Royal Pharmaceutical Society of Great Britain

Pharmaceutical care of detainees in police custody

The Department of Health issued Guidelines for the Clinical Management on Substance Misuse in respect of detainees in police custody in 1994, and "Drug Misuse and Dependence: Guidelines on clinical management" in 1999. In 2000, the guidelines relating to police custody were revised due to legislative changes and other developments in the management of substance misuse detainees in police custody. In August 2004, a working party was formed of relevant organisations to revise these guidelines, resulting in The Guidelines for Clinical Management (Third edition), Report of a Medical Working Group being published in May 2006, known as the Blue Guidelines ('the 2006 guidelines').These supplement and amplify, but do not replace the 1994 guidelines. The Code of Practice for the detention, treatment and questioning of persons by police officers (Code C), issued under the Police and Criminal Evidence Act 1984, gives guidance on the administration of medication (Home Office, 2006) in England and Wales. In Scotland it is the Criminal Procedure (Scotland) Act 1995. The Act is self explanatory and there are no standard operating procedures that accompany it.

The PACE Codes of Practice details the care and treatment of detained persons, including clinical treatment and attention.

The Home Office Memorandum 2003 on the Provision of Medical Services at police stations states that the quality of medical services at police stations is linked to the service provided by Forensic Physicians (also known as police surgeons, forensic medical examiners and forensic medical officers). There is a move towards a greater role for registered healthcare professionals (HCP) within custody suites, but where they work in partnership with Forensic Physicians, it is clearly defined that it is the responsibility of the Forensic Physician to intervene where their broader skills are required. As well as improving standards of delivery of clinical treatment for detainees, the introduction of nurses and other HCP to police custody suites is key to reducing the number of deaths in police custody. The 2006 Guidelines for Clinical Management provides guidance on the circumstances as to when a Forensic Physician should administer drugs to a detainee.

Treatment

Oral treatment should be given if opiate substitution treatment is required in the custodial setting. There is no recognised indication for prescribing amphetamines, cocaine or injectable benzodiazepines for the treatment of dependence in police custody. Temazepam is not used routinely for night sedation as under the PACE Code of Practice – Code C, the doctor would need to supervise the dose, therefore other benzodiazepines or non- benzodiazepines should be considered. Many forensic physicians use dihydrocodeine as a substitute treatment although it should be noted that the drug is not licensed for treatment of drug dependence.

Prescribing

Individuals in police stations are entitled to the same standard of medical care as any other member of the public. The decision to prescribe opiate substitute treatment and supervise self administration is the responsibility of the doctor, even when the drug is picked up from the usual clinic or pharmacist.

The 2006 Guidelines state that a Forensic Physician should prescribe any medication which a detainee should need. An eligible doctor can prescribe methadone and most opioids to a drug misuser and may arrange for the prescription to be dispensed at a local pharmacy. (A special licence is required for prescribing diamorphine, dipipanone and cocaine for the treatment of addiction.)

The pharmacist must ensure that the patient has not been prescribed methadone by the Forensic Physician, and also picked up his regular medication, which could result in the patient being double scripted and taking a double dose. The regular prescribing doctor, and the pharmacist responsible for dispensing, should be informed when a patient is detained to avoid duplicate dispensing, and also should be made aware if the detainee is released from custody earlier than previously anticipated.

The 2006 Guidelines state that all drugs should be prescribed for detainees on a private prescription. Where the private prescription is for a controlled drug, the new standardised private prescription form must be used (See later) and all medication in the police station is held by the custody officer. This is then either dispensed at a pharmacy and would then be administered to the detainee, by the doctor, another police officer or a nurse. Any medicine dispensed by a pharmacy should be appropriately labelled and leafleted, so there should be no ambiguity as to the dose to be administered by the nurse or other HCP.

NHS prescriptions should not be issued for persons detained in custody (Home Office circular 17/00). Drugs should be prescribed on a private prescription paid for by the police. Where the private prescription is for a controlled drug, the new standardised private prescription form must be used.

