of mortality, so the doses of both drugs may need to be modified. Similarly, pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone.

Withdrawal effects

The following effects have been associated with (especially) pregabalin withdrawal: insomnia, headache, nausea, anxiety, diarrhoea, flu-like illness, convulsions, nervousness, depression, pain, hyperhidrosis and dizziness suggestive of physical dependence.

Detainees receiving prescribed pregabalin or gabapentin should have their treatment continued whilst in police custody as long as it is clinically safe to do so. Detainees misusing these drugs should be treated symptomatically.

88 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/491854/ACMD_Advice_-_Pregabalin_and_gabapentin.pdf Accessed 8/11/2019

89 https://www.england.nhs.uk/publication/rescheduling-of-gabapentin-and-pregabalin-as-schedule-3-controlled-drugs/ Accessed 8/11/2019

3.6 Stimulants

Problem cocaine users include users of powder cocaine or crack cocaine. Powder cocaine users commonly also use alcohol problematically. Many heroin users may also use crack cocaine as an integral part of their drug-using repertoire. Amphetamine and methamphetamine users may seek treatment (with methamphetamine being increasingly seen among men who have sex with men and are involved in 'chemsex'[90]).

Intoxication

Effects of intoxication with stimulants such as cocaine and amphetamine include, at low doses, euphoria, insomnia, dry mouth, hyperthermia, tachycardia, hypertension, increased respiration, sweating and dilated pupils. With increasing doses, irritability, impulsiveness, aggressiveness, agitated delirium, paranoia, delusions and seizures may occur.

Over the last few years the duration of action of amphetamine-type stimulants appears to have increased and it is not uncommon for a detainee to remain intoxicated for prolonged periods (18 hours) whilst in custody. This may be frustrating to custody staff as these detainees are often not unwell enough to warrant transfer to hospital but remain in the custody suite in a 'hyper' intoxicated state not being fit to be dealt with until very near the expiry of their custody clock.

Users of cocaine or amphetamines may present with Acute Behavioural Disturbance (ABD).

ABD is not a diagnosis as such.[91] It is the 'umbrella' term for a number of conditions, hence the importance of considering the differential diagnosis. It may occur secondary to substance misuse (both intoxication and withdrawal), physical illness (such as post head injury, hypoglycaemia) and psychiatric conditions (including psychotic and personality disorders); excited delirium syndrome (ExDS) is the most extreme and life-threatening, and has been defined as 'a state of extreme mental and physiological excitement, characterised by extreme agitation, hyperthermia, hostility, exceptional strength and endurance without apparent fatigue'.[92]

Often individuals are highly agitated and paranoid, die suddenly, and in some cases have been restrained in police custody because of excited behaviour shortly before death. Patient restraint time in suspected ABD should be kept to an absolute minimum – the degree of restraint used must be justifiable, reasonable, and proportional to the situation.[93]

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90 Chemsex is used in the UK to describe intentional sex under the influence of psychoactive drugs (mephedrone, γ-hydroxybutyrate (GHB), γ-butyrolactone (GBL), and crystallised methamphetamine) mostly among men who have sex with men

91 FFLM 2019 Acute behavioural disturbance: guidelines on management in police custody. https://fflm.ac.uk/publications/guidelines-for-the-management-of-excited-deliriumacute-behavioural-disturbance/ Accessed 8/11/2019

92 Wetli CV, Fishbain DA (1985) Cocaine-induced psychosis and sudden death in recreational cocaine users. *Journal of Forensic Sciences* 30: 873–80.

93 RCEM 2016 Best Practice Guideline. Guidelines for the Management of Excited Delirium / Acute Behavioural Disturbance (ABD) https://www.rcem.ac.uk/docs/College%20Guidelines/5p.%20RCEM%20guidelines%20for%20management%20of%20Acute%20Behavioural%20Disturbance%20(May%202016).pdf Accessed 8/11/2019

Cases of suspected ABD should be taken directly to the Emergency Department (ED) of the local hospital.

If a detainee exhibits any of the following signs, **it is a time-critical medical emergency**[91]**:**

- Tactile hyperthermia (hot to touch)
- Constant or near constant physical activity
- Extreme agitation/aggression

If the detainee is taken to custody HCPs need to be aware of the guidance issued by the FFLM and RCEM and should take the following preliminary steps:[93,95]

- endeavour to establish the underlying diagnosis behind the ABD before making any treatment decisions; however investigation should not delay the management of the condition, e.g. calling for an emergency ambulance; it is essential to try and establish the cause concurrently with treatment

- employ appropriate verbal and non-verbal techniques when attempting to communicate with the detainee, and attempt de-escalation where possible

- consider oral tranquillisation with lorazepam.

The HCP should contact a senior clinician in the receiving hospital and appraise them of the situation. It is essential that the HCP stays with the patient and personally hands over to ambulance staff. It may be prudent to have resuscitation equipment including a defibrillator at hand whilst awaiting the ambulance.

Withdrawal from stimulants

Stimulants such as amphetamines, ecstasy and cocaine can cause psychological dependence but do not produce a major physical withdrawal syndrome.

Withdrawal from such drugs is best achieved by discontinuation. Insomnia and depression may require symptomatic treatment and close supervision while in custody, in conjunction with assessment and management of suicide risk. There is no indication in the British National Formulary for the use of CNS stimulant drugs for the treatment of substance misuse.

3.7 Hallucinogens

Hallucinogenic drugs such as lysergic acid diethylamide (LSD) do not cause physiological dependence. They may be discontinued abruptly. Subsequent psychological disturbances (such as anxiety) may require treatment. LSD is a Class A controlled drug under the Misuse of Drugs Act 1971 and its possession is illegal.

LSD is usually taken orally and results in sympathomimetic effects such as tachycardia, hypertension, pyrexia and dilated pupils within 10–30 minutes, with psychological effects

after 30–60 minutes. There is a recovery period of up to 12 hours, during which there may be periods of normal perception and cognition alternating with degrees of intoxication that may affect fitness for interview. Emotional lability, euphoria and anxiety, visual and auditory illusions (although true hallucinations can occur) and synaesthesia (a mixing of the sensory input: 'seeing' sounds or 'hearing' smells) may all occur. Polydrug users may use benzodiazepines to alleviate anxiety and panic attacks.

3.8 Volatile substances

Volatile substance misuse is the deliberate inhalation of fumes given off by volatile substances (solvents) in order to achieve intoxication. The smell of solvents may be noticed on the detainee's clothing or breath, and regular users may have nasal sores.

Effects begin within 1 minute and may only last for 15–45 minutes; they are similar to the effects of sedative/hypnotic drug intoxication, resulting in CNS depression and alcohol-like intoxication, although with more perceptual distortions and sometimes frank hallucinations. Tolerance and psychological dependence may develop with regular use.

HCPs are reminded that sudden death is a recognised hazard of volatile substance misuse and may occur during exposure or in the subsequent hours,[94] especially during struggling or arousal. No specific management is required, even after abrupt discontinuation. There is no physical withdrawal syndrome.

Nitrous oxide

Nitrous oxide has widespread legitimate medical, dental and veterinary uses but there has been an increase in recreational use. On inhalation the gas results in a brief period of euphoria. The use of nitrous oxide in combination with alcohol and/or other psychoactive drugs may increase the potential for harm.[95]

94 Shepherd R T (1989) Mechanisms of sudden death associated with volatile substance abuse. Human Toxicology, 8, 287–92.

95 https://www.gov.uk/government/publications/acmd-advice-on-nitrous-oxide-abuse Accessed 8/11/2019

3.9 Cannabis

Cannabis intoxication results in euphoria and psychomotor impairment, with incoordination, dysarthria and ataxia. There may be cognitive impairment and precipitation or aggravation of psychotic states. Mild withdrawal symptoms may occur, with disturbed sleep, irritability and restlessness. No specific treatment is required.

Synthetic cannabinoid receptor agonists (SCRA) are often sold in herbal products such as the smoking mixture 'Spice'. They are the largest group of NPS monitored by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). They act within minutes but last longer than cannabis. Their use has caused severe poisonings and death. Adverse effects include agitation, nausea, tachycardia, as well as more severe effects such as stroke, seizures, heart attack, breakdown of muscle tissue, kidney damage, psychosis, and acute behavioural disturbance. There is an increased risk of the serotonin syndrome.

