ARCHIVED MARCH 2020

Substance Misuse Detainees in Police Custody

Guidelines for Clinical Management

(Fourth edition)

Report of a Medical Working Group

Royal College of Psychiatrists, Royal College of General Practitioners, Faculty of Forensic and Legal Medicine & College of Emergency Medicine

College Report CR169

November 2011

Substance Misuse Detainees in Police Custody

Guidelines for Clinical Management (Fourth edition)

Approved by the Central Policy Coordination Committee of the Royal College of Psychiatrists: August 2011

Due for review: 2016

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The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Printed in the UK by Bell & Bain Limited, Glasgow

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library.
ISBN 978-1-908020-38-3

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Foreword

There has been a major increase in substance misuse over the past couple of decades and a corresponding increase in the numbers detained in police custody who misuse substances. Most of these detainees are vulnerable individuals and the recognition of their substance use problems is now perceived as important and is receiving local and national attention.

Accurate assessment of morbidities associated with substance misuse, 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. Many such detainees have not received the treatment and care in custody that they need because it is particularly difficult to undertake a proper assessment and initiate an appropriate response in the environment in which they are seen. However, a detained substance-dependent person who is at risk of complications is entitled to the same quality of healthcare as they would v receive in other locations.

The first edition of these guidelines was produced by a Joint Working Group chaired by Professor Hamid Ghodse and comprising representatives of the Association of Police Surgeons, relevant Colleges and Faculties, the Department of Health and the Home Office. The Association of Police Surgeons developed into the Association of Forensic Physicians, then in 2006 into the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London. This Working Group has now revised the guidelines, bringing them up to date and providing an excellent text for forensic physicians, other doctors and the staff of law enforcement agencies who are involved in care of detainees with substance misuse.

The guidelines recognise that the assessment and treatment of substance misusers present forensic physicians with particular challenges that require certain skills and experience to ensure appropriate management. They stress the importance of good communication, of working closely with custody officers and of shared responsibility for the safety and care of detainees with substance misuse. In particular, they stress the importance of:

- the full participation of forensic physicians 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 misuse/dependence

- comprehensive contemporaneous records
- appropriate sharing of information in accordance with the law and the General Medical Council's advice on professional confidentiality
- being aware when making all interventions that the interests of the detainee as a patient are paramount.

We believe that these guidelines will be of immense value to all practitioners in helping and supporting detainees and that they will also be useful for teaching purposes for medical and nursing staff and arrest referral officers. We congratulate the Working Group on its hard work in preparing them.

Dr Dinesh Bhugra, President, Royal College of Psychiatrists
Dr Iona Heath, President, Royal College of General Practitioners
Professor Ian Wall, President, Faculty of Forensic and Legal Medicine, Royal College of Physicians
Mr John Heyworth, President, College of Emergency Medicine May 2011

Membership of the Medical Working Group

Chair

Professor Hamid Ghodse
Professor of Psychiatry and Director of the International Centre for Drug Policy, St George's, University of London

Members

Dr Meng Aw-Yong
Associate Specialist Emergency Medicine, Hillingdon Hospital; Council Member, College of Emergency Medicine; Forensic Physician, Metropolitan Police

Ms Sharon Beattie
Head of Strategic Partner ships, Criminal Justice Depart ment, Northern Ireland

Dr R. E. Boggs
Chair, Faculty of Addictions, Royal College of Psychiatrists in Northern Ireland

Dr Owen Bowden-Jones

Consultant Addic tion Psychiatrist, Central and North West London NHS Foundation Trust; Chair, Faculty of Addictions, Royal College of Psychiatrists

Dr Malcolm Bruce
Consultant Psy chiatrist in Addiction, Community Drug Problem Service, Edinburgh; Faculty of Addictions, Royal College of Psychiatrists in Scotland

Mrs Cathy Cooke
Royal Pharmaceutical Society; Chair, Secure Environment Pharmacists Group, Royal Pharma ceutical Society

Professor Ilana Crome
Consultant Addiction Psychiatrist; Academic Director of Psychiatry, Keele University Medical School

Professor John Farnan
Professor of Forensic and Legal Medicine, University of Ulster; Principal Administrative Forensic Medical Officer, Northern Ireland

Dr George Fernie
President, Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London

Dr Emily Finch
Clinical Director for Addictions, South London and Maudsley NHS Foundation Trust

Dr Eilish Gilvarry
Consultant in Addiction Psychiatry, Northumber land, Tyne and Wear NHS Foundation Trust

Dr Linda Harris
Chief Executive, Spectrum Community Health; Clinical Director, Substance Misuse and Associated Health Unit, Royal College of General Practitioners

Mr David Hedley
Forensic Physician and Associate Specialist in Accident & Emergency, Isle of Man

Chief Inspector Mark McEwan
Police Service of Northern Ireland

Dr Ian McMaster
Medical Adviser, Department of Health, Social Services and Public Safety, Northern Ireland

Dr K. A. H. Mirza
Consultant Child and Adolescent Psychiatrist and Honorary Senior Lecturer, Institute of Psychiatry and South London and Maudsley NHS Trust; Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists

Dr Mini Mishra
Senior Medical Officer, Scottish Government

Ms Jan Palmer
Clinical Substance Misuse Lead (Secure Environments), Department of Health

Mark Prunty
Consultant Addiction Psychiatrist; Senior Medical Officer for Substance Misuse Policy, Department of Health (England)

Mr Jerry Randle
College of Paramedics; Clinical Governance Manager, G4S Forensic and Medical Services (UK) Ltd

Ms Jennie Smith
Forensic Nurse Practitioner Team Leader, Merseyside Police

Dr Margaret Stark (Rapporteur)
Academic Dean, Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London

Dr Nick Swift
Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London

Professor Ian Wall
Fellow, Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London; Visiting Professor, Teesside University

Preface to fourth edition of the *Guidelines*

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 susbtance-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 third edition of the *Guidelines*

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 second edition of the *Guidelines*

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 xii 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

General preface

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 xiii 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

The substantial prevalence of substance misuse in detainees in police custody makes guidelines necessary for forensic physicians (police surgeons, forensic medical examiners and forensic medical officers) on the acceptable minimum standards for the assessment and treatment of drug- and alcohol-dependent individuals. Unless such guidelines are explicit and are published, it will continue to be difficult to establish what constitutes good practice and whether good practice has or has not been followed in any particular instance. The *Guidelines* is not a comprehensive textbook or manual for the treatment of substance misuse. Doctors and other healthcare professionals should access more detailed information and specialist advice about interventions described in the *Guidelines* (Ghodse, 2010).

1.1 The Working Party

In 1994, the Department of Health published guidelines on the clinical management of substance misuse detainees in police custody (Department of Health *et al*, 1994). In April 1999, it published a major update to the general drug misuse clinical guidelines, *Drug Misuse and Dependence: Guidelines on Clinical Management* (Department of Health *et al*, 1999). Following this, in 2000, the guidelines relating to police custody were also revised (Association of Police Surgeons & Royal College of Psychiatrists, 2000). A number of legislative changes as well as other developments in the management of substance misuse detainees in police custody necessitated a further revision in 2006 (Association of Forensic Physicians & Royal College of Psychiatrists, 2006). A year later, *Drug Misuse and Dependence: UK Guidelines on Clinical Management* was published (Department of Health (England) and the devolved administrations, 2007).

In February 2011, the Royal College of Psychiatrists, at the request of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London, convened a working party of relevant organisations to revise the third edition of the present document, *Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management*. This group included representation from the Faculty of Forensic and Legal Medicine, the Royal College of Psychiatrists, the Royal College of General Practitioners, the College of Emergency Medicine and the Association of Chief Police Officers. The group included officials from the

Home Office and Department of Health (who consulted with officials of the devolved administrations in contributing to the work of the group).

1.2 The Guidelines

1.2.1 Guidelines, not rules

These guidelines are intended to supplement and appropriately amplify, but not replace, the Department of Health's publication *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health (England) and the devolved administrations, 2007). All doctors who are likely to be managing substance misusers should have a copy of that publication and be familiar with the advice given. *Clinical Management of Drug Dependence in the Adult Prison Setting* (Department of Health, 2006)

is also a useful resource, as it addresses some of the unique challenges of providing treatment to substance misusers in a secure environment.

The guidelines presented here pay particular attention to aspects of management that are unique to the care of substance misusers when in police custody.

This document contains recommendations, not rules. It is intended that these should be flexible enough to fit into the clinical practice of all forensic physicians.

Clinical decisions may vary in accordance with the specific needs and circumstances of individual detainees.

The term 'substance misuse' is used throughout this document to include the misuse of prescribed drugs with dependence potential as well as the use of illicit substances, chemicals (such as volatile substances), overthe-counter medicines and alcohol.

1.3 The scope of the problem

Substance misuse is a substantial and growing problem. Forensic physicians are increasingly being asked by the police to assess substance misusers with respect to their fitness for detention, need for treatment and fitness for interview. According to the British Crime Survey for 2009–2010, 8.6% of adults and 20% of young people aged 16–24 years had used an illicit drug in the past year (Hoare & Moon, 2010). Therefore, all detainees should be asked about substance misuse,

including alcohol and benzodiazepines, so that early intervention can be provided (HM Government, 2010).

The Arrestee Survey (Boreham *et al*, 2007) is a nationally representative survey of drug use and crime among individuals arrested in England and Wales. Three cycles of self-reported drug misuse have now been collected, and the most recent, for 2005–2006, shows that 52% of all respondents reported having taken one or more drugs in the month before arrest; cannabis was the most widely taken drug, with 41% having taken it in the previous month, followed by heroin and powder cocaine (13%), crack cocaine (11%) and ecstasy (8%).

