

Detainees with Substance Use Disorders in Police Custody

Guidelines for Clinical Management (Sixth Edition)

A working group report by:
The Faculty of Forensic & Legal Medicine of the Royal College of Physicians of London

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DRAFT

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1. Introduction

1.1 Overview

The substantial prevalence of substance use disorder including alcohol in detainees in police custody necessitates standardised and excellent practice, based on evidence and clinical consensus. Guidelines support this standardisation of practice in the assessment and acute management of detainees in police custody. All healthcare professionals (HCPs) working in the field of forensic & legal medicine (FLM) need to be aware of these updated guidelines intended to supplement and amplify the Department of Health's Drug Misuse and Dependence UK Guidelines on Clinical Management¹ and Department of Health and Social Care Clinical guidelines for alcohol treatment.²

These guidelines pay particular attention to the assessment and acute management of those with alcohol and drug problems in the unique setting of police custody. HCPs should use the Guidelines and other evidence in making clinical decisions by exercising professional judgement. Professional judgement in FLM involves considering all relevant factors, including evidence, ethical considerations, and the specific circumstances of the patient, to arrive at the most appropriate management plan for them.³ These decisions will vary with the specific needs and circumstances of individual detainees.

The guidelines are not meant to be rigid protocols though HCPs are expected to be familiar with this guidance, and to consider the recommendations and advice when making clinical decisions and providing effective treatments.

Treatment and care for those in the criminal justice system (CJS) should aim to be safe, effective, and equivalent to that in the community. Detention in police custody provides an opportunity for an individual to be screened for any alcohol or substance use disorder as well as physical or mental health issues which may require urgent treatment or onward referrals, e.g. to alcohol and drug workers. Opportunities for targeted interventions and motivational interviewing should be utilized.

Recent research has found evidence of stigmatising attitudes of staff impacting healthcare delivery to detainees with the denial of treatment as a form of punishment and doubt and distrust of detainee's medical histories.⁴ The authors recommend that staff within police custody should be trained to approach detained

¹ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug Misuse and Dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 10/07/2026

² Department of Health and Social Care. (2025) Clinical guidelines for alcohol treatment. <https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment> Accessed 10/07/2026

³ Stark MM, Butler B, Devlin M, Gorton A (2026) Professional judgement in Forensic & Legal Medicine (FLM). Journal of Forensic and Legal Medicine 118; 103084

⁴ Rees G, Mulrine S, Blel M, McKinnon I, Addison M, Finch T (2025) What is Equivalence in Police Custody Healthcare <https://research.ncl.ac.uk/equivalence-in-custody-healthcare/> Accessed 10/07/2026

persons with professional curiosity rather than scepticism. Speculation that detainees may be feigning illness is not appropriate and has previously been reported.⁵ The HCP needs to have the competencies and capabilities (see Appendix A) to perform a comprehensive assessment before deciding on the management and treatment of a detainee. Reviews and re-assessments may be required to adequately manage drug and alcohol intoxication and withdrawal along with any associated issues of physical and mental health conditions.

Transitions to, from, and between, criminal justice settings such as police custody to courts, prisons and then release, create potential for interruption of medication and heightens the risk of deaths from overdose.⁶ The evidence for the level of these preventable deaths/risks places a clear responsibility on all clinical assessments, services and treatment providers, in the community and in custodial settings, to ensure there are effective channels of communication to facilitate continuity of any prescribed medication and highlight any risks.

1.2 The working group

This is the sixth iteration of these guidelines, first published in 1994, then 1999, 2006 and 2011, and 2020. In 2025, the Faculty of Forensic & Legal Medicine of the Royal College of Physicians convened a working group to update the Guidelines.

The group brought together individuals with a wide range of expertise, and knowledge of guidelines in the alcohol and drug field including independent clinicians from differing jurisdictions, and representation from the Royal College of Psychiatrists (RCPSYCH), the Independent Office for Police Conduct (IOPC), the National Police Chiefs Council (NPCC), NHS England, the Office for Health Improvement and Disparities (OHID), the Royal College of Emergency Medicine (RCEM), the National Poisons Information Service (NPIS), the Royal College of General Practitioners (RCGP), The Royal College of Paramedics, the Royal College of Pharmacy, and the UK Association of Forensic Nurses and Paramedics UKAFNP). Membership of the group was by nomination from the individual organisations.

Consideration was given to diversity, equality and inclusion during the review of the guidelines to ensure they reflect fair, accessible, and culturally informed practice. The Advisory Council on the Misuse of Drugs (ACMD) published a report in May 2026 on “Drug Use in Ethnic Minority (DUEM) Groups”⁷ concluding that:

‘Structural barriers, including stigma, mistrust, cultural insensitivity, and negligible service visibility have been found to limit engagement with treatment services.’

The ACMD recommended that workforce planning should define competencies needed for a culturally sensitive service to include stigma and shame.

⁵ Havis S, Best D (2003) Drug-related deaths in police custody A Police Complaints Authority Study.

⁶ Sordo L, Barrio G, Bravo MJ, et al. (2017) Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies BMJ 357:j1550 <https://www.bmj.com/content/357/bmj.j1550> Accessed 10/07/2026

⁷ Advisory Council on the Misuse of Drugs (ACMD) (2026) Drug use in ethnic minority groups: a review and recommendations. <https://www.gov.uk/government/publications/drug-use-in-ethnic-minority-groups-a-review-and-recommendations> Accessed 10/07/2026

The group considered a wide range of updated evidence and considered this within the context of police custody with the recent changes in legislation, policing and forensic healthcare service delivery.

1.3 The scope of the problem

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

The National Drug Treatment Monitoring System (NDTMS)⁸ consistently reports that referrals into substance misuse treatment are generated via criminal justice sources. The criminal justice system continues to be increasingly used as a setting to offer treatment or as a gateway for accessing support. As a result, clinicians are more often required to deliver treatment within these criminal justice environments and may encounter individuals referred from several different points in the system, such as police custody, courts, probation, and prisons. It's important that clinicians have a clear understanding of how these arrangements operate and where their involvement will be most effective.

The Crime Survey for England and Wales (CSEW) ending March 2025⁹ estimated that 8.7% of people aged 16 to 59 years (around 2.9 million people) reported using any drug in the previous 12 months with around 3.3% of people (approximately 1.1 million people) reported using a Class A drug in the last 12 months.

Drug use was higher among people aged 16 to 24 years, with 15.1% reporting any use in the last 12 months. Around 2.0% of people were frequent drug users (more than once a month). Use of nitrous oxide and novel psychoactive substances (NPS) decreased among those aged 16 to 59 years compared with the previous year, from 0.9% to 0.5%, and 0.5% to 0.3%, respectively. Use of hallucinogens (including magic mushrooms) among those aged 16 to 24 years decreased compared with year ending (YE) March 2024, from 2.9% to 1.5%. Cannabis has consistently been the most used drug in England and Wales since estimates began in YE December 1995.

Polydrug use along with alcohol remains common. Intoxication in the setting of police custody presents challenges in terms of fitness for detention and fitness for interview. Detainees with substance use disorders may present with poor physical and mental health, both directly and indirectly related to problematic use/dependence.

Of concern are the increased rates of drug related deaths in community settings in the UK with significant increases in the last few years. Of the 5,565 registered drug poisoning deaths in 2024, in England and Wales 3,746 were identified as drug misuse, accounting for 67.1% of all drug poisonings.¹⁰ Northern Ireland has seen deaths due to drug related causes

⁸Office for Health Improvement & Disparities. National Drug treatment Monitoring System (NDTMS) <https://www.ndtms.net/> Accessed 10/07/2026

⁹ Office for National Statistics (ONS) Centre for Crime and Justice. Drug misuse in England and Wales: year ending March 2025. An overview of the extent and trends of illicit drug use. Data are from the Crime Survey for England and Wales. December 2025 <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2025> Accessed 09/03/2026

¹⁰ ONS. Deaths related to drug poisoning in England and Wales: 2024 registrations

rise by 98% from 110 to a peak of 218 in 2020 and to 213 in 2021.¹¹ In 2024, there were 1,017 drug misuse deaths registered in Scotland and the drug poisoning mortality rate in Scotland was found to be 2.8 times as high as the rates in England and Northern Ireland, and 1.9 times as high as the rate in Wales.¹²

Regarding deaths in police custody, a review of the international evidence¹³ reported that natural causes were the most common cause of deaths in police custody in England and Wales during the ten-year period 2004/05 to 2014/15, accounting for 51% of deaths in this period. Drugs and/or alcohol also featured as causes in around half of deaths (49%). An even higher proportion of deaths identified drugs or alcohol (82%) as an associated factor.

The most recent annual report from The Independent Office for Police Conduct (IOPC) on deaths during or following police contact in 2024/25 in England and Wales was published on 31 July 2025.¹⁴ There were 17 deaths in or following police custody. Nine people had mental health concerns, and fifteen people were known to have a link to alcohol and/or drugs. In relation to the 60 apparent suicides following police custody, 37 people had known mental health concerns and 28 people had links to drugs and or alcohol.

There are no equivalent statistics for deaths during or following police contact for NI or Scotland.

It is important to recognise and treat withdrawal, especially in relation to opiates^{15,16,17} and alcohol, to prevent deaths in custody.