3.10 Novel psychoactive substances (NPS)[96]

Since the last edition of these guidelines there has been a proliferation in the number of novel psychoactive substances (see Table 3.5). NPS are a range of drugs that have been designed to mimic established illicit drugs such as cannabis, cocaine, ecstasy and LSD.

Table 3.5 Novel Psychoactive Substances	
Depressants	GHB, GBL
	Nitrous oxide
	Dissociative drugs e.g. Ketamine Methoxetamine
Stimulants	Cocaine, synthetic cocaine derivatives Piperazines Amphetamine-type substances Methamphetamine MDMA, MDA, PMA, PMMA Mephedrone Ethylphenidate Synthetic cathinones Pipradrols and derivatives
Hallucinogens	Lysergamides LSD Tryptamines Phenethylamines
Emerging drugs	New benzodiazepines
	New synthetic opioids

96 NEPTUNE http://neptune-clinical-guidance.co.uk/ Accessed 8/11/2019 has been developed to improve clinical practice in the management of harms resulting from the use of club drugs and novel psychoactive substances. It is aimed at clinicians working in a range of frontline settings, including drug treatment and recovery services, emergency departments, sexual health services, primary care and mental health services. See clinical guidance document: http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf Accessed 8/11/2019

Given that the chemicals in these drugs are constantly changing, it is possible to receive a very different product from batch to batch, even if the packaging and name are the same. Equally, due to the mechanism of production, dosage of active drug can vary significantly between samples taken from the same package.

Often referred to in the past as 'legal highs', these drugs were rapidly brought under legislative control if a certain level of harm was recognised. NPS have been banned collectively in the UK under the Psychoactive Substances Act which received Royal Assent on 28 January 2016 and came into force on 26 May 2016.

Serotonin Syndrome is associated with the use of NPS, especially when taken with antidepressant medications (see section 3.18).

With so many NPS available, often of variable content, unknown individual tolerance, and intentional and unintentional polydrug use, HCPs should have a low threshold for early referral to an emergency department.

Up-to-date specific drug information on new substances is available from the National Poisons Information Service (www.toxbase.org). The EMCDDA is monitoring the availability and possible health impact of known and emerging substances.[97]

Public Health England have a website for HCPs to report cases of suspected harm with illicit substances: https://report-illicit-drug-reaction.phe.gov.uk/

Many of these new psychoactive substances may influence a detainee's fitness for interview. After being in a stimulated/agitated state for a prolonged period, a detainee may require rest, which could affect the legal aspects of the required period of detention.

3.11 Diversion and illicit supply of medicines (DISM)[98]

The diversion and illicit supply of medicines is an increasing problem. Most commonly misused are opioids and benzodiazepines; increasingly gabapentin and pregabalin; drugs prescribed for ADHD; codeine in OTC preparations; Z-drugs; antihistamines e.g. promethazine; anti-depressants, e.g. mirtazapine; and anti-psychotics, e.g. quetiapine.

Antipsychotic drugs are commonly prescribed and are often used as part of a 'polypharmacy regimen'. These drugs have been associated with 'long QT syndrome' and care should be taken when co-prescribing any other medication which may interact and potentiate sudden death. Quetiapine (Seroquel™ or 'squirrel') does now appear to be a drug of abuse and is known to cause a long QT interval, especially when combined with other antipsychotic drugs.

97 EMCDDA. Fentanils and synthetic cannabinoids: driving greater complexity into the drug situation — an update from the EU Early Warning System. June 2018 http://www.emcdda.europa.eu/publications/rapid-communications/fentanils-and-synthetic-cannabinoids-ews-update_en Accessed 8/11/2019

98 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/580296/Meds_report-_final_report_15_December_LU__2_.pdf Accessed 8/11/2019

3.12 Alkyl nitrites – 'poppers'

Alkyl nitrites are volatile, yellowish, clear liquids that have vasodilatory properties, used as a euphoric relaxant in the dance culture and to relax the anal sphincter and enhance sexual performance. The effect of inhaling the vapour is instantaneous and very short-lived, resulting in a 'rush', but adverse effects such as dizziness, flushing, tachycardia and palpitations, headache, cold sweats and hypotension may occur. It is not illegal to possess these drugs.

There is a dangerous interaction between alkyl nitrites and phosphodiesterase 5 inhibitors (PGE5) (sildenafil, tadalafil, vardenafil, udenafil and avanafil) commonly used for erectile dysfunction and abused in the 'club scene'. As both are potent vasodilators, profound hypotension can occur. PGE5 inhibitors (most commonly sildenafil) are used within the club sex scene as a sexual adjunct and may be used in conjunction with 'Poppers'. Deaths have been reported.

3.13 Ecstasy

Ecstasy (3,4-methylenedioxymethamphetamine) is used orally as a recreational drug in the dance culture or 'rave' scene for its central stimulant and psychedelic effects. Adverse effects such as a polydipsia, hyponatraemia, and catatonic stupor have been reported. Other adverse effects have been described, including flashbacks and psychosis, hyperthermia, coagulopathy, rhabdomyolysis, and cardiovascular complications resulting in death. Ecstasy is a Class A drug under Schedule 1 of the Misuse of Drugs Act 1971 (1977 Modification Order) and its possession is illegal.

3.14 Gamma-hydroxybutyrate (GHB) and gamma-butyrolactone (GBL)

GHB is structurally related to gamma-aminobutyric acid (GABA). It is a naturally occurring substance in the human brain and may be a neurotransmitter. Gamma-butyrolactone (GBL) is inactive but is rapidly converted to GHB when ingested. It is available as a colourless, odourless liquid, powder or capsules, taken orally, and rarely injected.

Initial effects include: euphoria, sedation, confusion, agitation and amnesia; nausea, vomiting and diarrhoea; ataxia, seizures, hypotonia and tremor; vertigo and dizziness; bradycardia, hypotension, hypothermia; and coma and respiratory collapse. There is a narrow margin between intoxication and coma. The clinical effects are potentiated by use of other CNS depressants such as alcohol, opioids, benzodiazepines and antipsychotics. Early hospitalisation maybe required.

Dependence may occur rapidly, resulting in a withdrawal syndrome, with wide individual variation, of anxiety, sweating, tachycardia, tremor and eventually delirium (especially in frequent users). Withdrawal should be treated with high-dose benzodiazepines and occasional use of baclofen. Both GHB and GBL are now controlled under Class C of the Misuse of Drugs Act 1971.

3.15 Khat

Khat consists of the young leaves of the *Catha edulis* plant. Its main components are cathine and cathinone, with effects similar to those of amphetamine. It is usually chewed for its stimulant effect, resulting in euphoria, increased alertness and anorexia; anxiety and insomnia may occur. Khat is now a Class C drug.

3.16 Ketamine

Ketamine is a commercially available anaesthetic for intravenous and intramuscular use, but it can be found on the street in powder, tablet and liquid form. It can be smoked or taken intranasally ('snorted'), as well as orally, intramuscularly or intravenously. It has analgesic properties; the onset of its effects depends on the route of administration. Ketamine is a prescription-only medicine, controlled under Class C of the Misuse of Drugs Act 1971.

Physical effects may include a cocaine-like rush, hypertension, arrhythmias, nausea and vomiting, slurred speech, nystagmus, lack of coordination, and seizures. Respiratory depression may occur, and this can be a particular problem when ketamine is taken with other respiratory depressant drugs such as benzodiazepines and alcohol.

3.17 Hallucinogenic mushrooms

These mushrooms grow wild in many areas of Europe and the USA, although more commonly they are cultivated, and their use has been increasing. The mushrooms are usually eaten or made into tea. Their effects, due to psilocybin and psilocin, are unpredictable and, as they include nausea and panic attacks, limit their recreational popularity.

3.18 Nicotine

The vast majority of smokers can refrain from smoking for a period, but it should be remembered that the effects of withdrawal from any substance, including nicotine, are likely to be exacerbated by the circumstances of acute enforced detention and may affect the legal process. Many of the features of nicotine withdrawal are indistinguishable from anxiety. Certainly, craving for nicotine can result in dysphoria and threats of self- harm. Nicotine replacement treatment should be available for detainees in police custody.[99]

In most police custody suites the HCP may have little involvement with administration of nicotine replacement therapy, and it will be managed by the custody staff.