1.4 Changing provision of forensic medical services

In recent years, the provision of clinical forensic medical services has radically changed from the traditional doctor-only model. Forensic physicians now work more commonly in multidisciplinary teams with nurses and paramedics. The Home Office published a circular amending the Codes of Practice of the Police and Criminal Evidence Act 1984 (PACE) to allow other healthcare professionals to perform many of the roles previously carried out by registered medical practitioners (Policing & Crime Reduction Group, 2003). These Codes cover the jurisdictions of England, Wales and Northern Ireland. Similar changes have been effected in Scotland (HM Inspectorate of Constabulary for Scotland, 2008), where the Chief Executive has also emphasised the importance of partnership working in a letter to all NHS Board Chief Executives (Dr Kevin Woods, personal communication, 5 December 2008). The Act and the associated PACE codes (Home Office 2011) are different in the islands of Jersey (the Police Procedures and Criminal Evidence (Jersey) Law 2003) and Guernsey (the Police Powers and Criminal Evidence (Bailiwick of Guernsey) Law 2003) and so practitioners should make themselves fully aware of local variation. In the Isle of Man, the Police Powers and Procedures Act 1998 is the relevant legislation.

In the Home Office circular, the term ‘healthcare professional’ refers to a clinically qualified person who is working within the scope of practice as determined by their relevant professional body (General Medical Council, Nursing and Midwifery Council, Health Professions Council) and who is registered with that body as competent to practice (Policing & Crime Reduction Group, 2003). The circular contains guiding principles on recruitment and management, professional independence, clinical supervision, clinical governance, confidentiality and disclosure in relation to individual records and treatment.

Any healthcare professional 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 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
- 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.

The Faculty has produced quality standards for doctors working in the field of forensic medicine (Faculty of Forensic and Legal Medicine, 2010*a*) and is now working on similar standards for other healthcare professionals. National occupational standards for healthcare professionals working in police custody have also been developed (Skills for Health, 2007).

The statutory responsibility to ensure that detainees have access to appropriate healthcare while in custody is that of the Chief Officers of Police (National Centre for Policing Excellence, 2006). Her Majesty's Inspectorate of Prisons and Her Majesty's Inspectorate of Constabulary have also published criteria for assessing the treatment and conditions for detainees in police custody (HM Inspectorate of Prisons & HM Inspectorate of Constabulary, 2009). Their expectations include that detainees have access to competent healthcare professionals working within robust clinical governance arrangements, which include initial and ongoing training, supervision and support.

It is essential that robust clinical governance procedures are developed for the provision of clinical forensic medical services covering training in the area of substance misuse and mental health and ensuring that individual practitioners have the competencies to perform the role that they are required to perform, with clear protocols as to who to refer to and when.

2 History and examination

2.1 What is required?

2.1.1 Liaison with custody staff

Early and effective liaison with the police custody officer can yield relevant information, particularly about the circumstances of the arrest, the behaviour of the detainee on arrest and whether any physical restraint was used, and 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. The forensic physician 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 examination

Careful and well-documented history-taking and examination (including mental state examination) are essential to provide safe and effective care for the detainee and to establish the degree of substance misuse and/or dependence (Fig. 2.1).

Forensic physicians should explain their role as independent medical practitioners. Consent for the examination should be obtained after an explanation of the nature and purpose of the examination. The doctor 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 (*Re C (Adult: Refusal of Treatment)*, 1994). Consideration should be given as to whether the detainee has the capacity to consent. For example, intoxicated or young detainees may not have this capacity. In a genuine emergency, where there is no possibility of obtaining consent, forensic physicians 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.

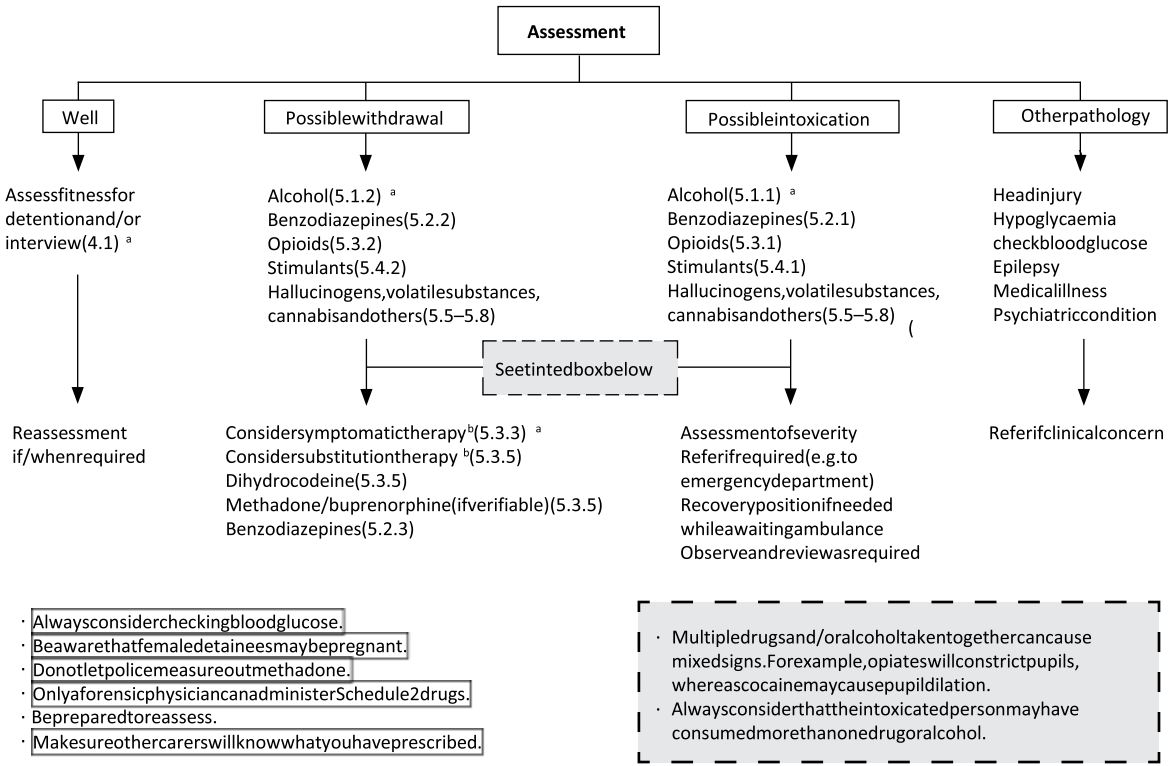

Fig.2.1 Assessmentprocedure.(a)Numbersinparenthesesrefertosectionsinthe *Guidelines*;(b)iftheindividual isaknownaddict.

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 (also see section 3.2.6). If the person is living in a supported setting, it is important to obtain their agreement to inform their carer (family member or paid staff) of their detention.

All substance misuse detainees, 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. Forensic physicians may have to examine a person who is a foreign national or whose first language is not English. Police forces often use interpreters in these situations and their help may be required during an assessment.

The history should cover details of past and present drug use, including alcohol. The following information should be obtained:

- type(s) of substance(s) misused
- duration of substance misuse
- quantity taken per day, on an average/typical day and/or amount spent on substances
- frequency of use
- route of administration (noting any sites of injection)
- 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 and 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.

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 a significant morbidity and mortality if untreated.

Physical examination should involve looking for signs of intoxication, dependence or withdrawal. Mental state examination should include assessment of disorders of speech, mood, perception, thought, cognitive function, insight and risk of self-harm. The risk of self-harm is increased during withdrawal, when individuals may have a tendency to 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 14 times more common among women than men during their prison term(Møller *et al*, 2007: pp. 159–160).

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.

At the conclusion of the examination, the forensic physician should clearly inform the custody officer about any future medical needs of the detainee and should ensure that this information is included in the police medical record form. If the doctor identifies any specific risk in relation 8 to the detainee (for example, linked to their medical or mental condition, their use of drugs or alcohol or any propensity for self-harm), the doctor should ensure that these are clearly drawn to the custody officer's attention verbally and in writing.

Detailed contemporaneous notes should be made of any consultation with a detainee. If the detainee is transferred, a copy of the medical record form should be sent with the detainee; this is especially important where medication has been prescribed or authorised.

2.2 Reliability of histories

2.2.1 In therapeutic situations

Studies have shown that substance misusers 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% (Brown *et al*, 1992), although there are also reports of exaggeration and underestimation of misuse.

2.2.2 In police custody

Frankness on the part of substance misusers 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 forensic physician is required to initiate any medication.

Many substance misusers have negative perceptions of their medical management while detained in police custody (Gregory, 2007).

Honesty is more likely if the detainee feels confident of a sympathetic hearing and the availability of effective care. Forensic physicians should stress their independence from the police by making it clear that, like any other doctor, they are concerned about the physical and mental care of their patient. It is essential that forensic physicians remain non-judgemental and non-confrontational. Detainees have the right to refuse to be examined by a forensic physician and then have the right to be examined by a medical practitioner of their own choice at their own expense.

3 Principles of medical management

3.1 General considerations

3.1.1 The rights of detainees

Individuals in police stations are entitled to the same standard of medical care as any other member of the public. Forensic physicians need to give careful attention to the issue of the 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.

3.1.2 Clinical safety of detainees

10 The overriding consideration of the attending forensic physician is the clinical safety and well-being of the detainee.

Detainees should be assessed for signs of intoxication and/or withdrawal and prompt attention 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 3.6.2) 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 A. 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 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 Chapter 5), before such treatment is initiated the forensic physician 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. Doctors must be alert to the dangers of 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 other misusers, 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.

It may be useful to check any available police records regarding previous medical examinations, for example National Strategy for Police Information Systems (NSPIS) medical forms. Where care is delivered through the NHS it may be possible to access the emergency care record with the detainee's consent.