Deaths related to drug poisoning in England and Wales from 1993 to 2024, by cause of death, sex, age and substances involved in the death. October 2025

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2024registrations#drug-misuse-in-england-and-wales> Accessed 10/07/2025

¹¹ NISRA (2024) Final statistics Statistical bulletin Drug-related and drug misuse deaths in Northern Ireland, 2022 <https://www.nisra.gov.uk/news/drug-related-and-drug-misuse-deaths-northern-ireland-2012-2022> Accessed 10/07/2026

¹² National Records of Scotland (2025) Drug-related deaths in Scotland, 2024 <https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-2024/> Accessed 10/07/2026

¹³ Lindon G, Roe S (2017) Deaths in police custody: A review of the international evidence. Research Report 95. Home Office https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655710/Deaths_in_police_custody_A_review_of_the_international_evidence.pdf Accessed 10/07/2026

¹⁴ IOPC (2025) Deaths during or following police contact Statistics for England and Wales 2024/25. <https://www.policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-202425> Accessed 10/07/2026

¹⁵ McGlinchey and Others v The United Kingdom, ECHR (2003)

¹⁶ Darke S, Larney S, Farrell M (2016) Editorial. Yes, people can die from opiate withdrawal. *Addiction* 112; 199-200

¹⁷ Stark MM, & Payne-James JJ (2017) People can die from opiate withdrawal. *MedSciLaw* 52(2); 103

1.4 Changing provision of forensic health services covering general forensic medicine

Since the publication of the fifth edition of the Guidelines there have been further changes in the provision of forensic healthcare services (general forensic medicine (GFM)) throughout the UK. Services are mainly provided by multiprofessional teams of nurses and paramedics working in the custodial environment, with occasional doctor involvement. These teams are increasingly supported by criminal justice liaison and diversion mental health services.

GFM services are not commissioned consistently or uniformly across the UK. Instead, commissioning arrangements differ by area, provider, scope, and funding model. Many HCPs work embedded within custody centres in designated police stations,¹⁸ whilst others remain mobile. Some police services in the Isle of Man and Jersey still operate (at the time of writing) the traditional model with a forensic physician only.

The Home Office Circular in 2003¹⁹ introduced the role of the healthcare professional (HCP), referring to a clinically qualified person who is working within the scope of practice as determined by their relevant professional body, and who is registered with that body as competent to practise. For doctors this is the General Medical Council (GMC); for nurses, the Nursing and Midwifery Council (NMC); and for paramedics the Health and Care Professions Council (HCPC). The circular contains guiding principles on recruitment and management, professional independence, clinical supervision, clinical governance, and confidentiality and disclosure in relation to individual records and treatment. All HCPs working in the custody environment must be appropriately trained and work within the scope of their professional competence and according to recommended clinical guidelines.

The Faculty of Forensic & Legal Medicine of the Royal College of Physicians of London (FFLM) was formally established in 2005 to:

- promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine in all its classes
- develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.²⁰

¹⁸ A designated police station is a facility authorised under Section 35 of the Police and Criminal Evidence Act 1984 (PACE) specifically for detaining arrested persons. These stations are chosen by chief officers to ensure adequate, safe, and regulated accommodation for suspects, featuring custody suites and dedicated custody officers to protect detainees' rights.

<https://www.legislation.gov.uk/ukpga/1984/60/section/35> Accessed 10/07/2026

¹⁹ Home Office. 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)

²⁰ FFLM <https://fflm.ac.uk/about/> Accessed 10/07/2026

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

Guidance as to the level of professional and clinical qualification required for doctors or nurses is issued by the [FFLM] ... Responsibility for recruitment of healthcare professionals is a matter for individual chief police officers, and it is for each police force to make a decision on an individual basis against this guidance ... The FFLM will have an opinion as to what duties should, or should not, be performed by staff at each level in each professional role. There is no mandatory guidance from the police service.²¹

The FFLM, working with the UKAFNP and the Royal College of Paramedics have produced Quality Standards for all HCPs working in the field of GFM.^{22,23} These standards cover recruitment, initial training and induction support, workplace-based supervision, and continuing professional development, and they outline a service level standard. The service level standard includes access to expert advice from an experienced forensic physician with the FFLM Membership. The FFLM continues to work to establish forensic & legal medicine as a distinct specialty that requires an appropriate career path. There is still a need for minimum standards and equivalence of training.²⁴

HCPs working in the custody environment **must** have specialty-specific training^{22,23} Immediate Life Support (ILS) as accredited by the Resuscitation Council UK (RCUK), Safeguarding for Children and Young People Level 3,²⁵ along with specific training in the Safeguarding of Vulnerable Adults Level 3.²⁶ HCPs should also have training in equality, diversity and inclusion issues as well as training in statement writing and courtroom skills. HCPs should be working towards the relevant postgraduate qualifications for their discipline.²⁷

The Police and Criminal Evidence Act 1984 (PACE) Codes of Practice Code C sets out the statutory framework for custodial care and the rights and entitlements of a detainee in police custody in England and Wales.²⁸ The Police and Criminal Evidence (Northern Ireland) Order 1989 Code C covers Northern Ireland.²⁹ The

²¹ Hansard, March 18th 2009, Column 1164W <https://hansard.parliament.uk/Commons/2009-03-18/debates/09031889000078/ForensicScience> Accessed 10/07/2026

²² Wall I, Stark MM (2025) Quality Standards in Forensic Medicine General Forensic Medicine (GFM) and Sexual Offence Medicine (SOM). FFLM. <https://fflm.ac.uk/resources/publications/fflm-quality-standards-in-forensic-medicine/> Accessed 10/07/2026

²³ Smith J, Stark MM, Wall I (2024) Quality Standards for Nurses and Paramedics General Forensic Medicine (GFM). FFLM. <https://fflm.ac.uk/resources/publications/fflm-quality-standards-for-nurses-and-paramedics-general-forensic-medicine-gfm/> Accessed 10/07/2026

²⁴ Stark MM, Norfolk GA (2011) Training in clinical forensic medicine in the UK - Perceptions of current regulatory standards. Journal of Forensic and Legal Medicine 18: 264-275

²⁵ Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff. <https://child-health-safeguarding.rcpch.ac.uk/> Accessed 10/07/2026

²⁶ RCN (2024) Adult Safeguarding: Roles and Competencies for Health Care Staff Second Edition. <https://www.rcn.org.uk/Professional-Development/publications/rcn-adult-safeguarding-roles-and-competencies-for-health-care-staff-011-256> Accessed 10/07/2026

²⁷ FFLM Examinations <https://fflm.ac.uk/exams/> Accessed 09/03/2026

²⁸ Home Office (2023) PACE Code C Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 10/07/2026

²⁹ Department of Justice (2015) PACE Code C: detention, treatment and questioning of persons by police officers <https://www.justice-ni.gov.uk/publications/pace-code-c-detention-treatment-and->

College of Policing publishes Authorised Professional Practice (APP) which is the official source of professional practice on policing.³⁰

In April 2025 HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) published the police effectiveness, efficiency and legitimacy also known as PEEL assessment framework (PAF) 2025–2027³¹ which includes reviewing how good a force is at providing a safe and lawful custody environment:

‘The force should keep detainees in police custody safe and treat them fairly and with dignity. Detainees should be able to exercise their legal rights promptly. The force should pay particular attention to the needs of children and vulnerable adults. Any use of force in custody must be lawful, necessary and proportionate, and subject to scrutiny by the force’s leadership team. Detainees should be able to access healthcare services for any substance misuse needs and mental or physical health needs.’

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

The Drug Interventions Programme (DIP) no longer operates as a single, centrally funded scheme. The core functions remain in place through local arrangements. Individuals detained in police custody who present with drug-related needs must be identified, assessed, and referred into appropriate support through locally commissioned criminal-justice drug and alcohol services. Custody staff should work in partnership with Liaison and Diversion teams, commissioned treatment providers, and police-led diversion schemes to ensure that detainees with substance use disorders receive timely screening, harm-reduction advice, and pathways into treatment or support (see Section 2.4.3).

1.5 The rights of detainees

Individuals in police stations are entitled to the same standard of medical care as any other member of the public.

Concerns as to confidentiality were mentioned by those with lived experience in custody stating that they were never sure what information is confidential and what information would be provided to the police. This may limit the discussion between HCP and the detainee. It is essential that HCPs explain their role fully and that they are required to disclose information obtained during the examination that might affect the safe management of the detainee in custody as well as information

[questioning-persons-police-officers](#) Accessed 10/07/2026

³⁰ College of Policing. (2024) Authorised Professional Practice.

<https://www.college.police.uk/app/using-app> Accessed 10/07/2026

³¹ HMICFRS PEEL assessment framework (PAF) 2025–2027

<https://hmicfrs.justiceinspectorates.gov.uk/publication-html/peel-assessment-framework-2025-2027/> Accessed 10/07/2026

relating to the offence.³²

HCPs need to give careful attention to the issue of informed consent of a detainee to any examination. Detainees have the right to have prescribed medication continued while in custody, as long as it is clinically safe and appropriate to do so.

There should not be any delay in requesting an HCP assessment where this is required even when the detainee appears to be under the influence of drugs and/or alcohol. There has never been an overarching recommendation to wait for six hours of detention before an assessment is requested or before providing medication to a detainee. Any delay in providing prescribed medication needs to be documented and justified.³³

Detainees should be informed of the outcome of the assessment and the consequent clinical decisions.

1.6 Clinical safety of detainees

The overriding consideration of the attending HCP must be the clinical safety and well-being of the detainee. The HCP should be aware of, and have access to, the National Poisons Information Service guidance (NPIS)/TOXBASE® (www.TOXBASE.org) for the most up to date guidance and advice on the immediate management of specific drug toxicity and advice re ongoing clinical management.

HCPs should be aware that they may be asked to assess detainees who have used substances for the first time or are more occasional/“recreational” substance users with issues that relate more to acute toxicity rather than the broader complications relating to problematic drug users and those who are dependent on substances.