99 PHE. HCSCT. ASH. 2016 Joint briefing: Managing nicotine withdrawal in police custody. http://ash.org.uk/information-and-resources/briefings/joint-briefing-managing-nicotine-withdrawal-in-police-custody/ Accessed 8/11/2019

3.19 Serotonin syndrome (SS)

Serotonin syndrome is typically caused by use of two or more serotonergic medications or drugs; it is a predictable consequence of excess serotonin acting on the central nervous system. The degree of symptoms can range from mild to severe, and they include hyperthermia, agitation, hyperreflexia, tremor, sweating, dilated pupils, hypertension and diarrhoea. Complications may include seizure and rhabdomyolysis.

The combination of serotonin-boosting antidepressants, such as citalopram and fluoxetine, with stimulants such as MDMA, cocaine and amphetamines, as well as NPS substances, has been implicated in serotonin syndrome. Additionally other drugs such as tramadol, MAOIs and triptans, as well as the 'herbal preparation' St John's Wort, have been associated with it when combined with antidepressants. This is a serious and potentially fatal condition that warrants admission to hospital when suspected.

3.20 Neuroleptic malignant syndrome

Neuroleptic malignant syndrome (NMS) is a life-threatening reaction that occasionally occurs in response to neuroleptic or antipsychotic medication. Symptoms include high fever, confusion, rigid muscles, variable blood pressure, sweating, and tachycardia.

Complications may include rhabdomyolysis, hyperkalaemia, renal failure, or epileptiform seizures.

Any medications within the family of neuroleptics can cause the condition, though typical antipsychotics appear to have a higher risk than atypicals.

This is a serious, albeit rare, condition with a mortality of about 10%; any individual suspected of suffering from NMS should be referred to hospital without delay.

3.21 Z-drugs: zopiclone, zolpidem, zaleplon

These are non-benzodiazepine hypnotic drugs which act on the benzodiazepine receptors. Acute intoxication cause sedation, slurred speech, loss of coordination; they are relatively safe in overdose unless mixed with other drugs and/or alcohol. They may cause impairment of memory and problems with cognition, and somnambulism, and can result in physical and psychological dependence, with withdrawal effects.

4. Forensic aspects of detainee management

4.1 Fitness for interview[100,101,102]

General considerations

An opinion may be requested of an HCP as to the detainee's fitness for interview. The HCP should ask the custody officer the probable period of detention and the likelihood and timing of any proposed interview. Withdrawal or intoxication may affect a detainee's fitness to be interviewed, and symptoms and signs may vary with time, so a finding of fitness for interview is potentially time-limited. The HCP should ensure that an accurate record is made of the examination conducted, including the reasoning behind their decision regarding fitness for interview.

Definition[103]

A detainee may be at risk in [a police] interview if it is considered that:

- conducting the interview could significantly harm the detainee's physical or mental state;

- anything the detainee says in the interview about their involvement or suspected involvement in the offence about which they are being interviewed might be considered unreliable in subsequent court proceedings because of their physical or mental state.

When HCPs identify risks, they should attempt to quantify the risk (definite, major risk, some risk, no discernible risk).[104] They should also inform the custody officer:

- whether the person's condition is likely to improve
- whether the condition requires or is amenable to treatment
- how long it may take for any improvement to take effect.

100 Stark MM. Rix KJB. Fitness to Be Interviewed & Charged. Chapter 11. In Clinical Forensic Medicine – A Physician's Guide. Ed. Stark MM. Humana Press, Totowa, New Jersey, 2019. Fourth edition. Springer, New York
101 Ventress MA., Rix KJB., Kent JH. Keeping PACE: fitness to be interviewed by the police. Advances in Psychiatric Treatment 2008: 14: 369-381
102 Rix KJB. (2011) Expert Psychiatric Evidence. RCPsych Publications. pp 64 – 72
103 Home Office. Code C Revised. Code of Practice for the detention, treatment and questioning of persons by Police Officers. Annex G. August 2019 https://www.gov.uk/government/publications/pace-code-c-2019 Accessed 21/11/2019
104 Home Office. The report of the Home Office Working Group on Police Surgeons. 2001 Home Office

In assessing whether a detainee should be interviewed, the following must be considered:

- how the detainee's physical or mental state might affect their ability to understand the nature and purpose of the interview, to comprehend what is being asked, and to appreciate the significance of any answers given, and to make rational decisions about whether they want to say anything

- the extent to which the detainee's replies may be affected by their physical or mental condition, rather than representing a rational and accurate explanation of their involvement in the offence

- how the nature of the interview, which could include particularly probing questions, might affect the detainee.

Therefore the HCP must consider the various vulnerability factors that render an individual more likely to provide an unreliable confession. These factors include the personality traits that increase vulnerability – suggestibility, acquiescence and compliance; the health of the individual (physical and mental, including substance use disorders, intoxication, withdrawal states), the likely demand characteristics of the interview, and the totality of the circumstances – (personality/health/interview/totality of the circumstances: PHIT).[105]

Code C Annex G stresses the importance of a functional assessment of the detainee:

> It is essential that HCPs who are consulted consider the functional ability of the detainee rather than relying on a medical diagnosis, e.g. it is possible for a person with severe mental illness to be fit for interview.

The definition of fitness for interview is distinct from the definition of fitness to plead.[106]

HCPs should be aware that the risk of unreliability with regard to those people with substance use disorders may vary; for example, there may be a major risk, with severe intoxication or withdrawal, where the detainee will be unfit for interview, and reassessment may be considered necessary to establish fitness at a later stage.

Alternatively, there may only be some risk of unreliability, where certain precautions may be advised, such as the presence of an appropriate adult for a detainee who has mental health and substance use problems and/or intellectual disabilities. Alcohol- or drug-related memory deficit may also produce temporary or permanent (for example, Korsakoff states) impairment of fitness for interview.

105 Norfolk, G. A. (2001) Fit to be interviewed by the police – an aid to assessment. Medicine, Science and the Law, 41, 5–12.

106 In assessing fitness to plead and fitness to stand trial, medical witnesses are asked whether the accused can participate effectively in the trial process which means having the ability to (1) understand the nature and effect of the charges; (2) decide whether to plead guilty or not; (3) exercise their right to challenge jurors; (4) instruct solicitors and counsel so as to prepare and make a proper defence in their case, which includes understanding the details of the evidence which can reasonably be expected to be given in their case, and advise their solicitor and counsel in relation to that evidence (this applies to their ability to instruct their legal advisers before and/or during his trial; (5) follow the course of the proceedings; and (6) give evidence in their own defence.

False confessions[107,108]

HCPs need to be aware of the various types of false confession, as the HCP's primary concern is to recognise any characteristics that might render the individual vulnerable to providing one, so that adequate safeguards can be put in place.

Suggestibility and compliance have been shown to be relevant to the issue of false confessions; however, their assessment is best performed by a clinical or forensic psychologist.

False confessions have been divided into:

- voluntary
- coerced–compliant or pressured–compliant
- coerced–internalised or pressured–internalised (memory distrust)
- accommodating–compliant[109]
- coerced–reactive.[110]

A voluntary false confession is made without any external pressure from the police and may occur for a number of reasons, such as a morbid desire for notoriety.

A coerced–compliant false confession results from the pressure of the police interview or custody. The suspect gives in to the demands and pressure of the interviewers for some immediate gain, such as being allowed to go home. The suspect may be preoccupied with escape from a stressful situation, while giving little attention to the potentially serious long-term implications of making a false confession. Those dependent on substances are at risk of this type of false confession, where they are fully aware of not having committed the crime but will confess in an attempt to escape from an intolerable situation.

A coerced–internalised false confession happens when the suspect comes to believe, at least temporarily, that they may have committed the crime of which they are accused. Suspects may do this even though they have no actual memory of committing the crime. A history of alcohol and drug misuse may lead to a coerced–internalised false confession, where people come to distrust their own memory or have frank memory impairment (temporary or permanent) and are suggestible to external cues. Comorbid severe mental illness can also lead to this type of confession.

An accommodating–compliant false confession is made by people for whom acquiescing with the police is more important than contradicting police assertions about what has happened. In such circumstances, a false confession is borne out of a strong need for approval and to be liked.