Confirmation of current medication brought in by the detainee

The Code of Practice for the detention, treatment and questioning of persons by police officers (Code C), issued under the Police and Criminal Evidence Act 1984, gives guidance on the administration of medication (Home Office, 2006.)

It states that 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 health care professional before the medication is used. The custody officer is responsible for the safekeeping of any medication and for making sure the detainee is given the opportunity to take or apply prescribed or approved medication.

The police officer may therefore telephone the pharmacy to verify that the detainee has been prescribed a particular medication by a GP in the community or drug dependency clinic. The pharmacist would have to be satisfied that the person telephoning is who they are purporting to be by asking for identification that can be verified. This may include asking the police officer for his number and the station from where he is calling from. Subsequent checks should be sought by obtaining the telephone number of the police station from the telephone directory to confirm the identity of the caller. Pharmacists should also ensure that they respect and protect confidentiality, and only disclose information acquired in the course of their professional practice with the consent of the individual or in the circumstances described in the Code of Ethics (Part 2.C page 91 of the Medicines, Ethics and Practice -a guide for pharmacists and pharmacy technicians, edition 30.)

Any medication brought in by the detainee should be clearly identifiable otherwise it should be destroyed, with the detainee's permission, and a further supply prescribed by the doctor.

NHS Prescription already held by pharmacist written by a community GP

1. Where a patient already has a prescription held at a community pharmacy, he may request the police to collect it on his behalf when in custody, if the Forensic Physician has approved its continued use. The pharmacist, on receiving such a request from a patient held in a police custody

suite should request a letter of authorisation from the patient, authorising the police officer to collect their medication on their behalf. A letter of authority from the patient should be obtained on every occasion a representative collects the prescription on the patient's behalf and such letters should be kept in the CD register. This could also include a collection request for a POM, so the pharmacist has an audit trail in these circumstances.

2. The pharmacist should confirm that the request from the police is genuine and that the Forensic Physician is prepared to take responsibility, and if satisfied the pharmacist could then supply the Controlled Drug to the police officer.

3. A request for supervision is not a legal requirement and therefore whilst it would not be unlawful to supply the Controlled Drug, the pharmacist would have to consider the professional and ethical issues of not supplying in accordance with the prescribers wishes in relation to supervision, bearing in mind the best interests of the patient. The pharmacist may contact the prescriber so that he is aware the pharmacist is not supervising the consumption, and also the PCO if the pharmacist is being paid for supervision.

Guidance for the police states that a police officer may not 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 Forensic Physician authorising their use. This includes methadone mixture, methadone tablets, buprenorphine, temazepam and drugs listed in Schedule 4 or 5 may be distributed by the custody officer for self-administration if he or she has consulted the registered medical practitioner authorising their use. This would include measuring out doses of medicines to be administered to detainees. Self administration of buprenorphine must be personally supervised by the Forensic Physician, who should observe the patient to ensure that the drug has fully dissolved in the mouth.

4. The pharmacist should be aware of the PCO Guidelines concerning supervised methadone consumption.

5. In addition to the CD prescription requirements (as detailed on page 26-27 of the Medicines, Ethics and Practice - a guide for pharmacists and pharmacy technicians, edition 30), the following need to be complied with:

- The pharmacist must ascertain whether the person, who may be a police officer or other person delegated to collect, collecting a Schedule 2 CD is the patient's representative or a health care professional acting in their capacity as such. If the person collecting the Schedule 2 CD is the patient or the patient's representative the pharmacist should ask for proof of identity and may refuse to supply the CD if he or she is not satisfied as to the identity of the person. This means that pharmacists will have the discretion to decide whether to ask for proof of identity and also the discretion to supply the CD, even if they are not satisfied that the person collecting is who they say they are. Circumstances where ID may not be required include when the person collecting the CD is known to the pharmacist (the patient, close relative or friend) or where the pharmacist believes that asking for ID may compromise patient confidentiality. If the person is a HCP, (i.e. if a nurse of other HCP was sent by the police), the pharmacist must obtain the person's name and address and must ask for proof of identity unless the HCP is known to them. However, even if ID is not provided the pharmacist may still supply the CD.