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

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

³² For more information see: BMA (2024) Ethical issues in forensic and secure environments. A toolkit for doctors <https://www.bma.org.uk/advice-and-support/ethics/working-in-detention-settings/forensic-and-secure-environments-ethics-toolkit> Accessed 10/07/2026

³³ Every NHS Trusts and many non-NHS Trust healthcare providers have a Chief Pharmacist who can be contacted using the Trust’s switchboard or web-site information. Any issues with HCPs delaying access to medicines can be escalated via the Chief Pharmacist.

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

Although treatment to limit or prevent a withdrawal syndrome (e.g. from alcohol, opioids, benzodiazepines) may seem desirable (see Section 3), before such treatment is initiated the HCP must be satisfied that the detainee is not under the influence of any other substance, including alcohol, that might significantly alter the action of the prescribed medication, thus making it unsafe. HCPs must be alert to the potential risks of administering and/or over-prescribing substitute drugs and balance these with the potential benefits on an individual basis.

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 diverted to others who misuse drugs, and drugs from illicit sources may be used in addition to prescribed drugs. Before any medication is administered in police custody these possibilities must be reviewed, and additional safeguards (such as the provision of smaller, divided doses) should be considered, to reduce any risk.

1.7 Detainees' expectations

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

2. Principles of clinical management

2.1 History and examination

2.1.1 Liaison with custody staff

When asked to see a detainee and/or on arrival at a custody centre, early and effective liaison with the police custody officer is essential and can yield relevant information, particularly about the circumstances of the arrest, gathering information from the arresting officers where possible about the behaviour of the detainee on arrest, whether any physical restraint was used, the extent to which the detainee has been searched, and whether any substances were found or items that may be associated with drug use.

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.³⁴ The HCP should ask the custody officer how long the person is likely to be detained and if, and when, he or she is likely to be interviewed, if the information is currently available.

HCPs are often on site in the custody centres. This is the preferred model in England and Wales so reducing delays in providing clinical assessments and medication, where required.³⁵ In other jurisdictions the HCP may be contacted by a call centre or occasionally directly by the custody team and travel to the custody centre to see detainees. It is important for HCPs to be able to triage their workload, even when embedded. **Cases with the most urgent clinical need should be prioritised.**

All clinical assessments should be conducted face to face by a suitably trained and registered HCP. Guidance for the police for the care and treatment of detained persons is outlined in Code C of the PACE Codes of Practice in England, Wales, and NI (Section 9).^{36,37}

Conversations with custody staff may occur by phone for a variety of reasons when the HCP is not on site and many service providers record these telephone conversations providing a record of advice given.³⁸ A written account should be made of any advice given.

³⁴ McKinnon I, Grubin D. (2014) Evidence-Based Risk Assessment Screening in Police Custody: The HELP-PC Study in London, UK. *Policing: A Journal of Policy and Practice* 8(2), 174-182.

³⁵ Rees G., Mulrine S., Blell M., McKinnon I., Addison M., & Finch T (2025) What is Equivalence in Police Custody Healthcare <https://research.ncl.ac.uk/equivalence-in-custody-healthcare/> Accessed 10/07/2026

³⁶ Home Office (2023) PACE Code C. Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 10/07/2026

³⁷ Department of Justice (2015) PACE Code C: detention, treatment and questioning of persons by police officers <https://www.justice-ni.gov.uk/publications/pace-code-c-detention-treatment-and-questioning-persons-police-officers> Accessed 10/07/2026

³⁸ Stark MM (2024) Telephone advice proforma (custody) <https://fflm.ac.uk/resources/publications/proforma-telephone-advice/> Accessed 11/07/2026

Where robust remote-prescribing arrangements are in place, prescribers must be satisfied that the information on which they base prescribing decisions is accurate, appropriate, and obtained through a direct clinical assessment.^{39,40}

2.1.2 History and consent

Careful and well-documented history-taking and examination are essential to provide safe and effective care for the detainee. This is essential in informing risks from acute toxicity and to establish the degree of substance use disorder.

At the conclusion of the assessment the HCP needs to confirm whether there is evidence of intoxication or withdrawal from alcohol and/or substances or whether there is no evidence of intoxication or withdrawal, i.e. the detainee is stable but from the history provided may need a review later (See Figure 2.1 – Assessment procedure and Table 2.1 Diagnostic Criteria for Acute Alcohol Intoxication).

If the HCP is unable to conduct a full assessment, for example when the detainee declines to be seen, the HCP has a responsibility to ensure that they have made some form of assessment/observation of the detainee.⁴¹ The HCP needs to document this interaction clearly as well as recording any observations made regarding the detainee. Where there is information suggesting that the detainee may have a substance use disorder and/or other medical conditions, the HCP should attempt to review the detainee after a period of time in order to complete a full assessment.

Research has shown that a detainee who cannot be reliably risk assessed on entry to custody should be regarded as a significant warning indicator.⁴² In addition, the APP makes clear that detainees who are unwilling or unable to engage with the risk-assessment process represent an elevated and distinct risk factor, requiring heightened vigilance and enhanced safeguards.⁴³

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

³⁹ GMC (2024) Good practice in proposing, prescribing, providing and managing medicines and devices. <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices> Accessed 10/07/2026

⁴⁰ GMC Remote Consultations. <https://www.gmc-uk.org/professional-standards/ethical-hub/remote-consultations> Accessed 10/07/2026

⁴¹ Stark MM, Gorton AJ, Chariot P (2020) Care of Detainees. Chapter 9. In: Stark MM. Editor. Clinical Forensic Medicine. A Physician's Guide. Fourth Edition. Springer Nature Switzerland

⁴² Best D, Havis S, Payne-James JJ, Stark MM (2006) Near miss incidents in police custody suites in London in 2003: A feasibility study. Journal of Clinical Forensic Medicine 13: 2: 60-64

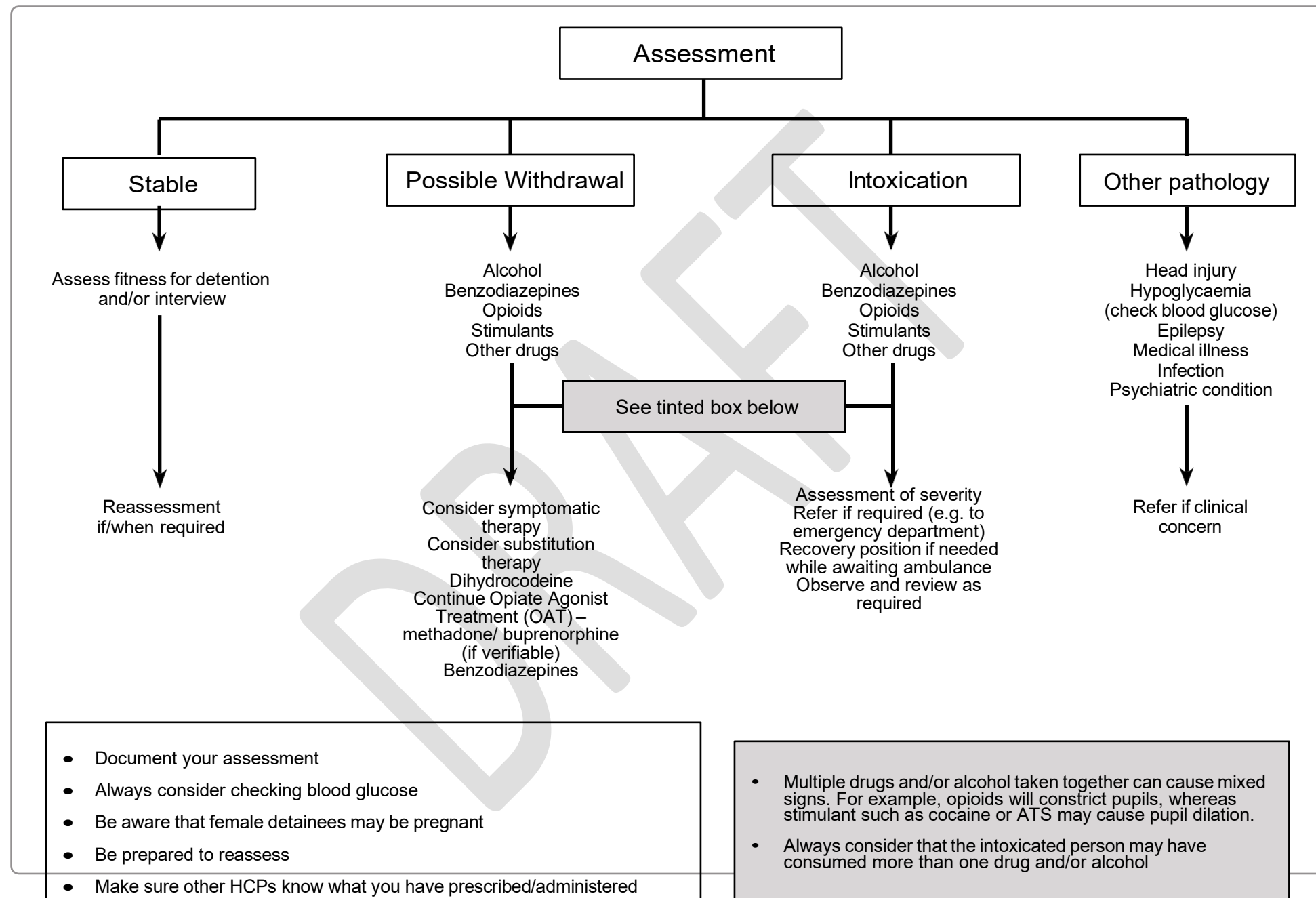
⁴³ College of Policing (2024) Authorised Professional Practice. Detention and custody risk assessment <https://www.college.police.uk/app/detention-and-custody/detention-and-custody-risk-assessment> Accessed 08/07/2026

Table 2.1 Diagnostic criteria for Acute Alcohol Intoxication (see Section 3.3)

1. Recent ingestion of alcohol; and 2. Clinically significant problematic behavioural or psychological changes (e.g., inappropriate sexual or aggressive behaviour, mood lability, impaired judgment) that developed during, or shortly after, alcohol ingestion; and 3. One (or more) of the following signs or symptoms developing during, or shortly after, alcohol use: i. slurred speech ii. lack of coordination iii. unsteady gait iv. nystagmus v. impairment of attention or memory vi. stupor or coma and 4. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance

From: Diagnostic criteria for diagnosis of Acute Alcohol Intoxication according to the Diagnostic and Statistical Manual of Mental Disorders 5th edition text revision (2023)

Figure 2.1 – Assessment procedure flowchart



The HCP may be able to access the National Care Record Summary (NCRS) in England, and equivalent healthcare record systems in other jurisdictions with informed consent from the detainee or without patient consent in an emergency. Previous clinical notes made by colleagues in hard copy or as computerised records, such as SystmOne™, should be reviewed.