3.1.3 Detainees' expectations

Suitable treatment may not necessarily involve the prescribing of a substitute 11 for the drug of dependence, although this may be the case.

Detainees must 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 drug misuser may be different from the treatment that the doctor judges to be appropriate. Addiction often leads to confusion between good care and a ready supply of drugs.

3.2 Mental disorder

3.2.1 Mental illness and substance misuse

Mental state examination is important for the general care of the detainee. For example, there may be depression, psychosis or other psychiatric conditions requiring treatment. When assessing the mental state of an individual, the forensic physician 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.

Comorbidity of severe mental illness and substance misuse 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 (Ghodse & Kreek, 1998) and cannabis (Ghodse 1986; Mathers & Ghodse, 1992). 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 misuse 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 a diagnosis of attention-deficit hyperactivity disorder (ADHD) who have been prescribed stimulants or any other medication should have this continued in custody.

3.2.2 Risk of suicide and self-harm

Research has shown that episodes of self-harm typically occur soon after arrest (Ingram *et al*, 1997) and that particular risk factors include histories of self-harm, psychiatric illness (Ingram *et al*, 1997; Norfolk, 1998) and addiction (Oyefeso *et al*, 1999). The risk is higher in women in a custodial setting.

A risk assessment should be made as part of the mental state assessment (e.g. National Collaborating Centre for Mental Health, 2004). If referral to an emergency department (formerly known as A&E) is not necessary (for 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.

Where such assessments highlight a risk of self-harm, the forensic physician should inform the custody officer and provide him or her (within the bounds of patient confidentiality; General Medical Council 2009) 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.

3.2.3 The Mental Health Acts

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 substance misuser who has a mental disorder, including mental disorders precipitated by or associated with substance misuse. Substance misuse and dependence alone are not, however, sufficient grounds.

A patient may be detained in hospital 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.

3.2.4 Learning (intellectual) disabilities

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 13 development. This definition encompasses people with a broad range of disabilities.

3.2.5 Liaison with local psychiatric services

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 forensic physician communicates clearly with the psychiatric services as well as with the medical and surgical teams.

The Home Office encourages the police service to form effective arrangements with local health services to ensure their speedy involvement when a person in custody is suspected of having a mental disorder. It would be helpful for the forensic physician to establish whether such links exist locally, since these should improve relationships with psychiatric services, including policies in relation to application of Section 136 of the Mental Health Act 1983.

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

3.2.6 Appropriate adults

In England and Wales, if a person in police detention is a juvenile, i.e. is or appears to be under the age of 17 (under 18 years of age in Northern Ireland), mentally disordered or otherwise mentally vulnerable, or mentally incapable of understanding the significance of questions or their replies, then the custody officer must inform an ‘appropriate adult’ and ask that adult to come to the police station to see the person. A history of substance misuse alone is not an indication that an appropriate adult needs to be present.

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 or employed by the police.

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 (PACE; Home Office, 2006). The PACE Code applies in England, 14 Wales and Northern Ireland. In Scotland, recommendations regarding the calling in of an appropriate adult are given in the Scottish Office Police Circular 7/1998 (Scottish Office, 1998).

A key purpose of the appropriate adult is to advise the detainee during questioning, to observe whether or not the interview is being conducted properly and fairly, and to facilitate communication with the detainee. More broadly, the appropriate adult is in a position 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 doctor 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.

3.3 Special considerations concerning female detainees

3.3.1 The pregnant drug addict

Sudden cessation of opioid use in a dependent pregnant woman may be life-threatening for the fetus.

The need to safeguard the patient and her pregnancy is paramount. It is important to consider whether or not a female detainee is pregnant before initiating treatment. A pregnancy test should be performed (with consent), if required after risk assessment, on women of child-bearing age who are being assessed for alcohol and/or drug dependence. Amenorrhoea is associated with substance misuse, so it is not unusual for women to be unaware that they are pregnant.

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

Special care should be taken to ensure that pregnant women with substance misuse have their prescribed medication 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.

There is a need to avoid withdrawal and intoxication, and therefore stabilisation of a pregnant detainee in custody may not be possible. Forensic physicians should have a low threshold for early referral to hospital for obstetric assessment and substance misuse treatment.

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 of fluctuations in blood pressure.

3.4 Special considerations concerning young people under 18 years of age (Crome *et al*, 2004; Mirza & Mirza, 2008)

3.4.1 Special characteristics

Among young people, the most commonly used drugs are cannabis and alcohol, and a substantial minority use multiple drugs. There is an earlier age of initiation into drug use than previously, with roughly equal frequency of use in boys and girls. Young people who engage in problematic substance use have a greater than average likelihood of coming from a dysfunctional family and are at risk of multiple disadvantage, including criminality, unemployment, truancy, and social and economic deprivation. Many young substance misusers have multiple antecedent and co-occurring mental health problems, self-harm and unrecognised learning difficulties, and many are not in employment, education or training. Thus, young people who find their way into police custody often present with multiple complex needs, including child protection concerns, and their reports or claims regarding substance misuse should be thoroughly assessed and not disregarded.

Although the majority of young people who misuse substances might not suffer serious harmful consequences, a significant minority will develop substance dependence, as well as physical and/or psychiatric comorbidity whether or not they are dependent.

Common comorbid psychiatric disorders include conduct disorders, depression, post-traumatic stress disorder and attention-deficit disorder (with or without hyperactivity). A small minority present with eating disorders and psychosis. Rates of

self-harm are high, including self-cutting and overdose. Children who present with comorbid disorders are at very high risk, and the combination of depression, conduct disorder and 16 substance misuse is particularly suggestive of self-harm, with substance misuse the most powerful of the three factors (Zeitlin, 1999).

In assessing a young person, the forensic physician should enquire about current substance misuse and mood problems as well as a past episodes of self-harm, as this may be an indicator of risk of self-harm while in custody.

Young people are engaging in more binge drinking (defined as more than 5 units at one sitting), and the incidence of drunkenness at least once in the past 30 days has risen. It has been found that 5–10% of both boys and girls aged 14–15 years are drinking more than the recommended levels for adults. As binge drinking and occasional drunkenness are more frequent than sustained high levels of consumption, forensic physicians 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.

The forensic physician should take a detailed drug history, as young people who come into custody show higher likelihood of using multiple drugs, including cocaine, ecstasy, ketamine, volatile inhalants, newer synthetic drugs and benzodiazepines.

3.4.2 Issues regarding consent

The following section is taken from the Faculty of Forensic and Legal Medicine's (2008) *Recommendations: Consent from Children and Young People in Police Custody in England and Wales* (amended with permission).[1]

The legal position concerning consent and refusal of treatment and examination by detainees under the age of 18 is different from that for adults. In the following paragraphs the terms 'child' and 'young person' are used interchangeably.

3.4.2.1 Therapeutic examinations

In the UK, children become adults for medical, that is therapeutic, purposes at age 16, at which age they are entitled to *consent* to their own medical treatment.

[1] . Prepared by Dr Peter Franklin and Dr Guy Norfolk and reproduced with permission of Drs Stark, Rogers and Norfolk, March 2008. Updated by Dr George Fernie, April 2011 on behalf of the Academic Committee of the Faculty of Forensic and Legal Medicine. © April 2011, Faculty of Forensic and Legal Medicine.

As for 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 proposed intervention. 17 This is sometimes described as being 'Gillick competent', where such a decision in England and Wales is based on case law, including this landmark authority (*Gillick v. West Norfolk & Wisbech Area Health Authority*, 1985).

In England, Wales and Northern Ireland, if a young person of 16 or 17, or a child under 16 but Gillick competent, *refuses* treatment, such a refusal can be overruled either by a person with parental responsibility for the child or by the court. This power to overrule must be exercised on the basis that the welfare of the young person is paramount.

In contrast, in Scotland the Age of Legal Capacity (Scotland) Act 1991 states that if, in the opinion of the registered medical practitioner, the young person understands what medical treatment is proposed and its likely consequences, then they have the requisite capacity and their refusal of treatment cannot be overruled.

A life-threatening emergency may arise in which consultation with a person with parental responsibility or the court is impossible. If a young person refuses consent in such circumstances, any doubt should be resolved in favour of the preservation of life and it is acceptable to undertake treatment to preserve life or prevent serious damage to health wherever that scenario arises within the UK.

3.4.2.2 Forensic examinations

Although not decided in law, it is 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 16 it is good 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 good 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 18 (Scotland) Act 1991.

Forensic physicians need to be aware that there are additional procedural considerations with regard to forensic examinations of young people. In the eyes

of the Police and Criminal Evidence Act 1984 (PACE), juveniles become adults at age 17 and thus 17-year-olds can give consent. However, when dealing with detainees under this age, the police are required to follow certain rules to ensure that evidence obtained from juveniles in custody is legally admissible in court.

The rules with regard to obtaining intimate samples from a detained person require 'appropriate consent' in order for the intimate sample evidence to be admissible. 'Appropriate consent' is defined in Section 65 of PACE as meaning:

(a) in relation to a person who has attained the age of 17 years, the consent of that person;

(b) 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

(c) 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 forensic physician.

3.5 Special considerations concerning people with learning (intellectual) disabilities

Substance misuse is uncommon among people with learning (intellectual) disabilities (Huxley *et al*, 2007), partly because many live supervised lives and partly because most cannot afford it. 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 19 for and may not recognise when individuals have learning disabilities. The suggestibility of such individuals is not well understood and police officers rarely ensure adequate legal protection for these vulnerable individuals, or adequate support to enable them to cope with the stress of being interviewed (Gudjonsson, 2010).

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

problems are often of a 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'.