- The NHS prescription forms in England and Scotland contain a space on the back of the prescription for those collecting Schedule 2 or 3 CDs for human use, to confirm that they have done so. Pharmacists will have the discretion whether or not to supply if the collector, in this case the police officer, does not sign the back of the prescription.

See PJ 1st July 2006 for further information on the changes in the management of CDs.

http://www.pjonline.com/Editorial/20060701/society/p23controlleddrugs.html
http://www.rpsgb.org.uk/worldofpharmacy/useofmedicines/controlleddrugs.html

Private Prescriptions written by a Forensic Physician

The Department of Health has confirmed that the Forensic Physician's prescription form has to be on the standardised private prescription form, as it is not NHS treatment. Therefore the amendments to the Misuse of Drugs Regulations 2001 which came into force on 7th July 2006 apply to private prescriptions from Forensic Physicians.

In addition to the CD prescription requirements (as detailed on page 26-27 of the Medicines, Ethics and Practice - a guide for pharmacists and pharmacy technicians, edition 30), the following need to be complied with:

- The standardised private prescription form will be required to be used for the private prescribing of all Schedule 2 and 3 CDs for human use that will be dispensed in community pharmacy. (PPCD91) in Scotland*, FP10 (PCD) in England, WP10PCD and WP10PCDSS in Wales.

- Private prescriptions for all Schedule 2 and 3 CDs for human use must contain a prescriber identification number.* (* To be obtained from the Primary Care Organisation.)

- Private prescriptions for all Schedule 2, 3 and 4 CDs are only valid for 28 days from the appropriate date on the prescription, as a legal requirement.

- Quantity of all Schedule 2, 3 and 4 CDs to be prescribed should not exceed 30 days as good practice.

See PJ 1st July 2006 for further information on the changes in the management of CDs.

Records for both NHS and private CD prescriptions

The pharmacist must make an entry of the supply in the CD register.

In January 2008, further changes to the record keeping requirements will come into place, which will require a record of the person collecting the Schedule 2 CD (the patient, patient's representative or HCP, name and address of HCP and whether evidence was provided by the patient or patient's representative when they collected the Schedule 2 CD. (See Law and Ethics Bulletin 9th September 2006 page 322).

Records for private POM prescriptions

The pharmacist should record, in the usual manner, the details of all POMs supplied on private prescriptions to a detainee, as detailed on page17, Medicines, Ethics and Practice - a guide for pharmacists and pharmacy technicians, edition 30.

Submitting private CD prescriptions

The private prescription should be sent to the NHS Business Services Authority or National Services Scotland (NSS) (Common Services Agency) at the end of the month, as a separate submission form and in addition to the usual NHS prescription forms and a copy kept in the pharmacy.

Receipt of a requisition for stock of medicine to be stored in a Police station

Whilst there is no specific provision to enable stocks of POM medicines to be held at a police station unless it is the doctor's stock, different constabularies have varying arrangements under proscribed

conditions. There is no provision for a nurse to order a supply of medication, but a nurse could administer a pharmacy medicine or a general sale list medicine or a non-parenteral prescription - only medicine in accordance with a protocol from the forensic medical examiner, as appropriate. A parenteral prescription only medicine could only be administered under the directions of a practitioner, in accordance with NMC guidelines, after it had been prescribed by a doctor, (this however would be unlikely.)

A doctor may administer from his/her own stock, supplied on a requisition, which may be kept in either his drugs bag or a secure cupboard with limited access, to him/herself and possibly the nurse. It must be made clear that it is only those authorised by the prescriber who has access to the doctor's stock, which remains the doctor's responsibility at all times, even if a detainee needed medication urgently and there was going to be a delay before the doctor arrived to prescribe for that patient.

The Blue Guidelines (2006) state that all medication in the police station be held by the custody officer on behalf of the detainee and should be kept in a locked receptacle to prevent unauthorised access.