All HCPs should explain their role as independent practitioners and as doctors, nurses or paramedics.⁴⁴ Consent for the examination should be obtained after an explanation of the nature and purpose of the examination. The HCP must be satisfied that the patient can comprehend and retain the relevant information, believes the information, and can weigh up the pros and cons in order to arrive at a choice (see below).⁴⁵

2.1.3 Assessment of capacity (and see Examples in Police Custody – Appendix K)

Capacity is the ability to make an informed decision. It is the responsibility of the HCP to assess whether a detainee understands the decisions relating to any forensic procedures and health care whilst detained in police custody. Where the HCP is not confident in performing an assessment, they should seek advice from a senior colleague.

The legislation governing mental capacity varies across the UK but is broadly similar.^{46,47,48} The legislation comes into force in all UK Jurisdictions when an individual turns sixteen years of age (see also section 2.2.5 for Children (under 18 years of age)). It is important to remember that capacity to make a decision is time and decision specific. The principles are outlined in Table 2.2.

⁴⁴ Fenoulhet S, Fewkes S, Smith J, Stark MM (2024) The Role of the Healthcare Professional FFLM. <https://fflm.ac.uk/resources/publications/the-role-of-the-healthcare-professional/>

Accessed 11/07/2026

⁴⁵ Re C (Adult: Refusal of Treatment), [1994] 1 WLR 290 & The Mental Capacity Act 2005

<https://www.legislation.gov.uk/ukpga/2005/9/contents>

Accessed 11/07/2026

⁴⁶ England and Wales: [Mental Capacity Act 2005](#) AND [Mental Capacity Act: making decisions - GOV.UK](#) Accessed 11/07/2026

⁴⁷ Scotland:

[Adults With Incapacity \(Scotland\) Act 2000](#) AND [Supporting documents - Adults with incapacity: guide to assessing capacity - gov.scot](#) Accessed 11/07/2026

⁴⁸ Northern Ireland: [Mental Capacity Act \(Northern Ireland\) 2016](#) AND [Mental Capacity Act | Department of Health](#) Accessed 11/07/2026

Table 2.2 Principles of a Capacity Assessment

1.	Adults must be assumed to have capacity (presumptive capacity), unless during the consultation it becomes apparent through what is said, or by their demeanour, that they do not have the capacity to make informed decisions. In all consultations HCPs need to ensure patients are making informed choices and understand the decision(s) to be made. Presumptive capacity is not a defense for not doing a capacity assessment for someone who should have had one.
2.	Detainees must be supported to make decisions about their forensic procedures and health care, to enable them to have the most opportunity to make decisions for themselves. This may mean providing written information, or 'easy read' information. ⁴⁹ Simple measures like ensuring a person can hear you and has their glasses on will enhance decision making.
3.	A detainee can make decisions that the HCP views to be unwise, PROVIDING THEY HAVE THE CAPACITY TO DO SO.
4.	If an individual lacks capacity for the decision to be made, then a 'best interest decision' must be made on their behalf. Occasionally a detainee will not agree with the HCP's best interest decision, but if the HCP is sure they lack the capacity the 'best interest decision' should be adhered to.
5.	Any decision made on behalf of the detainee should be the least restrictive option.

The HCP should first identify the specific decision that needs to be made. The assessment should then address four key questions as outlined in Table 2.3.

Table 2.3 Key Questions for Capacity Assessments

• Can the individual understand the information?
• Can they retain the information?
• Can they weigh up the information?
• Can they communicate their decision?

In relation to communication all reasonable efforts must be made to facilitate communication, for example for people who do not have English as a first language via an interpreter, or other communication aids.⁴⁹

⁴⁹ [Mencap Easy Read Library](#) Accessed 11/07/2026

The HCP is responsible for the capacity assessment of an individual in custody that he/she is caring for and cannot delegate this to anyone else. If the detainee has a significant mental health disorder, then seeking advice from a senior colleague may be helpful. The presence of a mental disorder does not prevent a person from having capacity to make a decision.

2.1.4 Timing of capacity assessments

In custodial settings, there may be pressure to act quickly, due to limits on periods of detention without charge ('PACE Clock' or equivalent) in support of colleagues in the police service. However, on occasions waiting for a period of time, e.g. for alcohol intoxication to resolve, may result in the detainee having capacity to consent.

It is essential that decisions about capacity assessments are documented in a clear and logical way (see Table 2.4).

Table 2.4 Documentation to be included

• The information you gave the patient and how you supported them.
• Whether they retained the facts for as long as the capacity assessment took.
• Could they weigh up the 'pros and cons' of the decision.
• Could they communicate their decision, best practice would be to write briefly what they said.

In a genuine emergency, where there is no possibility of obtaining consent, HCPs have a duty to carry out treatment to safeguard the life and health of the patient in accordance with what would be accepted as appropriate treatment in the patient's best interests in keeping with the doctrine of necessity.

Capacity to consent may also be affected by the presence of mental disorder, including learning (intellectual) disability or other developmental disorder such as autism. If this is suspected, the assistance of an 'appropriate adult' may be required (see Section 2.2.1).

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

2.1.5 History taking

There is now a significant body of evidence regarding the health needs of detainees in police custody,^{50,51,52} with mental health problems, including substance use disorders, and physical conditions highly prevalent, requiring both emergency and routine care. Homelessness is associated with multiple complex needs. Therefore, it is essential that the HCP take a full medical history including:⁵³

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

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

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

⁵⁰ Rekrut-LapaT, Lapa A. (2014) Health needs of detainees in police custody in England and Wales. Literature review. *Journal of Forensic and Legal Medicine* 27; 69-75

⁵¹ Sondhi A, Williams E (2028) Health needs and comorbidity among detainees in contact with healthcare professionals within police custody across the London Metropolitan Police Service area. *Journal of Forensic and Legal Medicine* 57; 96-100

⁵² McKinnon IG, Thomas SDM, Noga HL, Senior J. (2016) Police custody healthcare: a review of health morbidity, models of care and innovations within police custody in the UK, with international comparisons. *Risk Management and Healthcare Policy* 9: 213-226

⁵³ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 10/07/2026

The detainee should be asked about any history of treatment for substance use disorder (SUD) and its effectiveness, as well as previous experience of withdrawal symptoms including physical and psychological consequences. It is particularly important to know whether the detainee is currently receiving treatment and medication as part of an opioid agonist 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 significant morbidity and mortality if untreated.

The use of an alcohol screening questionnaire is essential in identifying alcohol problems including Alcohol Use Disorder (AUD). There are a number of tests available but the Alcohol Use Disorders Identification Test (AUDIT)⁵⁴ is probably the best screening instrument in this environment. The Severity of Alcohol Dependence Questionnaire (SADQ) may be useful as a measure of the severity of dependence.⁵⁵

2.1.6 Reliability of histories

Studies have shown that those with SUD who are involved in OAT maintenance programmes are generally honest when reporting recent drug use: the accuracy of self-reported drug use has been reported at over 80%,⁵⁶ although there are also reports of exaggeration and underestimation of use.

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

Many detainees with a SUD have negative perceptions of their medical management while detained in police custody.^{57,58} Honesty is more likely if the detainee feels confident of a sympathetic hearing and the availability of effective care. HCPs should stress their independence from the police by making it clear that, like any other HCPs, they are concerned about the physical and mental care of their patient. It is essential that HCPs remain non-judgmental and non-confrontational. Detainees have the right to refuse to be examined by an HCP and have the right to be examined by a medical practitioner of their own choice, at their own expense.

⁵⁴ Alcohol Use Screening Tests <https://www.gov.uk/government/publications/alcohol-use-screening-tests> Accessed 11/07/2026

⁵⁵ Severity of Alcohol Screening Questionnaire. <https://www.smartcjs.org.uk/wp-content/uploads/2015/07/SADQ.pdf> Accessed 11/07/2026

⁵⁶ Brown J, Kranzler HR, Del Boca FK (1992) Self-reports by alcohol and drug abuse inpatients: factors affecting reliability and validity. *British Journal of Addiction* 87;1013–1024

⁵⁷ Gregory M (2007) Characteristics of drug misusers in custody and their perceptions of medical care. *Journal of Forensic and Legal Medicine* 14; 2092–2012.