107 Kassin, S. M. & Wrightsman, L. S. (1985) The Psychology of Evidence and Trial Procedure. Sage Publications, London

108 Gudjonsson GH. (2018) The Psychology of False Confessions. Forty Years of Science and Practice. John Wiley & Sons Ltd, West Sussex

109 Wolchover, D. & Heaton-Armstrong, A. (1996) *On Confession Evidence.* Sweet & Maxwell, London

110 McCann JT. (1998) A conceptual framework for identifying various types of confessions. Behavioural sciences and the Law, 16, 441-453

A coerced–reactive type of false confession results from pressure by persons other than police officers, such as family, friends and peers. This type is likely to involve a close emotional relationship between the false confessor and the coercer; it should be conceptualised separately from police-coerced confession.

The possible impact of substance use withdrawal states on the reliability of a confession

Vulnerability factors

Many confessions given in withdrawal states are reliable, and later attempts at retraction, coupled often with allegations of police malpractice, are properly dismissed by judge and jury. However, a person who is suffering from alcohol or drug withdrawal must be seen in some ways as especially vulnerable to giving a false confession.

HCPs should be aware of possible vulnerability factors. Detainees often believe that compliance will result in early release and charges being dropped or altered, and that stubbornness, on the other hand, will lead to further detention. There may be certain factors about which the HCP can do something, for example offering brief intervention/counselling, or reassurance that if detained for any length of time in the police station, they will have access to a HCP who can provide effective treatment to alleviate withdrawal symptoms.

It should be noted that drug withdrawal states may markedly affect levels of anxiety and prevailing mood, which in turn may affect the detainee's performance.

In assessing the likely impact of any vulnerability factors on a detainee's fitness for interview, the HCP needs to consider the likely demand characteristics of the interview; the perceived seriousness of the alleged offence seems to be the most important factor in determining how well a person will withstand the demands of an interrogation.

It is still important to recognise that an admission by a detainee to being dependent on drugs perhaps invites the obvious line of questioning by police officers as to how the individual finances their habit. Furthermore, any admission of involvement with an illicit market may later be brought up by the prosecution when cross-examining the accused in court, and the jury may well regard 'addiction' as a taint, bearing directly and negatively on credibility. Thus, the very fact of being an 'addict' may, in itself, add a further element of vulnerability.

The general impact of withdrawal on the mental and physical state of the accused

Individuals who are undergoing questioning are engaged essentially in an adversarial encounter, in which they are trying to retain coherence of their story and the integrity of their defence, particularly when questioning is carried out by people who are skilled in interview techniques. It is self-evident that the physical and mental distress occasioned by substance withdrawal may, at times, handicap a person who is subjected to this rather threatening and difficult experience.

Healthcare professionals and the treatment of withdrawal

HCPs deciding on treatment must at times be influenced by an awareness that if the accused person is interviewed after having been given therapeutic drugs, it may later be argued that the treatment itself had a bearing on fitness to undergo questioning and the admissibility of a confession. Continuing substitution therapy in police custody that the detainee has been receiving in the community is unlikely to influence fitness for interview. However, when substitution therapy is initiated in custody, or when symptomatic treatment alone is provided, the HCP may well need to assess the impact of the treatment before an interview takes place and, if it be so, explain to the court why they were of the opinion that the effects of the prescribed drug would not have a significant effect on fitness to be interviewed.

Symptoms and signs of mild opioid withdrawal may be no barrier to interview, whereas severe withdrawal may render an addict unfit to be interviewed until the peak of withdrawal subsides after 2–3 days or is brought under control with OST (opioid substitution treatment).

The Court of Appeal (Criminal Division) in R v Crampton[111] has ruled that the mere fact that an addict is withdrawing and might have a motive for confession does not necessarily make the confession unreliable. Whether an addict is fit to be interviewed, in the sense that his or her answers can be relied on as being true, is a matter for those present at the time. Considerable weight is likely to be given to the evidence provided by the HCP. However, the admissibility of any statement will be decided in court by the judge and its credibility decided by the jury.

Withdrawal from alcohol and other sedative/hypnotic drugs can be very severe and distressing, with a risk of delirium tremens and convulsions. Fitness to be interviewed may be seriously impaired and the detainee may first need to be stabilised on sedative medication, preferably a long-acting drug such as diazepam. Their mental state will then need re-examination to assess their fitness for interview. Polysubstance misuse, which is increasingly common, will complicate matters further, particularly where drugs and alcohol have been taken.

When the detainee is considered fit to be interviewed the HCP should, where possible, provide the custody officer with an estimate of how long the fitness is likely to last. In some cases, particularly with long interviews, the HCP may consider it prudent to recommend re-examination following the interview.

111 R. v. Crampton Court of Appeal (Criminal Division) (1990) The Times Law Report, 22 November 1990

The possible effect of intoxication related to substances on the validity of a confession

In practice, a problem due directly to intoxication probably arises less often than issues relating to withdrawal. If an individual is obviously under the influence of alcohol or drugs when brought into the police station, the police will usually wait until the intoxication has cleared before commencing questioning.

However NPS, in particular hallucinogenic substances, may give rise to difficulties in this respect. For example, the mental state may fluctuate in the recovery stages of a lysergic acid diethylamide (LSD) experience and, although the apprehension and distraction that this causes may not be immediately evident to onlookers, it may have a bearing on suggestibility and resistance to questioning. HCPs should be aware of this possibility and be prepared to advise the police accordingly.

Intoxication may present with subtle effects of drug use not amounting to obvious impairment of consciousness. For example, benzodiazepines may have effects on short-term recall, vigilance and self-monitoring; stimulants on aggression and inhibition; and cannabis on memory, perception and concentration. If there is doubt, then reassessment is recommended after an appropriate interval.

4.2 Intimate searches[112]

An intimate search consists of the physical examination of a person's body orifices other than the mouth. The Police and Criminal Evidence Act 1984 provides grounds under which an intimate search for weapons or drugs may be carried out in England, Wales and Northern Ireland: such a search requires the authorisation of a police officer of the rank of inspector or above, who has reasonable grounds for believing that the person has concealed on themselves:

- anything which they could and might use to cause physical injury to themselves or others at the stations; or
- a Class A drug which they intended to supply to others or to export.

The Faculty of Forensic and Legal Medicine of the Royal College of Physicians and the British Medical Association have issued comprehensive guidelines for doctors asked to perform intimate body searches.[113] (see flow chart Figure 2). An intimate search should be performed by a HCP, i.e. a registered medical practitioner or registered nurse.

In summary, the search for drugs must be carried out at a hospital or other medical premises (not a police station) by a suitably qualified person (a registered medical practitioner or registered nurse). The responsibility for performing the examination lies with

112 Home Office. Code C Revised. Code of Practice for the detention, treatment and questioning of persons by Police Officers. Annex A. Intimate and strip searches. August 2019 https://www.gov.uk/government/publications/pace-code-c-2019 Accessed 21/11/2019

113 FFLM & BMA. Recommendations for healthcare professionals asked to perform intimate body searches. September 2017 https://fflm.ac.uk/wp-content/uploads/2017/10/Recommendations-HCPs-Intimate-Body-Searches-September-2017.pdf Accessed 8/11/2019

the forensic physician/nurse and not the hospital doctor. Permission to use hospital accommodation should be sought from the senior medical/nursing staff at the hospital (in an emergency department) or other medical premises concerned. It is recommended that an emergency department with full resuscitation facilities is used because of the potential dangers involved.

It is essential that the doctor/nurse attends the detainee and discusses the police request for an intimate search in detail. The doctor or nurse must have obtained the detainee's fully informed consent to this examination (see Section 2.2.5 in relation to children). A detainee's competence to make a decision may be affected by illness, fear, fatigue, distress, or by the effects of alcohol or drugs. The doctor or nurse has an important role to play in ensuring that whatever decision the individual makes is based on accurate information about the options and possible consequences, including the health risks, if any, of refusing the search; for example, the risk that a package of concealed drugs might split, resulting in an overdose.

The doctor or nurse will be guided by the authorities as to which orifice(s) to search. It is essential that the doctor or nurse has the appropriate knowledge and skills and is competent to perform the required clinical examination. Any of the following orifices may be used to conceal drugs/weapons and should be examined in the following manner:[114]

- mouth: visual inspection with light source
- nostrils: visual inspection with auroscope
- ears: visual inspection with auroscope
- umbilicus: visual inspection with light source
- foreskin: visual inspection with light source
- rectum: gentle digital exploration followed, if necessary, by proctoscopy
- vagina: gentle digital exploration followed, if necessary, by insertion of speculum and inspection of the vaginal fornices.