3.6 Liaison with other agencies

3.6.1 General medical problems

Substance misusing detainees may have other medical problems, related or unrelated to substance misuse (for example, a recent head injury), which require hospital treatment. Forensic physicians should ensure that serious concurrent problems are not overlooked because of a history of substance misuse/dependence and should liaise with appropriate colleagues, such as the emergency (A&E) department, obstetrician or medical team. Communication should preferably be both oral and confirmed in writing.

The doctor responsible for the discharge of the patient from hospital should ensure that relevant confidential medical information is transferred with the detainee (General Medical Council, 2006) (by letter, copy of electronic discharge summary, or completion of any appropriate forms, e.g. Appendix B). 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 medical advice should be sought from the forensic physician on the detainee's return to the custody suite.

3.6.2 'Body stuffers', 'body pushers' and 'body packers'

3.6.2.1 Definitions

Body stuffers 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. The substance may be swallowed loose, or wrapped in cling-film, often not very securely.

Body pushers are those who insert drugs into either their vagina or rectum, also to avoid being found in possession of drugs.

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 purpose 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.

Typically, the substances concerned are cocaine or heroin, but other drugs may be involved. Diagnosis is based 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.

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 and, rarely, urinalysis may be negative owing to good packaging. 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.

3.6.2.2 Role of forensic physician

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 emergency (A&E) department of an NHS hospital with full resuscitation facilities and treated for a drug overdose until this is shown to be otherwise. If a forensic physician is contacted in this scenario, he or she 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 using the Custody Early Warning Score (CEWS). The CEWS is an adaptation of the Modified Early Warning Score (MEWS), the system recommended by the National Institute for Health and Clinical Excellence (Centre for Clinical Practice, 2007) for the early recognition of acutely ill patients. The CEWS may identify early symptoms of leakage.

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.

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 selfharm of varying degrees of intensity. 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 forensic physician 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 forensic physician is recommended. Further detention should only occur under suitable conditions. Some aspects of this 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 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. Most body packers can be managed conservatively; however, prompt treatment will be required should there be clinical signs of deterioration. Indications for surgical removal include intestinal obstruction, suspected rupture, and drug overdose.

3.6.3 Intimate searches

The Police and Criminal Evidence Act 1984 provides grounds under which an intimate search for 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 a person has concealed a Class A drug which he or she intended to supply to others or to export and that an intimate search is the only practicable means of removing it.

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 (British Medical Association & Faculty of Forensic and Legal Medicine, 2010).

Figure 3.1 outlines the conditions regulating intimate searches in police custody.

In summary, the search 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 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 (A&E) 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.

The doctor/nurse must have obtained the detainee's fully informed consent to this examination. 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/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.

In Scotland, 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

An intimate search is a physical examination of body orifices other than the mouth, and could therefore include the ear, nose, rectum or vagina. **It requires the authority of an inspector or above, and that the detainee is arrested, in police detention and:**

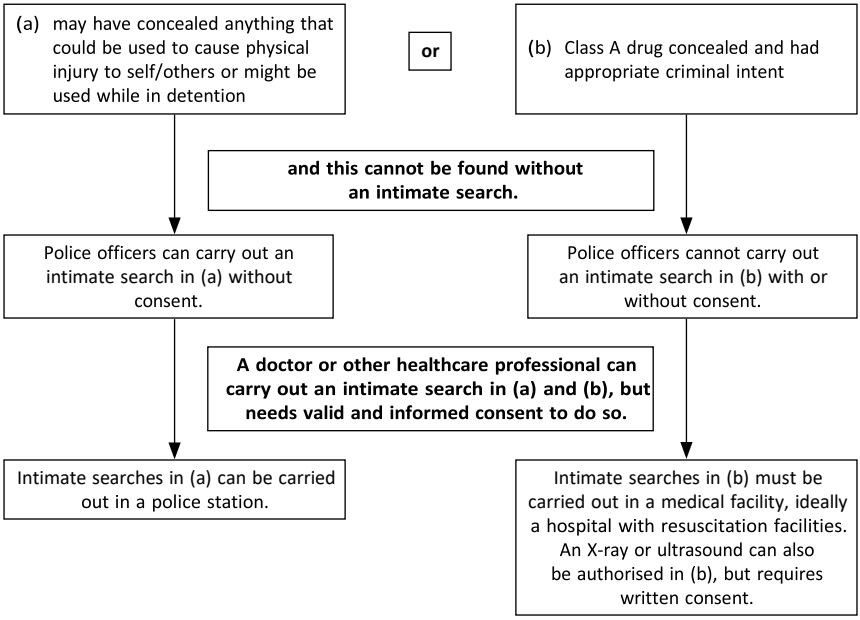

Fig. 3.1 Conditions regulating intimate searches in police custody (from Faculty of Forensic and Legal Medicine, 2010*b*).

Procedure (Scotland) Act 1995, or (c) a person detained at a police office for the purposes of search authorised by statute, then the search can take place only under the authority of a Sheriff's warrant. Where a warrant is obtained for this purpose, the search must be carried out by a police surgeon in a police medical room or at another suitably equipped premises that the police surgeon considers appropriate. A police officer of the same gender as the prisoner must be present to corroborate the search.

3.6.4 Liaison with prison

Remand prisons have specialist substance misuse nurses and a 24-hour healthcare presence. The assessment and treatment of drug and alcohol dependence in this setting tends, therefore, to be more in line with that provided in the community than in police custody, where the usually short period of detention restricts clinicians to 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.

24 To inform clinical assessment in prison, as indicated in Section 2.1 above, a record of any consultation provided by a forensic physician 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 the detainee. Any medication prescribed should be entered on the form. In addition, objective clinical measurements such as pulse rate, blood pressure and size of pupils 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 3.2.2 should be followed. Forensic physicians should (within the bounds of patient confidentiality) provide custody officers with sufficient information to allow them to give necessary care to the prisoner and to meaningfully pass on risk warnings. The custody officer will then communicate this suicide or self-harm risk warning to escort services, the court and the prison (using the Prisoner Escort Record Form). Again, forensic physicians 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. This is valuable in the context of continuation of prescribed medical management (see Section 3.11).

3.7 Drug treatment monitoring systems

In England, the National Drug Treatment Monitoring System (NDTMS) collects, collates and analyses information from, and for, those involved in the drug treatment sector. The NDTMS is a development of the system that previously involved the Regional Drug Misuse Databases (RDMDs), which had been in place since the late 1980s. Responsibility for the NDTMS lies with the National Treatment Agency for Substance Misuse. The data are submitted by treatment providers by electronic data transfer, and there is no need for forensic physicians to submit data.

For Northern Ireland, the Northern Ireland Drug Misuse Database

(NIDMD) is the system used to collect treatment attendance data. In Scotland, the equivalent system is the Scottish Drug Misuse Database (SDMD). Neither database requires completion by forensic physicians.

3.8 Statutory notification of addicts

Doctors in Great Britain are no longer required to notify cases of addiction to chief medical officers. However, the statutory requirement to report cases of addiction still applies in Northern Ireland.

The Misuse of Drugs (Notification of and Supply to Addicts) (Northern Ireland) Regulations 1973 require all doctors, including forensic physicians, to notify the Chief Medical Officer of the Department of Health, Social Services and Personal Safety in writing within 7 days if they attend a patient whom they consider to be, or have grounds to suspect is, addicted to any of the following controlled drugs: cocaine, methadone, dextromoramide, morphine, diamorphine (heroin), opium, dipipanone, oxycodone, hydrocodone, pethidine, hydromorphone, pentazocine, levorphanol and piritramide. Failure to notify within 7 days can result in disciplinary action against the doctor. Although notification does not imply that a prescription for a controlled drug has been, or will be, given by the doctor, where this is the case full details should be supplied.

The following information must be supplied on the notification: patient's name, address, gender, date of birth, health service number if known, the date of attendance and name of the drug or drugs concerned. All notifications should be sent to the Medical Officer at the Department of Health, Social Services and Public Safety (Medical Officer, C3.15 Castle Buildings, Belfast BT4 3SQ. Tel.: 028 9052 2421).

3.9 Arrest referral schemes and Drug Interventions Programme

Since April 2002, all police custody suites have had arrest referral or drug referral schemes. These schemes are partnership initiatives between the police, local agencies and drug action teams that aim to reduce drug-related crime by encouraging problem drug users who are arrested to take up appropriate treatment or other programmes of help. Involvement with the scheme is voluntary on the part of the arrestee.

In 2004, the Criminal Justice Interventions Programme, now known as the Drug Interventions Programme, was introduced as a critical part of the government's strategy for tackling drugs. It aims to direct drug-misusing offenders out of crime and into treatment through criminal justice and treatment agencies working together with other services. It draws together and builds on the best existing solutions, such as arrest referral, and introduces new elements. Delivery at a local level is through integrated teams using a case management approach to offer access to treatment and support. This begins at an offender's first point of contact with the criminal justice system and continues through custody, court, sentence and beyond, into resettlement.

Work in the custody suite, soon after arrest, is a crucial entry point into this overall programme. Arrest referral or Drug Interventions Programme workers seek to engage drug-using arrestees with the aim of providing information and, where appropriate, providing (or referring them on for) treatment or other means of assistance.

A range of offences now 'trigger' drug testing of offenders on arrest. This is another way of identifying problem drug users at an early stage of their contact with the criminal justice system. Research has linked all of the trigger offences to drug-related offending. The screening test is limited to looking for evidence of the presence of heroin, cocaine and crack cocaine. It is an accurate and non-intimate test that normally involves a swab under the tongue, is completed in minutes and provides results immediately. The results of the tests can lead to prompt referrals for treatment and are also used to inform court decisions on bail and sentencing. All of those testing positive should be given the opportunity to see an arrest referral worker, even if they have declined any previous offer. Disputed tests are referred to forensic science service providers for confirmatory laboratory analysis.