⁵⁸ Rees G, Mulrine S, Blel, M, McKinnon I, Addison M, Finch T (2025) What is Equivalence in Police Custody Healthcare <https://research.ncl.ac.uk/equivalence-in-custody-healthcare/> Accessed 10/07/2026

2.1.7 Physical examination

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

All HCPs should be trained in the use of a validated clinical tool for assessing alcohol-withdrawal symptoms, and repeated scoring may be valuable as part of the ongoing overall assessment of a detainee. At present, there is no evidence base indicating that any one withdrawal-assessment scale performs better than another in the police-custody environment.

The Clinical Opiate Withdrawal Scale (COWS) may be of use in the overall assessment of opiate dependent detainees.⁵⁹

A Mental State Examination should always be conducted (see Section 2.2.1). The risk of self-harm is increased during withdrawal, when individuals may tend towards impulsive and volatile behaviours.

Rates of self-harm in prison are now at the highest level since records began in 2012 with rates almost nine times higher in the female compared to the male estate, and highest for people on remand compared to those sentenced.⁶⁰

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

2.1.8 Medical complications of substance use and reducing health risk

Many detainees who have SUDs have little or no contact with doctors or other HCPs. Therefore chronic conditions, such as diabetes, heart disease and asthma, are often poorly managed. It is essential that HCPs use the opportunity to initiate a healthcare intervention (dependent on scope of practice), as contact can be transitory and interrupted by events in a detainee's life. Many suffer from self-neglect and malnutrition. Acute episodes of illness should be treated. Substance use may result in medical complications that require assessment and further treatment.

Preventable infections remain a problem in those who inject drugs.⁶¹ There are a wide

⁵⁹ Wesson D R, Ling W (2003) The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9. <https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf> Accessed 11/07/2026

⁶⁰ Ministry of Justice, HM Prison and Probation Service (2025) Safety in Custody Statistics England and Wales: Deaths in Prison Custody to June 2025, Assaults and Self-harm to March 2025.

⁶¹ For more information see UK Security Agency. Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021. Updated 19 February 2026 <https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk/shooting-up-infections-and-other-injecting-related-harms-among-people-who-inject-drugs-in-the-uk-data-to-end-of-2021>

Accessed 09/03/2026

range of bacterial infections causing problems in those who inject drugs: Group A streptococcus, methicillin-sensitive and methicillin-resistant *Staphylococcus aureus* and toxin-producing bacteria (botulism, tetanus, anthrax). Commonly there are superficial infections at injection sites. Sometimes these develop into generalised septicaemia. Bacterial endocarditis also remains a risk for anyone injecting drugs. Cellulitis and abscesses may be seen around injection sites, and septic arthritis may result if deep abscesses extend into joints. There is a higher prevalence of tuberculosis in people who use drugs.

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

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

- encouraging the detainee to see their general practitioner and/or attend hospital clinics to receive the appropriate care for long-term conditions
- referring them to an on-site arrest referral/drug worker for drugs and alcohol
- providing them with information about local agencies involved in counselling and treatment of substance-related problems, such as community drug and alcohol teams, treatment centres and needle exchange schemes
- providing them with information and advice about, and immunisation against, hepatitis B (and possibly hepatitis A)
- checking their tetanus immunisation status if they inject drugs
- providing advice and testing for blood-borne virus infections, hepatitis C and HIV, and referring them for treatment if required (see Table 2.5).

Table 2.5 Blood borne Infections

• Chronic hepatitis C prevalence continues to decline, but prevention of new and re-infections remains a challenge.
• Hepatitis B remains rare, but vaccine uptake has declined substantially.
• HIV prevalence remains low and stable, but outbreaks continue.

From: Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021. Updated 19 February 2026

- educating them on the hazards of injecting drugs, particularly with regard to shared injecting equipment
- educating them on the risks of overdose, of multiple use of substances, including alcohol, and of the variable purity of illicit drugs

- advising them regarding the loss of tolerance and risk of fatality following reduction in regular use or a period of abstinence such as may occur following time in prison or residential rehabilitation
- giving them contraception advice, reminders regarding cervical cancer screening, and safer sex advice and, where required, referring them to a sexual health service
- referring them to a dentist if they have oral health problems such as dental caries, tooth erosion, or periodontal disease.

A significant minority of injecting drug users have experienced a broken needle at some time in their injecting career.⁶² Central embolisation may occur within a few hours to several days, and can have potentially fatal consequences such as pericarditis, endocarditis and pulmonary abscess. It is recommended that needle fragments be removed as soon as possible to avoid future complications.

2.1.9 Near-patient testing

Detainees with a history of SUD should have a multi-drug urine screen. This needs to be a commissioning requirement for forensic healthcare providers. The use of an on-site drug-testing kit in the police station has been found to be helpful in the management of detainees with SUDs police custody.⁶³ Such tests give qualitative rather than quantitative results and so confirm whether or not a substance has been used rather than the quantity used. HCPs should ensure that they are familiar with the test employed and with its limitations, including false positives and false negatives. **The test should only be used with the consent of the detainee and with the clear understanding that this is an aid to clinical management which will remain part of the clinical record.**

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

Detainees may be tested for heroin and cocaine, following arrest for 'trigger offences', using oral fluid.⁶⁴ The result of this test may be useful in the overall assessment of a detainee and prior to providing treatment in the form of substitution therapy. The time limits for drug detection in oral fluid samples is between 24–48 hours, indicating recent drug use. Urine samples, if available, have the advantage of indicating drug use over the previous several days.

The results of any onsite testing in police custody (urine and/or oral fluid sampling) must be shared with other agencies (e.g. prison healthcare staff) as appropriate.

⁶² Norfolk GA, Gray SF (2003) Intravenous drug users and broken needles – a hidden risk? *Addiction* 98;1163–1166

⁶³ Stark MM, Norfolk GA, Rogers DJ, et al (2002) The validity of self-reported substance misuse amongst detained persons in police custody. *Journal of Clinical Forensic Medicine* 9; 25–26.

⁶⁴ Home Office (2021) Drug testing on arrest: guidance for police forces
<https://www.gov.uk/government/collections/drug-testing-on-arrest-guidance-for-police-forces>
 Accessed 11/07/2026

2.2 Special groups

2.2.1 Detainees with substance use and mental health disorders (CoSUM)

Co-occurring substance use and mental health disorders (CoSUM) are common especially in the vulnerable population detained in police custody.⁶⁵

Under the Codes of Practice of PACE (C1.4)⁶⁶ if at any time an officer has any reason to suspect that a person of any age may be vulnerable, in the absence of any clear evidence to dispel that suspicion, that person shall be treated as such for the purposes of this Code.

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

- (i) *may have difficulty understanding or communicating effectively about the full implications for them of any procedures and processes connected with*
 - *their arrest and detention; or (as the case may be)*
 - *their voluntary attendance at a police station or their presence elsewhere for the purpose of a voluntary interview; and*
 - *the exercise of their rights and entitlements*
- (ii) *does not appear to understand the significance of what they are told, of questions they are asked or of their replies;*
- (iii) *appears to be particularly prone to:*
 - *becoming confused and unclear about their position;*
 - *providing unreliable, misleading or incriminating information without knowing or wishing to do so;*
 - *accepting or acting on suggestions from others without consciously knowing or wishing to do so;*
 - *readily agreeing to suggestions or proposals without any protest or question.*

Mental disorder is defined as any disorder or disability of the mind.⁶⁷ A history of use of substances alone is not an indication that an appropriate adult needs to be present. The decision is one for the custody sergeant, but HCPs may be asked for advice.

Therefore, it is essential that HCPs working in the custodial environment are skilled in performing a mental state examination (see Table 2.6) and, where appropriate and

⁶⁵ Royal College of Psychiatrists (2025) Co-occurring substance use and mental health disorders (CoSUM) College Report 243 [https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2025-college-reports/co-occurring-substance-use-and-mental-health-disorders-\(cosum\)-\(cr243\)](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2025-college-reports/co-occurring-substance-use-and-mental-health-disorders-(cosum)-(cr243)) Accessed 10/07/2026

⁶⁶ Home Office PACE Code C (2023) Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 10/07/2026

⁶⁷ Mental Health Act 2007 <http://www.legislation.gov.uk/ukpga/2007/12/contents> Accessed 10/07/2026

requested, an assessment under the Mental Health Act (a pro forma⁶⁸ may assist).

Table 2.6 Mental State Examination	
Appearance	Self-care, clothing Motor e.g. restlessness, over-activity, or retardation Level of consciousness
Behaviour	Disinhibition, withdrawn, aggressive, Attitude to examiner – hostile, cooperative, friendly
Speech	Form and content of speech – talkative, pressure of speech, retardation, mute Presence of thought disorder, flight of ideas
Mood/affect	Objective and subjective Depression, anxiety, elation, hopelessness
Thoughts/perceptions	Hallucinations Delusions
Cognition	Orientation, Concentration attention Memory – short and long term
Insight	Understanding and acceptance of situation
Other considerations: Biological symptoms Self-harm and suicidal ideation Harm to others	Sleep, appetite, energy levels History of self-harm, type of self-harm, current Thoughts, intention, protective factors, plans Thoughts, intent, previous harm to others

The assessment of mental state is important for the general care of the detainee as there may be depression, psychosis, or other psychiatric conditions, requiring treatment, or support from an appropriate adult (see below Appropriate Adults).⁶⁹ When assessing the mental state of an individual, the HCP will need to decide whether to obtain the opinion of a psychiatrist, and if so, when.