In Scotland[115] if, in the interests of justice and to obtain evidence, it is necessary to carry out an intimate search of natural body orifices of (a) a person arrested, (b) a person detained under section 14 of the Criminal Procedure (Scotland) Act 1995, or (c) a person detained at a police office for the purposes of search authorised by statute, then the search may lawfully take place under the authority of a Sheriff's warrant. Where a warrant is obtained for this purpose, the search must be carried out by a forensic physician in a facility with full resuscitation facilities. Notwithstanding this, if an individual declines to consent, then a doctor should not proceed with the intimate examination. A police officer of the same gender as the prisoner must be present to corroborate the search. Ideally, a chaperone should also be present in addition to the police officer.

114 Stark M.M. (2016) Body Cavity Searches: Practical Issues and Consent. In: Payne-James J. and Byard R.W. (eds.) Encyclopedia of Forensic and Legal Medicine, 2nd edition, Vol. 1, pp. 433-436. Oxford: Elsevier.

115 Police Scotland & NHS Scotland. National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care. Management Guidelines for Persons Suspected of Having Drug Concealed Internally. Version 2, June 2015 http://www.knowledge.scot.nhs.uk/media/10840614/national%20guidance%20on%20the%20deliveryof%20police%20care%20healthcare%20and%20forensic%20medical%20services%20v2.0.pdf Accessed 8/11/2019

4.3 Management of detainees suspected of having drugs concealed internally

It is essential that clear and consistent terminology is used in relation to the clinical management of persons suspected of having drugs concealed internally.[116]

Body stuffers (also known as swallowers/contact-precipitated concealers) is a term commonly used to describe people who swallow illicit drugs (usually in a hurry) to avoid being found with the drugs in their possession by (police) authorities. The substance may be swallowed loose, or wrapped in cling-film, often not very securely. As a result of poor packaging leakage may occur in the hours following ingestion, dependent on digestive processes.

If police officers know or suspect that a detainee has swallowed or packed drugs, either for the purpose of trafficking or to avoid imminent arrest or detention by the police, they must treat the person as being in need of urgent medical attention and transfer them straight to hospital.[117]

A review of the limited literature on the subject provides evidence to suggest that a blanket policy of observation for only 6 hours is insufficient for the asymptomatic cocaine body stuffer.[118]

Body pushers are those who insert drugs into either their vagina or rectum, also to avoid being found in possession of them. Drugs inserted into the vagina or rectum are less likely to result in significant symptoms, but again the symptoms and signs that occur will dependent on the integrity of the packaging.

Body packers ('drug couriers' or 'surgical mules') is the term commonly used to describe people who swallow packets of illicit drugs or put them into body orifices (using condoms or other containers, often purposely designed to escape detection) as they pass through customs checks. The packets are intended to retain their contents as the individual crosses frontiers. However, the packets may leak or rupture at any stage, with the risk of severe and potentially fatal toxicity.

Facilitated by the introduction of long-distance flights from the 1970s onwards, the number of cases of body packaging reported in the literature count more than 6,000 recorded across the world. These included both men and women. Body packaging has also been documented amongst pregnant women and in children. Typically, the substances concerned are cocaine or heroin, but other drugs may be involved including methamphetamine, cannabis, ecstasy and prescription opioids. Diagnosis is often based

116 Department of Health & Social Care. The Medical Care of Suspected Internal Drug Traffickers – Independent Report of the Chief Medical Officer's Expert Group. January 2013 https://www.gov.uk/government/publications/report-on-the-care-of-suspected-internal-drug-traffickers Accessed 8/11/2019

117 College of Policing. Authorised Professional Practice. Detention in Custody (Alcohol and Drugs) https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/alcohol-and-drugs/#procedure Accessed 16/03/2019 and see Template Protocol for the Management of Detainees who are Suspected of Swallowing or Having Packed Drugs or Foreign Objects into Body Orifices or Cavities. http://library.college.police.uk/docs/NPIA/Protocol-for-the-Management-of-Detainees.pdf Accessed 8/11/2019

118 Norfolk GA. The fatal case of a cocaine body-stuffer and a literature review – towards evidence based management. Journal of Forensic and Legal Medicine 14 (2007) 49–52 http://www.jflmjournal.org/article/S1353-1131(05)00214-2/pdfAccessed 8/11/2019

on the presence of symptoms and signs on clinical examination. Signs of toxicity may be apparent, and packages may sometimes be felt through the abdominal wall or on rectal examination. However, many body packers are asymptomatic.

Urinalysis has a low sensitivity in detection of drug packages and should therefore play a limited role in primary diagnosis of body packing.[119] However, it has a very high sensitivity in instances of package leak. A near-patient urine or oral-fluid test can be helpful to confirm the presence of drugs, but it does not differentiate between smugglers and users.

Toxicological data on drugs detected and amount is important to treatment and documentation. If the urine is positive for cocaine, it is very likely that cocaine is responsible. If positive for opioids, the packages may contain heroin, but body packers often take opioids such as codeine to slow the bowel during a long flight. Thus, a positive test for opioids does not confirm that heroin has been taken. Other investigations may be required to confirm the presence of packages, including abdominal X-ray, abdominal ultrasound or computed tomography scanning.

The Police may request X-rays and/or an ultrasound scan under section 55A of PACE if:[120]

- authorised by an officer of inspector rank or above who has reasonable grounds for believing that the detainee:
  - may have swallowed a Class A drug; and
  - was in possession of that Class A drug with the intention of supplying it to another or to export

  and
- the detainee's appropriate consent has been given in writing.

If a detainee states that they have swallowed drugs before arrest, or if the arresting officer reasonably believes they have done so, they should be conveyed without delay to the ED of an NHS hospital with full resuscitation facilities and treated for a drug overdose until this is shown to be otherwise. If a HCP is contacted in this scenario, they should undertake a risk assessment and the custody officer should be advised accordingly.

If the detainee is symptomatic, immediate transfer to hospital should be made.

In cases of doubt, early and repeated examinations must be undertaken documenting changes to the detainee's symptoms and clinical signs. The CMO report recommended the development of a custodial early warning system (CEWS) adapted from the modified early warning system (MEWS)[121] with custody staff trained to take blood pressure, pulse, respiratory rate, temperature, and assess consciousness using the AVPU scale.

119 Bogusz, M. J., Althoff, H., Erkens, M., Maier, R-D., & Hofmann, R. (1995). Internally concealed cocaine: analytical and diagnostic aspects. *Journal of Forensic Sciences, 40*(5), 811-815

120 Home Office. Code C Revised. Code of Practice for the detention, treatment and questioning of persons by Police Officers. Annex K X-rays and ultrasound scans. August 2019 https://www.gov.uk/government/publications/pace-code-c-2019 Accessed 8/11/2019

121 Centre for Clinical Practice. (2007) Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. NICE clinical guideline 50. National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg50 Accessed 8/11/2019

The Expert Group concluded that body-packers in particular should only be detained in custody if:

i Twenty-four hour observation with a modified early warning system (CEWS) can be provided and any observed changes acted upon immediately;

ii There is rapid access to an emergency department with 24/7 acute surgical facilities;

iii Custody staff are suitably trained (HCPs should hold an Immediate Life Support certificate); and

iv All necessary emergency drugs and equipment are provided and staff are fully trained to use the equipment and to administer these drugs.

If such facilities and trained staff are not available twenty-four hours a day seven days a week, body-packers should be referred immediately to an emergency department with acute surgical facilities.

Although the development of Custody Early Warning Score (incorrectly referred to as a Custody Early Warning System in the CMO report) was recommended, to date no such score (or system) has been validated within the police custodial setting and thus the Expert Group's recommendation (i) cannot and should not be used until appropriate clinical research is undertaken.

Initially, there may be no symptoms and signs of intoxication. It may be possible to observe the detainee in the police station for a short period; however, it is not appropriate for non-medical personnel alone to conduct observation of a detainee over a prolonged interval because they may have insufficient knowledge of the symptoms and signs that are cause for concern. Additionally, the number of drug packages ingested can be highly variable. Self-reported information collected from body packers may be unreliable, and confirmation that all drug packages have been passed is therefore difficult to determine without supporting radiographic data.