Forensic physicians should be aware of test results where available, as these may assist in the overall assessment of a detainee. The time limit for a positive test result in an oral fluid sample is 24–48 hours.

Forensic physicians are in a position to encourage detainees, especially those who have tested positive, to make the best use of the arrest referral services. They might also refer an individual, with their consent, to the arrest referral worker if they identify a substance misuse issue. All custody suites should have information about arrest referral and Drug Interventions Programmes, and forensic physicians should be familiar with this.

Further information about the Drug Interventions Programme is available at www.homeoffice.gov.uk/crime/reducing-reoffending/dip.

3.10 Medical complications of substance misuse and reducing the health risks

Many substance misusers have little or no contact with doctors or other healthcare professionals and therefore chronic conditions such as diabetes, heart disease and asthma are poorly managed. It is essential that forensic physicians encourage detainees to see their general practitioner or attend hospital clinics to receive the appropriate care for long-term conditions.

Substance misuse may result in medical complications that require assessment and further treatment.

Infective endocarditis, 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.

Cellulitis and abscesses may be seen around injection sites, and septic arthritis may result if deep abscesses extend into joints.

Many substance misusers suffer from self-neglect: malnutrition and dental decay may be present, as may infectious diseases such as hepatitis B, C, HIV and AIDS.

It is essential that forensic physicians provide treatment where necessary, referring to hospital as appropriate.

A visit by a forensic physician or other healthcare professional provides an opportunity to advise the detainee on risk reduction in relation to continued substance misuse. Although they are not always possible, strategies that can be usefully employed during this consultation include:

- referral to an on-site arrest referral/drug worker
- 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
- special attention given to sexual health issues, particularly those associated with prostitution, enabling access to emergency contraception

where required, and providing advice with regard to screening and further treatment for sexually transmitted diseases

- general awareness of blood-borne viruses (hepatitis B and C and HIV) and guidance on the availability of hepatitis B vaccination and of the risk to themselves and to close family members
- education on the hazards of injecting drugs, particularly with regard to shared injecting equipment
- education on the risks of overdose, of multiple substance misuse, including alcohol, and of the variable purity of illicit drugs
- advice 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 (where detoxification is the chosen treatment option) or residential rehabilitation.

A significant minority of injecting drug users have experienced a broken needle at some time in their injecting career (Norfolk & Gray, 2003). Central embolisation may occur in 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. This will necessitate attendance at an emergency (A&E) department.

3.11 Prescribing

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 withdrawal, and in limiting the emergence of withdrawal symptoms. 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.

Forensic physicians may have access to certain medication in police stations with an agreed formulary or may carry their own supplies. Arrangements will vary as to how medication is obtained and it is important that forensic physicians are aware of local procedures.

3.11.1 Consideration of prescribing/authorising continuation of substitute drugs

It cannot be stressed too strongly that a comprehensive clinical examination (which includes the taking of a history and the keeping of accurate notes) should be carried out to assess 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 particularly useful when a reassessment is performed by the same doctor or a colleague. Information for colleagues should be left in a confidential, sealed envelope.

Care must be taken to exclude the presence of intoxication by substances and/or alcohol (including legitimately prescribed drugs such as benzodiazepines).

Information from other sources, including the prescriber (general practitioner, drug-dependency clinic or voluntary agency) and dispenser (pharmacist or voluntary agency), should be obtained if possible. The enquiry should include details of medication prescribed, dosage, duration of treatment 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, concealment (buprenorphine) or regurgitation (methadone) if the dose was not properly supervised, and/or a time lag since the last supervised dose because of a weekend. The detainee may, of course, be continuing to use illicit substances as well.

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 (as, for example, in Lothian & Borders); drugs should be prescribed on a private prescription paid by the police. For Schedule 2 and 3 controlled drugs, forensic physicians should use the private prescription FP10PCD (England), WP10PCD (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.

3.11.2 Near-patient testing

The use of an on-site drug-testing kit in the police station may be helpful in police custody (Stark *et al*, 2002). Such tests give qualitative rather than quantitative results and so confirm whether or not a substance has been used rather than the quantity of the substance used. Doctors 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 and it will remain part of the clinical record. Cross-reactivity occurs with codeine products, among other compounds, but not methadone or buprenorphine.

3.11.3 Assessment procedure

The following steps are recommended:

(1) 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, the full effects of which may not yet be obvious.

(2) *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.

(3) It should be remembered that most individuals are not detained in police custody for very long and that medical treatment in the form of substitute drugs may therefore not be required. However, for those detained for longer periods, previously prescribed substitution treatment should be continued, if in the forensic physician's judgement it is safe to do so.

(4) The forensic physician should recommend reassessment after a specific period depending on the history given by the detainee and the examination findings. Reassessment of a heroin user, for example, may be helpful after 8 hours, as heroin has a short half-life compared with methadone. Reassessment must be by a healthcare professional with appropriate expertise and the ability to prescribe or administer under a patient group direction (PGD) any medication identified as necessary.

(5) In the absence of withdrawal signs, confirmation of opioid substitution treatment should be sought from other reliable sources before authorising continuation of treatment.

(6) The prescribed dose of opioid substitution treatment does not necessarily accurately indicate actual consumption, as part of or the entire dose may be

given to other individuals. Therefore, the doctor needs to know not only the amount prescribed but also whether the detainee is actually taking the drug.

(7) *It should be remembered that even a small amount of opioids may be fatal to a non-dependent individual.*

(8) The decision to prescribe opioid substitution treatment and supervise self-administration is the responsibility of the forensic physician, even when the drug is collected from the usual clinic or pharmacist.

(9) If there is doubt about the daily dose, then the dose can be divided and given every 6–12 hours.

(10) 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.

(11) It should be remembered that if a single dose is prescribed and given by the forensic physician, 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 script to cover any missed instalments or liaise with the original prescriber to ensure continuation of therapy.

(12) If the detainee is not under current treatment or treatment details cannot be verified but he or she nevertheless has a clear history, signs of regular drug use and objective evidence of withdrawal symptoms and signs, then treatment should be given to alleviate the withdrawal syndrome.

(13) Forensic physicians should prescribe substitution treatment only if they are sure that it is clinically safe to do so. Even if the doctor is confident and has objective evidence of dependence on prescribed drugs, the doctor

should still advise the detainee and the police of the possible side-effects of intoxication as a matter of good practice.

3.11.4 Administration of medication in police stations

The PACE Code of Practice for the detention, treatment and questioning of persons by police officers (Code C) gives guidance on the administration of medication (Home Office, 2006). 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.'

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 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.'

This includes, for example, methadone oral solution, buprenorphine, methylphenidate, phenobarbitone and temazepam.

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 registered medical practitioner authorising their use. This may be done by telephone. 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 33 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 forensic physician to discuss those concerns and whether a visit is required.

The police should ensure that the treatment recommended by the doctor is properly administered by the detainee and documented and that all ingestion of medication is supervised (Faculty of Forensic and Legal Medicine, 2011).

No police officer should measure out doses of methadone or any other medicines.

Intravenous medication for treatment of substance misuse is generally inappropriate in this setting and should be avoided. If opioid substitution

treatment 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.

4 Fitness for interview

4.1 General considerations

An opinion may be requested as to the detainee's fitness for interview. The doctor 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. Consequently, the finding of fitness for interview is potentially time-limited. Forensic physicians should ensure that an accurate record is made of the examination conducted, including the reasoning behind their decision as to whether the detainee is fit or unfit for interview.

4.2 Definition (Annex G of PACE Codes of Practice Code C)

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

(a) conducting the interview could significantly harm the detainee's physical or mental state;

(b) 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.'

(Home Office, 2011: Code C, Annex G) When forensic physicians identify risks, they should attempt to quantify the risk. 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.

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

(a) 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 make rational decisions about whether they want to say anything;

(b) 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;

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

Therefore, the forensic physician must consider the various vulnerability factors that render an individual more likely to provide an unreliable confession. These factors include the health of the individual (physical and mental, including substance misuse), the likely demand characteristics of the interview, personality traits that increase vulnerability, and the totality of the circumstances (personality/health/interview/totality of the circumstances: PHIT) (Norfolk, 2001).

The definition of fitness for interview is distinct from the definition of fitness to plead.[2] Forensic physicians should be aware that the risk of unreliability with regard to substance misusers may vary; for example, 35 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 learning disabilities. Alcohol- or drug-related memory deficit may also produce temporary or permanent (for example, Korsakoff states) impairment of fitness for interview.

4.3 False confessions

Forensic physicians need to be aware of the various types of false confession, as the doctor's primary concern is to recognise any characteristics that might render the individual vulnerable to providing a false confession, 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 clinical psychologists.

[2] . In assessing fitness to plead, medical witnesses are asked whether the accused has capacity to instruct his or her lawyer, to plead to the charge, to challenge a juror and to understand the evidence (see Chiswick, 1990: p. 174).

False confessions have been divided into voluntary, coerced–compliant, coerced– internalised (Kassin & Wrightsman, 1985) and accommodating–compliant (Wolchover & Heaton-Armstrong, 1996: p. 99).

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.

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.

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 36 a stressful situation, while giving little attention to the potentially serious long-term implications of making a false confession. Addicts 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 that they are accused of. 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.

4.4 The possible impact of substance misuse withdrawal states on the validity of a confession

4.4.1 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.

Forensic physicians 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 doctor can do something, for example offering brief intervention/ counselling or reassurance that if detained for any length of time in the police station, there will be access to a doctor 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 doctor needs to consider the likely demand characteristics of the interview, as the perceived seriousness of the alleged offence seems to be the most important factor in determining how well a 37 person will withstand the demands of an interrogation.

Although the police service is actively supporting the operation of arrest referral schemes, it is still important to recognise that an admission by a detainee to being a drug addict 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.