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

Comorbidity of severe mental illness and substance use disorders is common; for example, a diagnosis of schizophrenia may coexist with a diagnosis of drug dependence. Drug use can cause rapid worsening of mental state even in stabilised psychotic illness. Substance use disorder may be associated with a psychotic state through a number of mechanisms. Intoxication may mimic psychosis, which may be triggered by stimulants⁷⁰

⁶⁸ Wall I (2022) Mental Health Act assessment proforma FFLM.
<https://fflm.ac.uk/resources/publications/proforma-mental-health-act-assessment/> Accessed 10/07/2026

⁶⁹ R v Aspinall (Paul James) (1999) MHLR 12 The failure to follow the requirements to have an appropriate adult in the interview of a mentally disordered suspect meant that, despite his apparent lucidity in interview, it was unfair to admit it in evidence.

⁷⁰ Ghodse AH, Kreek M (1998) Resurgence of amphetamine-type stimulants. Current Opinion in Psychiatry, 11, 245–247.

and cannabis.^{71,72} A psychotic state may arise that persists beyond the elimination of the drug. Withdrawal states such as those seen with alcohol or benzodiazepines may result in vivid hallucinations and clouding of consciousness.

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

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

Risk of suicide and self-harm

Research has shown that episodes of self-harm typically occur soon after arrest⁷³ and that particular risk factors include histories of self-harm, psychiatric illness,⁷⁴ and addiction.⁷⁵ The risk in a custodial setting is higher in women.

A risk assessment should be made as part of the mental state assessment. If referral to an emergency department (ED) is not necessary (for acute treatment of self-injury or self-poisoning), any consideration of urgent referral to secondary mental health services should be based on 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 HCP should inform the custody officer and provide them (within the bounds of patient confidentiality⁷⁶) 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 (see Table 2.7). The HCP should ensure that the detainee is kept under the appropriate level of observation (see Appendix C) whilst awaiting formal psychiatric assessment.

Apparent suicides⁷⁷ following police contact are included in the IOPC Annual Report on deaths during or following police contact in England and Wales.⁷⁸

⁷¹ Mathers DC, Ghodse AH (1992) Cannabis and psychotic illness. *British Journal of Psychiatry* 161; 648–653.

⁷² Ghodse AH (1986) Cannabis psychosis. *British Journal of Addiction* 81; 473–478

⁷³ 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.

⁷⁴ Norfolk GA (1998) Deaths in police custody during 1994: a retrospective analysis. *Journal of Clinical Forensic Medicine* 5; 49–54.

⁷⁵ Oyefeso A, Ghodse AH, Clancy C, et al. (1999) Suicide among drug addicts in the UK. *British Journal of Psychiatry* 175; 277–282.

⁷⁶ GMC. (2024) Confidentiality: good practice in handling patient information <https://www.gmc-uk.org/professional-standards/the-professional-standards/confidentiality>
Accessed 11/07/2026

⁷⁷ Apparent suicides following time in police custody are included in the IOPC statistics if they occur within two days of the person's release from custody. They are also included if experiences in custody may have been relevant to the death, and the death was referred to the IOPC.

⁷⁸ IOPC (2025) Deaths during or following police contact Statistics for England and Wales 2024/25 <https://www.policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or->

HCPs are increasingly being asked by police to perform a pre-release risk assessment (PRRA).⁷⁹ It is therefore particularly important to remember that the risk of suicide and self-harm increases with substance use disorder.

Table 2.7 Mental State Examination - abnormalities suggestive of a depressive disorder and/or suicide risk

Appearance	Self-neglect (clothing, hygiene)
Behaviour	Altered motor behaviour such as restlessness, agitation, retardation Withdrawn
Speech	Hesitancy, delayed responding, slow speech, low volume
Thought content	Feelings of life not being worth living, hopelessness, guilt, shame, suicidal thoughts, low self-esteem, worthlessness, loss of confidence
Mood/affect	Depression, anxiety, irritability
Abnormal beliefs/perceptions	Hallucinations and/or delusions reflecting depressed mood
Cognition	Impaired concentration Impaired short-term memory
Insight	Impaired insight into nature and severity of condition
Other considerations:	
Biological symptoms	Anhedonia, early morning waking, depression worse in the morning, objective evidence of definite psychomotor retardation or agitation, marked loss of appetite, significant weight loss, marked loss of libido
Self-harm and suicidal ideation	History of self-harm, type of self-harm, current thoughts, intention, protective factors, plans
Harm to or from, others	Thoughts, intent, previous harm to others, concern about retaliation

From: Stark MM., Rix K., & Rumalean Y. (2024) Pre-Release Risk Assessment – Recommendations for Healthcare Professionals working in the custody environment, FFLM.

[following-police-contact-202425](#) Accessed 11/07/2026

⁷⁹ Stark MM, Rix K, Rumalean Y (2024) Pre-Release Risk Assessment – Recommendations for Healthcare Professionals working in the custody environment. FFLM.

<https://fflm.ac.uk/resources/publications/pre-release-risk-assessment-recommendations-for-healthcare-professionals-working-in-the-custody-environment/> Accessed 11/07/2026

Risk is dynamic and assessment should be ongoing. The HCP needs to offer advice and options to support the detainee's welfare on release. An adult detainee charged with an offence can be refused bail and kept in custody under section 38(1)(a)(vi) of PACE if the custody officer has reasonable grounds to believe detention is necessary for his/her own protection.⁸⁰

Mental Health Acts (MHA)

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

A patient may be compulsorily admitted under the Acts where certain criteria have been met, including where detention is necessary in the interests of their own health or safety or for the protection of other people. When the offence for which an individual has been arrested is a serious offence, civil sections of the relevant mental health legislation (as above) may not be appropriate and senior expertise in forensic psychiatry should be sought to ensure appropriate assessment and management regardless of the cause of mental disorder.

Police stations have been used as a place of safety (POS) for assessments under section 136 of the Mental Health Act. Following changes to the Act in 2017⁸¹ this is no longer appropriate, and hospital places of safety should be used except in exceptional circumstances, where the adult poses an imminent risk of serious injury or death to themselves or another person. In this case the police officer must consult an appropriate doctor, nurse, or AMHP (Approved Mental Health Professional).

Furthermore, an HCP must be present on site throughout the detention and perform checks every half hour. This requirement is not ideal as not all HCPs are embedded in police custody, and even where they are there would not be sufficient time for this role. Police stations are never to be used as a place of safety for a person under 18 years of age. A patient may be moved from one place of safety to another such as a hospital, for example if physical treatment is needed, or community-based POS.

Liaison with local psychiatric services

There has been an increase in Criminal Justice Liaison and Diversion Services (CJLDS) in both police stations and courts in recent years. The liaison and diversion practitioners, when present on site, are available to give advice and help access mental health services and drug and alcohol treatment services. The aim is to improve appropriate

⁸⁰ College of Policing (2024) Authorised Professional Practice. Risk of self-harm and suicide after release <https://www.college.police.uk/app/detention-and-custody/detention-and-custody-risk-assessment#risk-of-suici> Accessed 11/07/2026

⁸¹ The Mental Health Act 1983 (Place of Safety) Regulations 2017 <https://www.legislation.gov.uk/uksi/2017/1036/regulation/1/made> Accessed 11/07/2026

intervention for those in mental health crisis presenting to the police. Assessment may also inform suitable sentencing/diversion options.

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

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

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

Appropriate adults (AA)

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

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

If there is evidence of mental disorder, as defined by the respective Mental Health Acts, then an appropriate adult will be required as set out in Code of Practice C issued under the Police and Criminal Evidence Act 1984.⁸² The PACE Code applies in England, Wales and Northern Ireland.

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

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

In Scotland, an appropriate adult is a person with prior experience (either in a professional or voluntary capacity) of working with adults who have mental health

⁸² Home Office (2023) PACE Code C. Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 10/07/2026

issues, learning disability, autistic spectrum disorder, dementia and/or acquired brain injury, in relation to overcoming communication issues. In Scotland, recommendations regarding the calling in of an appropriate adult are given in the Scottish Office Police Circular 7/1998.⁸³

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

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

It is recognised that special care and understanding is required when dealing with persons with learning disabilities or a mental disorder. When police officers are required to deal with such persons, an appropriate adult should be present. This applies whether the person is a witness, suspect or accused.

In Scotland an appropriate adult is defined as:

- someone who is not a police officer or employed by the police, who has
- experience in dealing with a person with a learning disability or a mental disorder and/or
- a relative, guardian or other person responsible for their care or custody; however, whenever possible their use should be avoided due to the relationship with the person with the learning disability

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

The role of the appropriate adult is to:

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

Local authorities across the Police Scotland area now operate to broadly consistent guidelines for the provision of trained Appropriate Adults. In all areas, the Social Work Department acts as the lead agency for the scheme and is responsible for arranging attendance. At the request of a police officer, the Social Work Department will contact and deploy a trained Appropriate Adult to support the individual concerned.

⁸³ The Scottish Office. Interviewing People Who Are Mentally Disordered: "Appropriate Adult" Schemes http://www.sehd.scot.nhs.uk/mels/1998_43.pdf Accessed 11/07/2026

2.2.2 Detainees with learning (intellectual) disabilities⁸⁴

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

Misuse of substances is uncommon among people with learning (intellectual) disabilities.⁸⁵ Those that do engage in misuse face significant problems. They can be very suggestible and easily caught and may take the blame for others. Police officers do not routinely screen for, and may not recognise, when individuals have learning disabilities. The suggestibility of such individuals is not well understood and police officers need to ensure adequate legal protection for these vulnerable individuals, as well as adequate support to enable them to cope with the stress of being interviewed.