Detainees who swallow or conceal drugs in their body cavities have various motives. Some are simply seeking to dispose of evidence of the offence (possession of drugs); others may have an explicit intention of self- harm of varying degree of intensity. Suicides by re-ingesting cocaine from excreted packages are reported in the literature,[122] highlighting the need to implement steps to prevent re-ingestion. Sometimes this arises from the belief that the claimed suicidal behaviour will lead to transfer to a psychiatric service and an avoidance of criminal charges. If there is evidence that suicidal or other self-harming intent lies behind the disposal of drugs in this way, the HCP should liaise as appropriate with the psychiatric assessment service in the general hospital.

If deliberate smuggling is suspected, an initial assessment by a suitably trained HCP is recommended. Further detention should occur only under suitable conditions, which include enhanced training of all custody staff, the ready availability of suitable resuscitation equipment, and rapid and easy access to a hospital emergency department with

122 Stichenwirth, M., Stelwag-Carion, C., Klupp, N., Honigschnabl, S., Vycudilik, W., Bauer, G., & Risser, D. (2000). Suicide of a body packer. Forensic Science International, 108(1), 61-66

full resuscitation facilities. There should be close cooperation between custody officers, emergency department staff and hospital security to safely manage these patients.

Whether it is safe for the detainee to be observed in a secure facility should be decided after discussion with hospital colleagues.[123] Most body packers can be managed conservatively; however, should a package rupture or cause obstruction prompt and often complicated medical treatment will be required, for instance IV administration of naloxone to reverse respiratory depression following an opioid overdose caused by leaks from packages in the stomach, or surgical intervention in the case of stasis of the packages inside the body. Indications for surgical removal include intestinal obstruction, suspected rupture, and drug overdose.

There is no evidence that the passage of a number of normal stools confirms that there are no other drug packages within the individual's body.

4.4 Forensic samples

HCPs may be asked to take intimate forensic samples from detainees in custody. It is essential that the HCP has the knowledge and skills for this role and has received initial training along with continuing professional development training in this field.

The Police and Criminal Evidence Act, 1984 (PACE) as amended by the Criminal Justice and Public Order Act, 1994, imposes a number of constraints on the police with regard to obtaining forensic samples from detained persons.

Intimate samples can only be taken if they are authorised by a police officer of the rank of inspector or above and the detained person gives written consent for the samples.

In deciding the appropriateness of the sampling the police and HCP need to be aware of the latest FFLM recommendations for the taking of forensic samples,[124] in particular for toxicology (blood, urine and hair). These are updated every six months.

123 The College of Emergency Medicine. Best Practice Guideline. Caring for adult patients suspected of having concealed illicit drugs. June 2014 https://www.rcem.ac.uk/docs/College%20Guidelines/5z1.%20Caring%20for%20adult%20patients%20suspected%20of%20having%20concealed%20illicit%20drugs%20(June%202014).pdf Accessed 8/11/2019

124 FFLM. Recommendations for the Collection of Forensic Specimens from Complainants and Suspects https://fflm.ac.uk/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-3/ Accessed 8/11/2019

4.5 Examination and samples under the Road Traffic Act

The police will request that the HCP assess detainees in relation to offences under road traffic legislation, including:

- assessing whether there is a medical reason for failing to provide a breath, blood or urine sample
- taking blood samples for alcohol or drug analysis
- performing a comprehensive examination under section 4 of the RTA.

It is essential the HCPs have the knowledge and skills for this role[125] and have received initial training along with continuing professional development training.[126]

HCPs should advise the detainee on the impact of their medical condition on safe driving ability, and on the legal requirement that the detainee notify the DVLA of any relevant condition.[127]

The GMC's guidance states that a doctor should explain to a patient that a condition may affect their ability to drive and that they have a legal duty to inform the DVLA or DVA about the condition.[128]

125 FFLM 2018 Drug-driving competencies. https://fflm.ac.uk/wp-content/uploads/2018/02/Drug-Driving-Competencies-Dr-Will-Anderson-Feb-2018.pdf Accessed 8/11/2019

126 Stark MM. (2016) Driving Impairment – the main risk factors. In Current Practice in Forensic Medicine, Eds Gall J. & Payne-James JJ. Volume 2, John Wiley & Sons Ltd, West Sussex.

127 DVLA (2016) Assessing fitness to drive – a guide for medical professionals. www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals Accessed 8/11/2019

128 Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA 2017 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---patients-fitness-to-drive-and-reporting-concerns-to-the-dvla-or-dva Accessed 8/11/2019

Figure 2 – Intimate searches flowchart

Faculty of Forensic & Legal Medicine

Intimate Searches in Police Custody

Jun 2017 Review date Jun 2020 – check www.fflm.ac.uk for latest update

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.

An Intimate Search is defined by law as a physical examination of body orifices other than mouth and could therefore include the ear, nose, rectum or vagina.

It requires the authority of a police inspector or above, if the detainee is arrested, *and* in police detention and:

A

The detainee may have concealed anything that could be used to cause physical injury to him/others or might be used whilst in detention.

Which cannot be found without an intimate search.

Police officers can carry out an intimate search without consent.

A doctor or other healthcare professional can carry out an intimate search but needs 'valid' and informed consent to do so.

Intimate searches can be carried out in a police station.

OR

B

The detainee had Class A drug concealed and had appropriate criminal intent.

Which cannot be found without an intimate search.

Police officers cannot carry out an intimate search with or without consent.

A doctor or other healthcare professional can carry out an intimate search in but needs 'valid' and informed consent to do so.

Intimate searches must be carried out in a medical facility ideally a hospital with resuscitation facilities.

An X-ray or ultrasound can also be authorised **a**nd requires written consent.

A doctor or other health care professional needs to

- Ensure that any urgent therapeutic interventions are prioritised.
- Ensure and document that proper authorisation has been obtained.
- Ensure that the detainee is fully aware of the risks of the search, the risk of not carrying out the search, the possibility that a police officer may carry out the search in certain cases and the fact that refusal may imply guilt.
- If consent is refused no further action in respect of the search should be carried out.
- If consent is agreed than the search should take place as detailed above.
- A local protocol between the police and local Emergency Department should be available to facilitate this.
- As sharp objects may be concealed in the rectum or vagina, consideration should be given to undertaking a proctoscopy or speculum examination before a digital examination.

Police sometimes attempt to argue that a Class A drug could be used to cause harm and that an intimate search under **(A)** could be authorised and carried out by an officer or doctor without consent. **THIS IS NOT THE CASE and healthcare professionals should explain why and refuse.**

For more detailed guidance please see the FFLM/BMA document *Recommendations for Healthcare Professionals asked to perform intimate body searches*.

Produced by the Faculty of Forensic & Legal Medicine
 Review date: Jun 2020
Send any feedback and comments to forensic.medicine@fflm.ac.uk

Appendices

Appendix A: Competencies for clinicians working with detainees with substance use disorders in police custody

As has been discussed earlier in this guidance, individuals in police custody have specific needs and vulnerabilities in addition to those encountered when managing substance misuse in other settings. It is therefore vital that clinicians managing this patient group have specific training, competencies, and support.

All clinicians working within police custody must have access to senior clinical support within a strong clinical governance framework. They must have access to a senior doctor who holds the MFFLM for discussion of complex cases. Clinicians should have excellent and precise communication skills.

Nurses and paramedics working within custody must have a minimum of three years' post registration experience in a patient-facing role within a relevant field (General Practice, Emergency Medicine, Walk in Centres, Substance Misuse Services, Prison Healthcare, Mental Health, or Ambulance Service).

Doctors working within the custody setting must have a minimum of three years' experience (post satisfactory completion of FY2) in a relevant field. For general forensic medicine relevant fields would include Emergency Medicine, General Practice, Substance Misuse or Psychiatry.

All clinicians practicing in clinical forensic medicine must:

- attend an FFLM accredited Introductory Training Course in General Forensic Medicine[129] prior to starting work unsupervised
- have training in Immediate Life Support
- complete training in Safeguarding of Children and Young People to at least Level 3
- complete training in Safeguarding of Vulnerable Adults
- have training in Equality and Diversity
- have shadowed and been supervised by an experienced forensic clinician prior to sign off to work unsupervised.