4.4.2 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 selfevident 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.

4.4.3 Forensic physicians and the prescription of drugs to allay withdrawal

Forensic physicians deciding on prescribing 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 doctor may well need to assess the impact of the treatment before an interview takes place.

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 opioid substitution treatment.

The Court of Appeal (Criminal Division) 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 (*R. v. Crampton Court of Appeal [Criminal Division]*, 1990). 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 medical evidence. However, the admissibility of any statement will be decided in court by the judge and its credibility 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. The mental state may then need re-examination to assess the individual's fitness for interview. Polysubstance misuse, which is increasingly common, will complicate matters further, particularly where both drugs and alcohol have been taken.

When the detainee is considered fit to be interviewed, the forensic physician 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 doctor may consider it prudent to recommend re-examination following the interview.

4.5 The possible effect of substance misuse intoxication 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 drunk or drugged when brought into the police station, the police will usually wait until the intoxication has cleared before commencing questioning.

However, 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. Forensic physicians 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 an effect on short-term recall, vigilance and self-monitoring; stimulants may have effects on aggression and inhibition; and cannabis on 39 memory, perception and concentration. If there is doubt, then reassessment is recommended after an appropriate interval.

5 Managing specific drug problems (Ghodse, 2010)

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

There should be a high level of awareness of alcohol problems when assessing substance misusers, and a high level of suspicion of organic disorder.

Female detainees should be asked about the possibility of pregnancy, as this may influence the choice of treatment (see Section 3.3.1).

Treatment of younger detainees by substitution or symptomatic medication should be undertaken with great caution (Department of Health, 2009). Younger people are less likely to be dependent and are more likely to suffer adverse effects to medicines used more commonly in 40 adult patients.

Great caution should be exercised in the medication of elderly patients who present with alcohol and/or opioid dependency or dependency on prescribed drugs. Doses of medication required for symptomatic relief are usually less than in adult patients. There is also a greater likelihood of an underlying organic problem.

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

5.1 Alcohol

5.1.1 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 may depress medullary function. The clinical effects of alcohol vary considerably between different individuals, depending on their degree of tolerance.

Alcohol intoxication may result in nystagmus; normal or dilated pupils (although as the level of intoxication increases and coma results, the pupils often become pin-point); slurred speech; increase in blood pressure and pulse with moderate doses; incoordination and ataxia.

Care should be taken to exclude concurrent medical problems in alcoholintoxicated detainees, in particular head injuries and hypoglycaemia, which may complicate the picture.

An intoximeter may be a valuable tool to assess the blood 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' blood alcohol levels (Rogers *et al*, 1995).

5.1.2 Symptoms and signs of withdrawal

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.

5.1.3 Treatment of withdrawal

Withdrawal from alcohol in police custody can pose a serious threat to the individual's health. 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 delirium tremens.

Benzodiazepines, for example chlordiazepoxide or diazepam, are the treatments of choice (Mayo-Smith, 1997). If the detainee is unable to take oral medication, transfer to a general hospital for parenteral treatment should be arranged.

5.2 Benzodiazepines

5.2.1 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.

Table 5.1 Benzodiazepine withdrawal syndrome

Anxiety symptoms	*Disordered perceptions*	*Major complications*
Anxiety	Feelings of unreality	Psychosis
Sweating	Abnormal body sensations	Epileptiform seizures
Insomnia	Abnormal sensation of movement	
Headache	Hypersensitivity to stimuli	
Tremor		
Nausea		

5.2.2 Symptoms and signs of withdrawal

Sudden cessation of benzodiazepines in dependent individuals can lead to a recognised withdrawal state, including delirium and seizures in severe cases (Table 5.1).

The withdrawal syndrome usually develops within 2 days, but 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 historytaking and examination are required.

Clonazepam is a second-line treatment for epilepsy (e.g. National Collaborating Centre for Primary Care, 2004), 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.

5.2.3 Treatment of withdrawal

Once intoxication has been excluded, benzodiazepine withdrawal can be treated. Treatment is aimed at alleviating symptoms and preventing the major complications of fits 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 10 mg three times a day should be adequate to prevent withdrawal seizures, but may need to be titrated upwards to prevent withdrawal symptoms and signs (Table 5.2).

Table 5.2 equivalent to 5 mg diazepam of common benzodiazepines and Z-drugs

Drug	*Dose*
Chlordiazepoxide	15 mg
Diazepam	5 mg
Loprazolam	0.5 mg
Lorazepam	0.5 mg
Oxazepam	15 mg
Temazepam	10 mg
Nitrazepam	5 mg
Zaleplon	10 mg
Zopiclone	7.5 mg
Zolpidem	10 mg

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

5.3 Opioids

5.3.1 Symptoms and signs of intoxication

Intoxication with opioids causes 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.

Pin-point 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. Rapid reversal of opioid effects may precipitate an abrupt withdrawal syndrome. Where severe opioid intoxication is suspected, an emergency ambulance must be called immediately and naloxone given in an initial dose of 0.4–0.8 mg intravenously or intramuscularly. If there is no response after 2–3 minutes, the dose should be repeated. If there is no response after further doses (to a maximum of 10 mg), the diagnosis is in question and other conditions, for example hypoglycaemia, should be considered.

5.3.2 Symptoms and signs of withdrawal

The severity of opioid withdrawal symptoms is influenced greatly by psychological factors. The environment in a police cell is likely to exacerbate these symptoms. Observable or measurable signs of opioid withdrawal include those shown in Table 5.3.

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.

The severity of withdrawal symptoms is not directly related to the quantity of drugs previously consumed.

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.

Table 5.3 Symptoms and signs of opioid withdrawal

Symptoms	*Signs*
Sweating	Dilated pupils

Lachrymation and rhinorrhoea	Goose flesh
Yawning	Flushing
Feeling hot and cold	Sweating
Anorexia and abdominal cramps	Running nose and eyes
Nausea, vomiting and diarrhoea	Tachycardia, hypertension
Tremor	Increased bowel sounds
Restlessness and insomnia	
Anxiety, agitation	
Generalised aches and weakness	

5.3.3 Symptomatic treatment of withdrawal

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

Symptomatic relief of withdrawal symptoms (Table 5.4) 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.

The routine use of benzodiazepines for anything other than benzodiazepine or alcohol dependence is not to be recommended in

Table 5.4 Symptomatic treatment of opiate withdrawal

Symptom	*Drug*	*Administration*
Vomiting	Buccal prochlorperazine	3 or 6 mg (one or two 3 mg tablets) absorbed from buccal cavity twice daily. Useful if unable to retain oral medication.
	Metoclopramide	10 mg three times daily. Not known to be harmful in pregnancy. Action antagonised by opioid analgesics.
Abdominal cramps	Mebeverine	135 mg three times daily, preferably 20 minutes before meals. Antispasmodic, not known to be harmful in pregnancy.
Diarrhoea	Loperamide	4 mg initially, followed by one after each loose stool; maximum 16 mg daily. An opiate receptor agonist which acts on the gut to reduce peristalsis, increase intestinal transit time and increase the tone of the anal sphincter.
Minor aches and pains	Paracetamol or NSAID such as ibuprofen	Paracetamol: 1 g up to four times daily. Not known to be harmful in pregnancy. Ibuprofen: initially 200–400 mg three or four times daily; maximum 2.4 g daily. Avoid NSAIDs in pregnancy, especially in the third trimester.
Insomnia	Zopiclone	7.5 mg at night. Elderly: initially 3.75 mg at night, increased if necessary. Nonbenzodiazepine acting at the benzodiazepine receptor, with lower incidence of dependency than benzodiazepines. Short duration of action so less likelihood of 'hangover' effect.

NSAID, non-steroidal anti-inflammatory drug.

police custody as such drugs may affect cognition and therefore fitness to be interviewed. Furthermore, if the detainee is subsequently transferred to prison he or she may claim to be dependent on benzodiazepines and, as these drugs will appear in the initial urine drug screen test on reception, this may result in a long, slow period of unnecessary detoxification.

5.3.3.1 Lofexidine

Lofexidine is not normally initiated in police custody but it should be continued if previously prescribed.

This is a non-opioid drug, an alpha-adrenergic agonist, which counteracts most of the symptoms of opioid withdrawal if given in adequate doses (e.g. 0.2–0.4 mg, 4–6 hourly). It is authorised for the management of opioid withdrawal (Department of Health (England) and the devolved administrations, 2007) and may be considered for

those who have decided not to use methadone or buprenorphine for detoxification, have decided to detoxify within a short period of time, or have mild or uncertain dependence (including young people) (National Collaborating Centre 46 for Mental Health, 2007). Lofexidine has potential adverse effects on the cardiovascular system (hypotension and bradycardia). Physical examination (including measurement of blood pressure and pulse) is therefore required before starting treatment and should be repeated regularly during treatment in police custody.

5.3.4 Use of substitute opioids

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

Caution should be exercised when prescribing opioid substitution treatment in the absence of withdrawal signs or other confirmatory information and confidence about previous consumption. Either liquid oral preparations (e.g. methadone oral solution 1 mg/ml) or codeine-based tablets are preferred. Opioid equivalents to 1 mg methadone are shown in Table 5.5.