Many detainees with learning disabilities are known to a care giver or caregiving 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'. HCPs need to be aware of the complicating factor of intellectual disability and ensure that appropriate safeguards are put in place to protect the detainee.

2.2.3 Older people with multiple co-morbidity^{86,87}

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

There are two distinct groups of older people with problem drug use. The first is older people with a long history of substance use persisting into later life, who tend to be polysubstance users, who have a chronic history of using heroin, crack cocaine, tobacco and alcohol. These are 'early-onset users' and are different to a sometimes quite distinct population of 'late-onset users' of substances who may have begun using them

⁸⁴ McKinnon I, Ali S, Marshall-Tate K (2024) Assessment of people with learning difficulties and disabilities in police custody. FFLM. <https://fflm.ac.uk/resources/publications/assessment-of-people-with-learning-difficulties-and-disabilities-in-police-custody/> Accessed 11/07 /2026

⁸⁵ Huxley A, Taggart C, Baker G, et al (2007) Substance misuse amongst people with learning disabilities. *Learning Disability Today* 7(3); 34–38

⁸⁶ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 10/07/2026

⁸⁷ Royal College of Psychiatrists (2018) Our Invisible Addicts <https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/our-invisible-addicts-2nd-edition-cr211-mar-2018> Accessed 11/07/2026

regularly only later in life, often following stressful life events or lifestyle changes (for example retirement, marital breakdown, social isolation, increasing morbidity or bereavement).

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

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

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

Continued injecting drug use in the older population remains a key factor in overdose deaths. In 2024, the highest rate of drug misuse deaths in England and Wales was found among those aged 40 to 49 years with the average for males (45.5) increasing since the late 1990s and at a historic high, while the average for females (48.5) has remained relatively consistent between 1993 and 2023.⁸⁸ Complications related to a long history of drug and alcohol use may occur (see Table 2.8).

⁸⁸ ONS. Deaths related to drug poisoning in England and Wales: 2024 registrations
Deaths related to drug poisoning in England and Wales from 1993 to 2024, by cause of death, sex, age and substances involved in the death. October 2025
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2024registrations#drug-misuse-in-england-and-wales> Accessed 11/07/2026

Table 2.8 Complications related to a long history of drug and alcohol use

Infection • hepatic damage due to hepatitis B or C infection and/or excessive alcohol use • HIV infection
Respiratory • chronic obstructive airways disease from smoking tobacco, from inhaling drugs, or from TB
Cardiovascular • increased cardiovascular disease risk due to alcohol, stimulant drugs, smoking and lifestyle • venous damage (IV access can be difficult) and/or arterial damage • past cardiac valve destruction • risk of QTc prolongation when methadone is co-prescribed with a range of medications including antipsychotics, tricyclic antidepressants, citalopram, and erythromycin
Liver disease • alcoholic liver disease is the principal cause of alcohol-specific deaths⁸⁹
Oral • poor dental health
Mental health • impaired mental health (with increased risk of self-harm and suicide)
Polypharmacy • increased risk of falls, sedation, cognitive impairment and road traffic accidents with polypharmacy; prescribing sedating medicines such as benzodiazepines, hypnotics, antipsychotics, antihistamines, anticholinergics or other opioids • ongoing risk of overdose • risk of drug–drug interactions which may increase or decrease methadone levels and to a lesser extent buprenorphine
Other • family breakdown/relationship problems • mobility problems consequent on groin injecting • traumatic injuries due to falls, accidents or assaults • impaired immunity • increased risk of cancer • chronic pain

⁸⁹ ONS (2026) Alcohol-specific deaths in the UK: registered in 2024

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2024>

Accessed 07/07/2026

2.2.4 Pregnant detainees⁹⁰

Sudden cessation of opioid use in a pregnant woman with dependence may be life-threatening to the fetus.

Sudden cessation of alcohol use in a pregnant woman with alcohol dependence causes risk to the fetus and the mother. Medically assisted alcohol withdrawal can only be safely managed in a hospital setting.

The need to safeguard the patient and her pregnancy is paramount, remembering vulnerabilities in BAME groups.⁹¹ It is important to consider whether a female detainee is pregnant before initiating treatment.

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

Amenorrhoea is associated with substance use disorder, so it is not unusual for women to be unaware that they are pregnant. Sensitivity is needed, however, around encouraging this testing for all women, as it will not be appropriate in all cases, such as for women who have been diagnosed as infertile, for some transwomen who are not able to be pregnant, and for women who have indicated it is not possible because of no recent, relevant sexual activity.⁹²

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

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

Special care should be taken to ensure that pregnant women who are taking prescribed medication for substance use disorders have this continued while in custody, as they are at high risk in terms of pre-term delivery, obstetric complications, and poor outcomes for both the fetus and the mother.

⁹⁰ Antenatal care (2021) NICE guideline. NG201 <https://www.nice.org.uk/guidance/ng201> Accessed 11/07/2026

⁹¹ Felker A, Patel R, Kotnis R, Kenyon S, Knight M (2025) (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Compiled Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. Oxford: National Perinatal Epidemiology Unit, University of Oxford DOI: 10.5287/ora-4javr692x <https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2021-2023> Accessed 11/07/2026

⁹² Department of Health and Social Care (2017) Guidance Drug misuse and dependence: UK guidelines on clinical management - Section 7.6.3 <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 10/07/2026

Best practice, when feasible, is to verify with the relevant service when the pregnant detainee was last seen in the drug and alcohol services or specialist antenatal clinic, and to confirm the results of any urine screening tests.

There is a need to avoid both withdrawal and intoxication, therefore stabilisation of a pregnant detainee while in custody may not be possible. **HCPs should have a low threshold for early referral to hospital for obstetric assessment and treatment of SUD.**

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

Antenatal assessment by the HCP must include the following:

- Obstetric history – prior history of miscarriage or premature delivery. These may indicate increased risks if withdrawal symptoms are allowed to develop.
- Social history – existing children, home circumstances, partner, Children and Young People Service (CYPS) involvement.
- Estimated date of delivery.
- Assessment of uterine size relative to dates.
- Blood pressure and urinalysis for proteinuria.
- Specific enquiry about fetal movements (excessive fetal movement may indicate withdrawal symptoms; reduced movements may indicate fetal compromise - both require specialist opinion).
- Specific enquiry about uterine tightening and abdominal pain as well as vaginal bleeding or discharge (rupture of membranes). Withdrawal can result in increased uterine irritability.
- Specific enquiry about domestic violence.

Assessment of SUD in pregnancy must include:

- Detailed history of recent (last 10 days) drug and alcohol use, including quantities, route of administration, and time of last use (see Section 2.1.2).
- Contact details for local services accessed by the patient.
- Recent efforts to reduce use of specific drugs or alcohol, because of the potential for reduced tolerance and for adverse effects on the fetus.
- Details of all prescribed and non-prescribed medication, times last taken for each and missed doses.
- Name of prescriber and when last seen.
- Details of pharmacy and dispensing arrangements.
- Examination and observation for signs of intoxication or withdrawal.
- Examination of any injecting sites (DVT is a major risk factor in this group).

Red flags requiring hospital assessment include:

- A pregnant woman who is acutely intoxicated to the point of drowsiness; she is at risk of aspiration and is more likely to have a fetus affected by hypoxia.
- Reduced fetal movements which may indicate fetal sedation and/or hypoxia.
- Active fetal movements which may indicate a fetus experiencing withdrawal symptoms of irritability.
- Uterine tightenings which may indicate uterine irritability due to withdrawal, and pose a risk of miscarriage or premature delivery.
- Vaginal bleeding.
- Alcohol withdrawal in pregnancy, which can only be safely managed in a medical setting with access to fetal monitoring.
- Drug-dependent patients not currently in treatment, requiring urgent specialist assessment and initiation of treatment by the specialist drug team.
- Patients receiving treatment who have missed medication doses in the previous week.
- Current crack or cocaine use, because of the risk of placental dysfunction, abruption and intrauterine growth retardation.
- Benzodiazepine use; although frequently prescribed as part of a management plan for substance use disorder, it is usually rapidly stopped by prescribers during pregnancy because of potential for fetal harm.
- Symptoms and signs of drug withdrawal.
- Multiple or high-risk injection sites (neck or groin), and presence of ulcers or abscesses.
- Other acute medical problems such as infection, possible DVT, and mental health issues.
- Homelessness – patients will rarely achieve or maintain stability whilst homeless.
- Nights or weekends when confirmatory information about antenatal care and substance use disorder treatment is unavailable.
- When the period of detention is likely to be prolonged e.g. public holidays.

Essential follow-up

There is a duty under adult and child safeguarding guidelines to inform the specialist midwifery services of any contact you have with a pregnant drug- or alcohol-dependent patient. Referral to social services is required, to inform the pre-birth child safeguarding plan.⁹³ Sharing of information is preferably done with the patient's consent, but child safeguarding concerns are sufficient to allow information-sharing without consent.⁹⁴

It may be necessary to alert the custody sergeant to establish the safety of other children whilst the woman is in custody. The detainee's midwife and GP should be informed, and the key worker from the substance use service; all, if possible, with consent of the detainee.