129 Recommendations for Introductory Training Courses in General Forensic Medicine (GFM) 2018 https://fflm.ac.uk/wp-content/uploads/2018/03/Recommendations-for-Introductory-Training-Courses-in-General-Forensic-Medicine-Dr-M-Stark-Jan-2018.pdf Accessed 8/11/2019

All clinicians working with detainees with substance use disorders must:

- be competent to take a comprehensive and complete medical history, which must include past medical, surgical and psychiatric history
- be competent to undertake a full clinical examination of the detainee as and when required
- be competent to assess the detainee's mental state and identify mental health conditions that may overlap with their substance misuse issues
- be competent to identify and manage the symptoms and signs of illicit drug use, intoxication and withdrawal
- be aware of the special precautions to be taken managing detainees who are pregnant with drug and/or alcohol dependence
- recognise the interplay between substance misuse and the criminal justice system
- be competent to manage detainees who have taken overdoses
- be able to deliver harm reduction interventions
- be competent in risk identification and management
- be able to manage co-existing physical, mental and social health problems
- demonstrate safe and effective prescribing/medication administration practice
- have knowledge of local referral pathways for support of detainees with substance use disorders in the community
- be competent to deliver forensic aspects of management.

Appendix B: PACE Code C Annex H – Detained Person: Observation List

If any detainee fails to meet any of the following criteria, an appropriate health care professional or an ambulance must be called.

When assessing the level of rousability, consider:

Rousability – can they be woken?

- go into the cell
- call their name
- shake gently

Response to questions – can they give appropriate answers to questions such as:

- What's your name?
- Where do you live?
- Where do you think you are?

Response to commands – can they respond appropriately to commands such as:

- Open your eyes!
- Lift one arm, now the other arm!

Remember to take into account the possibility or presence of other illnesses, injury, or mental condition; a person who is drowsy and smells of alcohol may also have the following:

- Diabetes
- Epilepsy
- Head injury
- Drug intoxication or overdose

Appendix C: Levels of observation[130]

Level 1 – General observation

Following full risk assessment, this is the minimum acceptable level of observation required for any detainee. It includes the following actions:

- the detainee is checked at least every hour (the risk assessment is updated where necessary)
- checks are carried out sensitively in order to cause as little intrusion as possible
- if no reasonable foreseeable risk is identified, staff need not wake a sleeping detainee (checks of the sleeping detainee must, however, continue and if any change in the detainee's condition presents a new risk, the detainee should be roused)
- if the detainee is awake, staff should communicate with them.

Level 2 – Intermittent observation

Subject to medical direction, this is the minimum acceptable level for detainees who are under the influence of alcohol or drugs, or whose level of consciousness causes concern. It includes the following actions:

- the detainee is visited and roused at least every 30 minutes
- physical visits and checks must be carried out – CCTV and other technologies can be used in support of this
- the detainee is positively communicated with at frequent and irregular intervals
- visits to the detainee are conducted in accordance with PACE Code C Annex H.

Level 3 – Constant observation

If the detainee's risk assessment indicates a heightened level of risk to the detainee (e.g. self-harm, suicide risk or other significant mental or physical vulnerability) they should be observed at this level. It includes the following actions:

- the detainee is under constant observation, and accessible at all times
- physical checks and visits must be carried out at least every 30 minutes
- CCTV is constantly monitored (other technologies can also be used)
- any possible ligatures are removed
- the detainee is positively communicated with at frequent and irregular intervals
- review by the HCP in accordance with the relevant service level agreement.

130 https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/#levels-of-observation Accessed 8/11/2019

The purpose of CCTV cell monitoring should be recorded in the custody record, together with the name of the designated officer or member of custody staff who is responsible for the monitoring.

Officers and staff must consider issues of privacy, dignity and gender.

Level 4 – Close proximity

Detainees at the highest risk of self-harm should be observed at this level. It must include the following actions:

- the detainee is physically supervised in close proximity to enable immediate physical intervention if necessary
- CCTV and other technologies do not meet the criteria of close-proximity observation but may complement it
- issues of privacy, dignity and gender are taken into consideration
- any possible ligatures are removed
- the detainee is positively communicated with at frequent and irregular intervals
- review by the HCP in accordance with the relevant service level agreement.

Every officer or member of custody staff required to conduct close proximity supervision must be fully briefed by the custody officer with regards their role, the needs of the detainee, and the risks presented by the detained person. They must be fully trained and equipped to respond accordingly. If there is a requirement to rouse, this must be done by a trained officer or member of staff. Any changes in the detainee's condition must be brought to the custody officer's attention immediately.

HCPs may work across different forces and be familiar with different categories or levels of observation. Custody managers should ensure that HCPs working within their force are aware of local procedures.

Appendix D: Letter to pharmacy for collection of methadone/buprenorphine preparations

Working together for a safer London

To the duty Pharmacist,

at

……

Chemists

Re: [Title, Forename, Surname, & Address of detainee]

Age:
DOB:
Custody number:

C/O [address of police station]

Duty Pharmacist,

Please supply the bearer of this note, a uniformed Metropolitan police officer, with my daily dose Methadone/Buprenorphine (delete as applicable) which is due on: (insert date)

[Insert exact requirements]

so that I can take it under the supervision of the Duty Forensic Medical Examiner (FME) whilst I am temporarily

detained at ……..Police station

Signed:

Dated:

Witnessed by the Duty FME/Custody Nurse Practitioner (CNP):

Name:……

Signed:……

Dated:……

At……Police station (insert as applicable)

Contact telephone number(s) of police station:

Contact number for FME/CNP:

Appendix E: Private prescription pro forma (non-controlled drugs)

Working together for a safer London

Name of Forensic Medical Examiner (Doctor):

GMC Number:

Contact number for FME:

Address of police station:

Date:

Re: [Title, Forename, Surname, & Address of detainee]
Age
DOB
Custody number:

C/O [address of police station]

℞

Number of day's treatment

Signature of Prescriber

Date

N.B. This form is not suitable for prescribing Schedule 1, 2 or 3 Controlled Drugs

Appendix F: Letter to hospital – Form 170

CONFIDENTIAL

METROPOLITAN POLICE

TOTAL POLICING

Form 170

REMOVAL TO HOSPITAL

Patient's Consent:

Do you give your consent for relevant medical information and/or treatment plans to be communicated by healthcare professionals to the custody staff looking after you, so that your medical welfare whilst in custody is maintained?

(tick appropriate box) Yes ☐ No ☐

Patient's Signature:	

I consider it necessary to remove ..... **Date:** D D M M Y Y

from ..... Police Station.

Name:		**Date of Birth:**	D D M M Y Y

Past History

Medical Conditions:	
Mental Health Conditions:	
Medication:	
Allergies:	

REASON FOR REMOVAL TO HOSPITAL:

.....

.....

.....

.....

Name in BLOCK capitals:		**Contact details:**	
Signature of Forensic Medical Examiner/Healthcare Professional/Custody Officer:			

Information handover to healthcare staff

The patient/detainee is currently under arrest and will be accompanied by police officers who will assess the risk to the detainee, hospital staff or the public. Please ask the officer for additional information relating to any mental health, relevant behavioural issues or learning difficulties.

Hospital Medical Staff – On discharge of patient

1. **Either** complete this form and hand it to the escorting police officer in a sealed envelope for the attention of the Healthcare Professional/Custody Officer. Please ensure that you explain clearly to the escorting police officer any relevant information which may be of assistance in ensuring the safety of the detainee or others.

2. **Or** please supply a copy of the discharge letter including treatment and medication given to the escorting police officer in a sealed envelope for the attention of the Healthcare Professional/Custody Officer

CONFIDENTIAL

Form 170 page 2

CONFIDENTIAL

CONFIDENTIAL INFORMATION SHOULD NOT BE DISCLOSED WITHOUT CONSENT.

Hospital:		**Discharge Time:**	H	H	M	M	
Name of patient:		**Date of Birth:**	H	H	M	M	
	Discharge Date:	D	D	M	M	Y	Y

If a discharge letter is not provided, please complete the below information

Brief details of symptoms

Diagnosis

Details of treatment and investigations

FBC Normal	☐ If abnormal details		U&E Normal	☐ If abnormal details	
LFTs Normal	☐ If abnormal details		Glucose Normal	☐ If abnormal details	
ECG Normal	☐ If abnormal details		X-ray Normal	☐ If abnormal details	

Other investigation, treatment or outpatient appointments or referrals made e.g.: sutures, X-ray or CT results

Medication administered at Hospital

Medication	Dose	Time Given

Please supply any medication the patient requires to police

Please provide a point of contact in case the Forensic Medical Examiner / Healthcare Professional wishes to contact you for further details.