'Street' heroin varies in purity and consumption cannot be accurately estimated. Therefore, the dose should be titrated against withdrawal symptoms and signs, starting, for example, with methadone 10 mg and

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Table 5.5 Opioid equivalents for withdrawal: related potencies for withdrawal protocols equivalent of 1 mg methadone[a]

Drug	*Dose*
Codeine	15 mg
Dextromoramide	0.5–1 mg
Dextropropoxyphene	15–20 mg
Dihydrocodeine	10 mg
Dipipanone (Diconal®)	2 mg
Pharmaceutical heroin	1–2 mg
Hydromorphone	0.5 mg
Methadone linctus	1 mg/2.5 ml
Methadone oral solution	1 mg/ml
Morphine	3 mg
Pethidine	15 mg
Buprenorphine[b]	0.04 mg
Pentazocine[b]	10 mg
Gee's linctus®	10 ml (1.6 mg of morphine)
J Collis Browne's mixture®	10 ml (1 mg extract of opium)

a. This table can be used to convert the dose of other opioids into milligrams of methadone but, owing to the different half-life of other drugs and their mode of administration, the conversion can only be a guide. Whichever drug of substitution is used, the dose should be titrated against the withdrawal symptoms and signs. The equivalence values are only a guide and are for licit drugs. They should not be used for drugs from illicit sources, as the purity of these varies and cannot be certain.
b. Mixed agonist/antagonist.

reviewing later to see whether withdrawal symptoms and signs have subsided. *It is essential that an initial low dose is used and NOT more than thirty milligrams (30 mg) of methadone in 24 hours in divided doses or equivalent should be prescribed*. Hospital admission may be required in certain circumstances.

5.3.5 Choosing substitute drugs

Preventive prescribing on the assumption that someone is dependent is not safe practice and should not be done unless the forensic physician is confident that a detainee is dependent.

5.3.5.1 Codeine-based drugs

Dihydrocodeine tartrate or codeine phosphate have a short duration of action and have 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 modified release (DHC Continus®) can be given every 12 hours.

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 60–90 mg (or greater) three or four times a day may be required. The decision as to the necessity and timing of any reassessment *is the forensic physician's responsibility* and should be based on the severity of dependence and other aspects of the clinical examination.

Many forensic physicians use dihydrocodeine as substitution treatment (Stark & Gregory, 2005). Although the drug is not licensed for the treatment of drug dependence it is efficacious for this environment (Robertson *et al*, 2006). The advantage of dihydrocodeine over the other opioid substitutes 48 is that it is less potent and has a shorter half-life, so that the likelihood of accidental accumulation or overdose is reduced.

5.3.5.2 Methadone

Methadone is available in liquid form for the treatment of dependence. Initiation of methadone substitution treatment in custody will be an exceptional necessity; the following applies mainly to detainees already on prescribed methadone.

Forensic physicians 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 1 mg/ml, which is typically green although there is a colour-free mixture; methadone oral concentrate is available in two strengths: 10 mg/ml (blue) and 20 mg/ml (brown).

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.

Methadone oral solution 1 mg/ml should 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.

Any doctor can prescribe methadone and most other opioids to a drug misuser. (A special licence is required only for the prescription of cocaine, dipipanone and diamorphine for the purpose of treating addiction.)

If there is doubt about the dose of methadone to be given, it should be divided and the detainee's condition should be reviewed after a proportion has been administered. It is important to document this procedure and why the dosage has been split, as would be the case in all other secure environments.

5.3.5.3 Buprenorphine

Increasingly, forensic physicians are asked to assess detainees who are on buprenorphine sublingual tablets, which are licensed in the UK for the treatment of opioid dependence. The drug is an opioid with agonist and antagonist properties claimed to be less of a risk in overdose when taken alone. The tablets are available in 0.4 mg, 2 mg and 8 mg strengths.

Direct equivalence between buprenorphine and methadone is difficult to estimate. However, 12–16 mg of buprenorphine is approximately as effective as 50–80 mg methadone in reducing heroin use and retaining 49 patients in treatment. Buprenorphine is usually administered once a day because of its long duration of action.

As long as it is clinically safe to do so, a prescribed course of buprenorphine, if verifiable, should be continued while in custody, regardless of whether it is prescribed for detoxification or maintenance.

Self-administration of the drug must be personally supervised by the forensic physician, 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. Initiation of treatment of opioid withdrawal with buprenorphine in police custody is not therefore recommended. It should also be remembered that dihydrocodeine will not be effective if an individual is currently taking buprenorphine.

5.3.5.4 Buprenorphine with naloxone

These drugs in combination (as 2 mg/0.5 mg and 8 mg/2 mg) are licensed as substitution treatment for opioid dependence. Forensic physicians should confirm the dose and frequency of administration before authorising self-administration, which they should supervise.

5.4 Stimulants

5.4.1 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.

Long-term users of cocaine or amphetamines may experience the syndrome of excited delirium (Wetli & Fishbain, 1985). This comprises four successive stages: hyperthermia, delirium, respiratory arrest and death. Individuals are highly agitated and paranoid, die suddenly and in some cases have been restrained in police custody because of excited behaviour 50 shortly before death. If excited delirium is suspected, the detainee should be transferred to an emergency (A&E) department immediately.

5.4.2 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.

5.5 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 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.

LSD is a Class A controlled drug under the Misuse of Drugs Act 1971 and its possession is illegal.

5.6 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.

Forensic physicians are reminded that sudden death is a recognised hazard of volatile substance misuse and may occur during exposure or in the subsequent hours (Shepherd, 1989), especially during struggling or arousal.

No specific management is required, even after abrupt discontinuation. There is no physical withdrawal syndrome.

5.7 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 are often sold in herbal products such as the smoking mixture 'Spice'.

5.8 Other substances (see Stark & Norfolk, 2011)

New psychoactive substances are constantly being identified. Since the last edition of these guidelines, there has been a proliferation in the number of emerging drugs. These include: cathinones such as mephedrone (Advisory Council on the Misuse of Drugs, 2010); piperazines such as benzylpiperazine (Advisory Council on the Misuse of Drugs, 2008); naphyrone (naphthylpyrovalerone); and 'ivory wave' (desoxypipradrol, 2-diphenylmethylpiperidine, or 2-DPMP). Often referred to as 'legal highs', these

drugs are rapidly brought under legislative control if a certain level of harm is recognised.

52 With so many new psychoactive substances available, often of variable content and unknown individual tolerance, and intentional and unintentional polydrug use, forensic physicians and healthcare professionals should have a low threshold, if concerned, 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 European Monitoring Centre for Drugs and Drug Addiction (2010) is monitoring the availability and possible health impact of known and emerging substances.

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.

Alkyl nitrites, volatile, yellowish, clear liquids that have vasodilatory properties, are 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.

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.

Gamma-hydroxybutyrate (GHB) is structurally related to gammaaminobutyric 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, followed by profound 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 53 are potentiated by use of other CNS depressants such as alcohol, opioids, benzodiazepines and antipsychotics. Dependence

may occur rapidly, resulting in a withdrawal syndrome of anxiety, sweating, tachycardia, tremor and eventually delirium. Withdrawal should be treated with high-dose benzodiazepines. Both GHB and GBL are now controlled under Class C of the Misuse of Drugs Act 1971.

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. Although both cathine and cathinone are controlled substances, it is not illegal to possess khat in the plant form.

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 contains analgesic properties; the onset of 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.

Hallucinogenic mushrooms (European Monitoring Centre for Drugs and Drug Addiction, 2006) 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.

5.8.1 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.

Appendix A: PACE Code C observation list

Annex H – Detained Person: Observation List, as outlined in Code C of the Codes of Practice July 2006 to the Police and Criminal Evidence Act 1984 (s.66(1)).

1. If any detainee fails to meet any of the following criteria, an appropriate health care professional or an ambulance must be called.
2. 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!

3. 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
   - Stroke

Appendix B: Metropolitan Police Form 170

The form on the following pages (Form 170) is used in the London Metropolitan Area to facilitate medical referrals and the transfer of information between the healthcare professional and the hospital doctor.

CONFIDENTIAL

METROPOLITAN POLICE Working together for a safer London

Form 170
Part A

EMERGENCY MEDICINE DOCTOR / ENP ..... Police Station

Telephone No...

..... Hospital Custody No...

Date

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 Metropolitan Police Service, so that your medical welfare whilst in custody is maintained?

Yes ☐ **No** ☐ (tick appropriate box)

Signed ..... **Date** ..... / ..... / .....

I consider it necessary to remove (name of person at police station):

..... to Hospital

REASON FOR REMOVAL:

Signature of Forensic Medical Examiner / Healthcare Professional/Custody Officer

Name in BLOCK capitals:

Form 170

Part B

Detainee released from hospital care – notification to police of treatment administered

Patient's Consent: Do you give your consent for relevant medical information and/or treatment plans to be communicated by healthcare professionals to the Metropolitan Police Service, so that your medical welfare whilst in custody is maintained?

Yes ☐ **No** ☐ (tick appropriate box)

Signed..... **Date**...../...../.....

Hospital Medical Staff – advice on completion

Please 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.

CONFIDENTIAL INFORMATION SHOULD NOT BE DISCLOSED WITHOUT CONSENT.

Hospital.....

Dept..... Date.....

To:

Forensic Medical Examiner / Healthcare Professional/Custody Officer

Full name of patient.....

Discharged at ☐☐☐☐ hours on.....(date)

Brief details of symptoms

.....

.....

.....

.....

.....

.....

Diagnosis

.....

.....

.....

.....

Details of treatment and investigations

Part B contd

Medication administered

Medication	Dose	Time Given

Recommended after-care (to include medication – any recommendations as to police action) **Please supply medication that the patient requires and give to police.**

The Forensic Medical Examiner / Healthcare Professional will be called to examine the detainee on arrival at the police station.

Do you wish the FME / Healthcare Professional to contact you? Yes (tick ☐ No ☐

Signature.....

Name in BLOCK capitals.....

Grade.....

Tel. No..... Ext.....

Medical Information (to be retained at custody facility)

60

Name.....

This person is suffering from:

.....

.....

He / She is having the following treatment:

.....

.....

.....

.....

.....

.....

Further details may be obtained from:

Name of Doctor / Healthcare Professional (BLOCK CAPITALS).....

Telephone No.....

Signature..... Grade.....

Date and Times	Further Management	Doctor

Form 170

Part C contd

Date and Times	Further Management	Doctor

Appendix C: Glossary

ACPO	Association of Chief Police Officers
AFP	Association of Forensic Physicians
APS	Association of Police Surgeons
CEWS	Custody Early Warning Score
CFM	clinical forensic medicine
Ecstasy	see MDMA
FFLM	Faculty of Forensic and Legal Medicine
FME	forensic medical examiner
FMO	forensic medical officer
FP	forensic physician
GBL	gamma-butyrolactone
GHB	gamma-hydroxybutyrate
GMC	General Medical Council
HCP	healthcare professional
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Prisons
HPC	Health Professions Council
Ivory wave	desoxypipradrol/2-diphenylmethylpiperidine 2-DPMP
MDMA	ecstasy 3,4-methylenedioxymethamphetamine
MEWS	Modified Early Warning Score
NMC	Nursing and Midwifery Council
NDTMS	National Drug Treatment Monitoring System
NIDMD	Northern Ireland Drug Misuse Database
NSPIS	National Strategy for Police Information Systems
NTA	National Treatment Agency for Substance Misuse
PACE	Police and Criminal Evidence Act 1984
PGD	patient group direction
SDMD	Scottish Drug Misuse Database
SIDT	suspected internal drug traffickers

References

Advisory Council on the Misuse of Drugs (2008) *Control of 1-Benzylpiperazine (BZP) and Related Compounds.* ACMD.

Advisory Council on the Misuse of Drugs (2010) *Consideration of the Cathinones.* ACMD.

Association of Forensic Physicians & Royal College of Psychiatrists (2006) *Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management (3rd edn).* (Council Report CR132). Royal College of Psychiatrists.

Association of Police Surgeons & Royal College of Psychiatrists (2000) *Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management (2nd edn).* (Council Report CR81). Royal College of Psychiatrists.

Boreham, R., Cronberg, A., Dollin, L., *et al* (2007) The Arrestee Survey 2003–2006. *Home Office Statistical Bulletin*, **12**/7**.**

British Medical Association & Faculty of Forensic and Legal Medicine (2010) *Recommendations for Healthcare Professionals Asked to Perform Intimate Body Searches: Guidance for Doctors from the British Medical Association and the Faculty of Forensic and Legal Medicine July 2010*. BMA Ethics Department (http://fflm.ac.uk/upload/ documents/1281533595.pdf).

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.

Centre for Clinical Practice (2007) *Acutely Ill Patients in Hospital: Recognition of and Response to Acute Illness in Adults in Hospital (Clinical Guideline 50).* National Institute for Health and Clinical Excellence.

Chiswick, D. (1990) Fitness to stand trial and plead mutism and deafness. In *Principles and Practice of Forensic Psychiatry* (eds R. Bluglass & P. Bowden), pp. 171–178. Churchill Livingstone.

Crome, I., Ghodse, H., Gilvarry, E., *et al* (eds) (2004) *Young People and Substance Misuse.* Gaskell.

Department of Health (2006) *Clinical Management of Drug Dependence in the Adult Prison Setting: Including Psychosocial Treatment as a Core Part.* Department of Health.

Department of Health (2009) *Guidance for the Pharmacological Management of Substance Misuse among Young People in Secure Environments.* TSO (The Stationery Office).

Department of Health (England) and the devolved administrations (2007) *Drug Misuse and Dependence: UK Guidelines on Clinical Management.* Department of Health (England), Scottish Government, Welsh Assembly Government & Northern Ireland Executive.

Department of Health, Scottish Office Home and Health Department & Welsh Office (1994) *Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management.* HMSO.

Department of Health, Scottish Office Department of Health, Welsh Office, *et al* (1999) *Drug Misuse and Dependence: Guidelines on Clinical Management.* TSO (The Stationery Office).

European Monitoring Centre for Drugs and Drug Addiction (2006) *Hallucinogenic Mushrooms: An Emerging Trend Case Study (EMCDDA Thematic Papers).* EMCDDA.

European Monitoring Centre for Drugs and Drug Addiction (2010) *Annual Report on the State of the Drugs Problem in Europe.* EMCDDA (http://www.emcdda.europa.eu/publications/annual-report/2010).

Faculty of Forensic and Legal Medicine (2008) *Recommendations: Consent from Children and Young People in Police Custody in England and Wales.* FFLM, Royal College of Physicians (https://fflm.ac.uk/upload/documents/1211556037.pdf).

Faculty of Forensic and Legal Medicine (2010*a*) *Quality Standards in Forensic Medicine:*

General Forensic (GFM) and Sexual Offence Medicine (SOM). FFLM, Royal College of Physicians (http://fflm.ac.uk/upload/documents/1304601986.pdf).

Faculty of Forensic and Legal Medicine (2010*b*) *Quick Reference Guide: Intimate Searches in Police Custody.* FFLM, Royal College of Physicians (http://fflm.ac.uk/upload/documents/1282835640.pdf).

Faculty of Forensic and Legal Medicine (2011) *The Safety and Security of the Administration of Medication in Police Custody.* FFLM, Royal College of Physicians.

General Medical Council (2006) *Good Medical Practice.* GMC.

General Medical Council (2009) *Confidentiality: Guidance for Doctors.* GMC.

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

Ghodse, A. H. (2010) *Drugs and Addictive Behaviour: A Guide to Treatment (4th edn).* Cambridge University Press.

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

Gillick v. West Norfolk & Wisbech Area Health Authority [1985] 3 WLR 830; UKHL 7.

Gregory, M. (2007) Characteristics of drug misusers in custody and their perceptions of medical care. *Journal of Forensic and Legal Medicine*, **14**, 2092–2012.

HM Government (2010) *Drug Strategy 2010. Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*. TSO (The Stationery Office).

HM Inspectorate of Constabulary for Scotland (2008) *Thematic Inspection: Medical Services for People in Police Custody.* The Scottish Government (http://www.scotland.gov.uk/Publications/2008/10/13112955/2).

HM Inspectorate of Prisons & HM Inspectorate of Constabulary (2009) *Expectations for Police Custody: Criteria for Assessing the Treatment and Conditions for Detainees in Police Custody.* Criminal Justice Joint Inspection (http://www.hmic.gov.uk/media/expectations-for-police-custody-20100120.pdf).

Hoare, J. & Moon, D. (2010) Drug Misuse Declared: Findings from the 2009/10 British Crime Survey England and Wales. *Home Office Statistical Bulletin* **13**/10.

Home Office (2006) *Police and Criminal Evidence Act 1984 (s. 66 (1)): Code of Practice C and Code of Practice H (July 2006)*. TSO (The Stationery Office).

Home Office (2011) *Police and Criminal Evidence Act 1984 (PACE) and Accompanying Codes of Practice*. Home Office (http://www.homeoffice.gov.uk/police/powers/ pace-codes).

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

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. Kassin, S. M. &

Wrightsman, L. S. (1985) *The Psychology of Evidence and Trial* 65 *Procedure.* Sage.

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

Mayo-Smith, M. F. (1997) Pharmacological management of alcohol withdrawal: a meta-analysis and evidence based practice guideline. *JAMA*, **278**, 144–151. Mirza, K. A. H. & Mirza, S. (2008) Adolescent substance misuse. *Psychiatry*, **7**, 357–362.

Møller, L., Stöver, H., Jürgens, R., *et al* (eds) (2007) *Health in Prisons: A WHO Guide to the Essentials in Prison Health.* World Health Organization (http://www.who.int/ hiv/topics/idu/prisons/e90174.pdf).

National Centre for Policing Excellence (2006) *Guidance on the Safer Detention & Handling of Persons in Police Custody: 2006.* NCPE.

National Collaborating Centre for Mental Health (2004) *Self-harm: The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care (Clinical Guideline 16).* National Institute for Clinical Excellence.

National Collaborating Centre for Mental Health (2007) *Drug Misuse: Opioid Detoxification (Clinical Guideline 52).* National Institute for Health and Clinical Excellence.

National Collaborating Centre for Primary Care (2004)*The Epilepsies: The Diagnosis and Management of the Epilepsies in Adults and Children in Primary and Secondary Care (Clinical Guideline 20).* National Institute for Clinical Excellence.

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

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

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

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

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.

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

Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290.

Robertson, J. R., Raab G., Bruce M., *et al* (2006) Addressing the efficacy of dihydrocodeine versus methadone as an alternative maintenance treatment for opiate dependence: a randomized controlled trial. *Addiction*, **101**, 1752–1759.

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.

Scottish Office (1998) *Circular No: SWSG8/98.* Scottish Office Home Department (http://www.scotland.gov.uk/library/swsg/index-f/c214.htm).

Shepherd, R. T. (1989) Mechanisms of sudden death associated with volatile substance abuse. *Human Toxicology*, **8**, 287–292.

Skills for Health (2007) *Functional Map for Healthcare Professionals Working in Police Custody Settings (National Occupational Standards).* Skills for Health.

Stark, M. M. & Gregory, M. (2005) The clinical management of substance misusers in police custody – a survey of current practice. *Journal of Clinical Forensic Medicine*, **12**, 199–204.

Stark, M. M. & Norfolk, G. (2011) Substance misuse. In *Clinical Forensic Medicine: A Physician's Guide (3rd edn)* (ed. M. M. Stark), in press. Human Press.

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.

Wetli, C. V. & Fishbain, D. A. (1985) Cocaine-induced psychosis and sudden death in recreational cocaine users. *Journal of Forensic Sciences*, **30**, 873–880.

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

Zeitlin, H. (1999) Psychiatric comorbidity with substance misuse in children and teenagers. *Drug and Alcohol Dependence*, **55**, 225–234.

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ISBN 978-1-908020-38-3