Name in BLOCK capitals:		**Telephone number:**	
Signature:		**Grade:**	

Custody: Confidential Medical Information (to be retained at custody facility)

Retention period: 7 Years
MP 80/14

CONFIDENTIAL

Appendix G: Glossary

AA	Appropriate Adult
ABD	Acute behavioural disturbance
ACMD	Advisory Council for the Misuse of Drugs
AMHP	Approved Mental Health Professional
AUDIT	Alcohol Use Disorders Identification Test
CJLDS	Criminal Justice Liaison and Diversion Services
CJIT	Criminal Justice Integrated Team
CJS	Criminal Justice System
CRHT	Crisis resolution and home based treatment service
CSEW	Crime Survey for England and Wales
DIP	Drug intervention programme
DVLA	Driver and Vehicle Licensing Agency
ED	Emergency department
FP	Forensic physician (forensic medical examiner, forensic medical officer)
FFLM	Faculty of Forensic and Legal Medicine
GMC	General Medical Council
HCP	Healthcare professional
HCPC	Health and Care Professions Council
IOPC	Independent Office for Police Conduct previously the Independent Police Complaints Commission (IPCC)
IPCC	Independent Police Complaints Commission, now superseded by IOPC
MHA	Mental Health Act 1983
NPCC	The National Police Chiefs Council
NICE	National Institute for Health and Care Excellence
NDTMS	National Drug Treatment Monitoring System
NPS	Novel psychoactive substances
NMC	Nursing and Midwifery Council
NSPIS	National Strategy for Police Information Systems
PACE	Police and Criminal Evidence Act 1984
PGD	Patient Group Direction
POS	Place of safety
SADQ	Severity of Alcohol Dependence Questionnaire

Appendix H: Useful websites

The Advisory Council on the Misuse of Drugs (ACMD)	gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs/
Crew	mycrew.org.uk/drugs-information
Driver and Vehicle Licensing Agency (DVLA)	gov.uk/government/organisations/driver-and-vehicle-licensing-agency
European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)	emcdda.europa.eu
Faculty of Forensic and Legal Medicine (FFLM)	fflm.ac.uk
Frank	talktofrank.com
General Medical Council (GMC)	gmc-uk.org
Health and Care Professions Council (HCPC)	hcpc-uk.co.uk
National Institute for Health and Care Excellence (NICE)	nice.org.uk
Nursing & Midwifery Council (NMC)	nmc.org.uk
Royal Pharmaceutical Society	rpharms.com
National Drug Treatment Monitoring System (NDTMS)	ndtms.net
National Poisons Information Service	npis.org
Neptune (NPS treatment network)	neptune-clinical-guidance.co.uk
The Royal College of Psychiatrists	rcpsych.ac.uk
The Royal College of Emergency Medicine	rcem.ac.uk
Royal College of General Practitioners	rcgp.org.uk
SMMGP	smmgp-fdap.org.uk
United Nations Office on Drugs and Crime (UNODC)	unodc.org

Appendix I: Research recommendations

1 Is buprenorphine safe and effective in managing those with opiate dependence in police custody (for those not already in treatment)?

2 Which scale is most effective and easy to administer to support alcohol withdrawal management, i.e. CIWA or Alcohol withdrawal scale?

3 Is it safe to manage body packers in custody using the custody early warning score (CEWS)? Is CEWS an appropriate tool to detect detainees at risk in custody (irrespective of intelligence suggesting body packing)?

Responses

1 Is buprenorphine safe and effective in initiating and managing those with opiate dependence in the context of police custody (for those not in treatment)?

This question should be answered using a randomised controlled design, that reports short- and medium-term outcomes including cost effectiveness outcomes, and safety of at least 6-12 month duration. While an RCT would be ideal, there may be difficulties in undertaking such a study within the complex police custodial setting. Additional problems may be caused by absence of appropriate research funding. An alternative research method which has been suggested is the use of before-and-after study design. Although this may provide an easier and cheaper way to generate research data it must be recognised that such a study design has a high risk of selection and information bias,[131,132] thus clinicians and researchers working in police custodial and substance misuse settings must emphasise the need for appropriate RCTs if the most appropriate clinical intervention evidence-base is sought.

Whatever research is undertaken, particular attention should be paid to the reproducibility of the treatment model, the training and supervision of those providing the intervention, and the safety measures. Any study needs to be of enough power and of the correct methodology to determine the presence or absence of clinically important effects.

Why this is important

Buprenorphine and or methadone are the treatment of choice, and licensed medication, for the management of opiate dependence in the community. There is a body of opinion among addiction specialists that buprenorphine can be suitable when used by competent staff for initiation in police custody suites. It has a superior safety profile at initiation and has been safely used in other secure settings. However, there is little published evidence to aid choice of opiate substitute managed dependence and withdrawal that is specific for the context of police custody. The evidence base for heroin dependence consistently indicates that where a need for opioid substitution is identified and safe induction onto methadone and/or onto buprenorphine is possible,

131 Costantini M, Di Leo S, Beccaro M. Methodological issues in a before-after study design to evaluate the Liverpool Care Pathway for the Dying Patient in hospital. Pallliat Med. 2011 Dec;25(8):766-73. doi: 10.1177/0269216311418870. Epub 2011 Aug 10

132 http://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/EPOC%20Study%20Designs%20About.pdf Accessed 8/11/2019

that is the most appropriate intervention for stabilisation of management of the patient. However the context for police custody is one of rapid transfer out of the cells, with risks associated with transportation, issues of monitoring and emerging intoxication, or developing withdrawal. The results of this research will have important implications for the provision of pharmacological treatment for drug misuse in the context of the police cells and in the broader NHS.

2 Which scale is most effective and easy to administer to support alcohol withdrawal management, i.e. CIWA or alcohol withdrawal scale?

This question could be answered in a comparison between the two withdrawal scales for ease of use, sensitivity and specificity in this context, and the time taken.

Why this is important

Alcohol withdrawal is a common problem in police cells, and diagnostic instruments are useful to aid both diagnosis and monitoring of a withdrawal treatment regime. However any scale needs to be both sensitive and specific, reliable and quick to use. The results will have important implications.

3 Is it safe to manage body packers in custody using the custody early warning score (CEWS)?

It has been proposed that a Custody Early Warning Score can be used to manage body packers in police custody. No such scoring system has been subject to formal clinical research or appropriately validated in police custody. It is suggested that it is an extension of, or equivalent to, the NEWS/MEWS. It is not, for two main reasons: a) the absence of appropriate research and b) that it is suggested it is a tool for non-healthcare professionals. The NEWS/MEWS scores have been intensively researched and validated in a variety of settings and are determined by HCPs. The proposed CEWS, to date, has not. Therefore no reliance can be placed on a) the score or b) its interpretation. For many years (since 1997 in London) individuals who come to the attention of police who swallow/stuff drugs (contact-precipitated concealers) have been treated as a medical emergency and taken to the emergency department for a full assessment and period of observation (Authorised Professional Practice (APP)). Body packers or those who may have pushed drugs into their rectum/vagina may be taken to a custody centre for management.

There are serious concerns regarding the proposed use a modified MEWS (CEWS) in custody as in the CMO report (2013). There has been no properly-designed, ethical study that has explored (let alone validated) such a system in police custody (as far as we are aware). Even where there is an embedded HCP (assuming 24 hour ‘cover’) there is no possibility that the HCP could devote enough time in a custody suite to the appropriate, safe monitoring of a detainee. Any HCP or custody team would be put at grave risk of professional sanction if any harm (or death) occurred.

The FFLM is working with the RCP to encourage high quality research into the validity of CEWS and other scoring systems in the custody setting.

A literature review on the management of body packers has been commissioned for this edition of the *Guidelines*. This review is being led by Dr Andreas Kimergård (PhD), Postdoctoral Research Associate, Alcohol Assertive Outreach Trial, National Addiction Centre, Institute of Psychiatry, Psychology & Neuroscience (IoPPN), King's College London.