⁹³ Butler B, Swift N (2023) Proforma – Child Safeguarding Summary Referral. FFLM <https://fflm.ac.uk/resources/publications/proforma-child-safeguarding-summary-referral/> Accessed 11/07/2025

⁹⁴ FFLM (2020) Child Safeguarding: Information Sharing Guidance for Healthcare Professionals working in Police Custody <https://fflm.ac.uk/resources/publications/recommendations-child-safeguarding-information-sharing-guidance-for-healthcare-professionals-working-in-police-custody/> Accessed 11/07/2026

2.2.5 Children (under 18 years of age)^{95,96}

It is important to remember that children and young people who have been detained in police custody are more likely in general to have multiple complex needs, including a higher incidence of mental health problems, a history of self-harm, learning and communication difficulties, and a high incidence of experiencing abuse, neglect or trauma.⁹⁷

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

HCPs in the custodial environment need to make a child safeguarding referral⁹⁸ if they have concerns that a child or young person is suffering or likely to suffer harm. Being in custody itself may be harmful, and this should be done despite the fact that police routinely share the details of their contact with children and young people with the local authority.⁹⁹

The NHS England survey of pupils aged between 11 and 15 years old in England, in 2023, found that 13% of pupils reported that they had taken drugs.¹⁰⁰ Prevalence increases with age, and frequency between girls and boys is about equal. Cannabis is the drug that pupils are most likely to have taken in the last year, with 6% saying they had done so in 2023. This is the same proportion as in 2021. E-cigarette use increases with age from 1% of 11-year-olds, to 10% of 14-year-olds and 19% of 15-year-olds.¹⁰⁰

When young people present for treatment cannabis remains the most common substance followed by alcohol, powder cocaine, and ecstasy with a recent increase in the number of young people in treatment for solvent and inhalant misuse including nitrous oxide in 2022/2023.¹⁰¹ There was also a rise in the number

⁹⁵ GMC (2024) Protecting children and young people. <https://www.gmc-uk.org/professional-standards/the-professional-standards/protecting-children-and-young-people> Accessed 11/07/2026

⁹⁶ GMC (2024) 0-18 years. <https://www.gmc-uk.org/professional-standards/the-professional-standards/0-18-years> Accessed 11/07/2026

⁹⁷ College Of Policing Authorised Professional Practice – Detention and Custody Children and Young Persons <https://www.college.police.uk/app/detention-and-custody/detainee-care/children-and-young-persons> Accessed 11/07/2026

⁹⁸ Butler B, Swift N (2023) Child safeguarding summary referral. <https://fflm.ac.uk/resources/publications/proforma-child-safeguarding-summary-referral/> Accessed 11/07/2026

⁹⁹ Green P (2020) Recommendations – Child Safeguarding: Information Sharing Guidance for Healthcare Professionals working in Police Custody. <https://fflm.ac.uk/resources/publications/recommendations-child-safeguarding-information-sharing-guidance-for-healthcare-professionals-working-in-police-custody/> Accessed 11/07/2026

¹⁰⁰ NHS England (2024) Smoking, Drinking and Drug Use among Young People in England, 2023 <https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2023/part-8-drug-use-prevalence-and-consumption> Accessed 11/07/2026

¹⁰¹ Office for Health Improvement & Disparities (2024) Young people's substance misuse treatment statistics 2022 to 2023: report. <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-2022-to-2023/young-peoples-substance-misuse-treatment-statistics-2022-to-2023-report> Accessed 11/07/2026

reporting problems with ketamine.

Prevalence of alcohol use has been falling with the proportion usually drinking once a week increasing with age, from 1% of 11- and 12- year-olds to 11% of 15-year-olds.¹⁰² For pupils who drank in the last week the median number of units of alcohol consumed was 6.4 units and 26% of pupils who drank in the last week were estimated to have drunk 15 or more units. This increased from 19% of 11–13-year-olds, to 31% of 15-year-olds.

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

Assessment should include a full substance use and alcohol history plus any details of comorbid psychiatric symptoms. Enquiry as to whether there has been a previous history of self-harm is particularly important, as this may indicate risk of self-harm while in custody. In performing an assessment of a young person consideration should be given to the presence of a chaperone, essential if an intimate examination is required.¹⁰³

Issues regarding consent¹⁰⁴

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

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

- The mother, who automatically has PR (unless removed by a court).
- The biological father, who acquires PR if he is married or in a civil partnership to the mother at the time of the child's birth or anytime thereafter or is named on the birth certificate.

¹⁰²NHS England (2024) Smoking, Drinking and Drug Use among Young People in England, 2023 <https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2023/part-5-alcohol-drinking-prevalence-and-consumption#top> Accessed 11/07/2026

¹⁰³ GMC (2024) Intimate examinations and chaperones. <https://www.gmc-uk.org/professional-standards/the-professional-standards/intimate-examinations-and-chaperones> Accessed 11/07/2026

¹⁰⁴ Green P, Paul S, Teebay L, Stark MM, Butler B, Gifford J, & Gorton A (2023) Consent from Children and Young People in Police Custody in England and Wales for Medical Examinations. FFLM & RCPCH <https://fflm.ac.uk/resources/publications/recommendations-consent-from-children-and-young-people-in-police-custody-in-england-and-wales/> Accessed 11/07/2026

- The father can obtain PR by jointly registering the birth with the mother, or by a court-registered Parental Responsibility Agreement with the child's mother, or a Parental Responsibility Order from the courts.
- Second female parent has PR if she is married to, or in a civil partnership with the birth mother, at the time of conception, and conception was through licensed fertility treatment with consent.
- The surrogate (birth) mother has PR at birth.
- Others with agreement or by court order (e.g. stepparents, grandparents or adoptive parents).

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

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

*Forensic examinations*¹⁰⁵

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

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

¹⁰⁵ Green P, Paul S, Teebay L, Stark MM, Butler B, Gifford J, & Gorton A (2023) Consent from Children and Young People in Police Custody in England and Wales for Medical Examinations. FFLM & RCPCH <https://fflm.ac.uk/resources/publications/recommendations-consent-from-children-and-young-people-in-police-custody-in-england-and-wales/> Accessed 11/07/2026

HCPs need to be aware that there are additional procedural considerations regarding forensic examinations of children (juveniles¹⁰⁶) – those under the age of 18 years. The police are required to follow certain rules to ensure that evidence obtained from those under 18 years of age in custody is legally admissible in court.

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

'Appropriate consent' is defined in Section 65 of PACE¹⁰⁷ as meaning:

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

Where the consent of a parent or guardian is required, it is not necessary for that person to be at the police station to give that consent. However, where the consent of the child 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 child is essentially a matter for the police and not the HCP.

2.3 Administration of medication in police stations

2.3.1 General principles

The overriding consideration of the attending HCP must be the clinical safety and wellbeing of the patient. The FFLM and Royal Pharmaceutical Society have developed recommendations to ensure the safe and secure administration of medication in police custody.¹⁰⁸ HCPs working in this environment must be fully aware of these recommendations.

HCPs will have access to certain medicines for treating a detainee. The FFLM have recommended a formulary since 2012.¹⁰⁹ There should be an agreed local formulary

¹⁰⁶ Under PACE Codes of Practice a "juvenile" is defined as anyone who appears to be under the age of 18 (Code C 1.5 and 1L)

¹⁰⁷ Police and Criminal Evidence Act 1984 <https://www.legislation.gov.uk/ukpga/1984/60/section/65> Accessed 11/07/2026

¹⁰⁸ Cooke C, Payne-James J (2023) Safe and Secure Administration of Medication in Police Custody. FFLM <https://fflm.ac.uk/resources/publications/recommendations-safe-and-secure-administration-of-medication-in-police-custody/> Accessed 11/07/2026

¹⁰⁹ Dean L, Fewkes S, Butler B, Starkie C (2026) Operational procedures & equipment for clinical & forensic examination rooms in police stations. FFLM. <https://fflm.ac.uk/resources/publications/recommendations-operational-procedures-and-equipment-for-clinical-rooms/> Accessed 11/07/2026

developed after an audit of local need to include drugs covered by Patient Group Directions (PGD).

Medicines may be provided by police, or outsourced providers; provided by the HCP; previously prescribed to the patient and brought in on arrest or by a relative or friend; previously prescribed and collected from a supervising pharmacy (e.g. Opioid Agonist Treatment (OAT)) (see Appendix D); and/or collected by police via a private prescription (see Appendix E). Arrangements will vary as to how medication is obtained, and it is important that HCPs are aware of local procedures.

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

The PACE Code of Practice for the detention, treatment and questioning of persons by police officers (Code C) also provides guidance on the administration of medication.¹¹⁰

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 medically prescribed controlled drugs of the types and forms listed in the Misuse of Drugs Regulations 2001, Schedule 1, 2 or 3. A detainee may only self-administer such drugs under the personal supervision of the registered medical practitioner authorising their use or other appropriate healthcare professional.

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

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

It remains good practice to advise police staff that, if they have any concerns regarding

¹¹⁰ Home Office. (2023) PACE Code C. Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 10/07/2026

the drug to be administered, they should have no hesitation in telephoning the HCP to discuss those concerns and whether a visit is required.

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

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

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

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

2.3.2 Administration of cannabis-based products for medicinal use (CBPMs) in police custody¹¹¹

The FFLM has produced Recommendations on the management of detainees who are prescribed Cannabis-based Products for Medicinal Use (CBPMs) providing the following advice:

'Where a detainee has an NHS prescription for a licenced CBPM, we would recommend, if appropriate, safe, and where possible, continuing the medication during periods of detention.'

If a detainee is receiving a private prescription for an unlicensed medication, we would advise that the Healthcare Professional reassesses the indication for the medication and considers the safety of the medication, taking into consideration the lack of evidence for prescribing in many conditions.'

Other challenges will be verification of the prescription, if issued by a private clinic, as these clinics may have limited accessibility and response times.

Mode of administration will also need to be considered. Neither smoking nor vaping is authorised in custody suites and therefore any CBPM that is vaporised should not be offered in a custody environment.'

¹¹¹ Evans D (2025) Recommendations on the management of detainees or prisoners who are prescribed Cannabis-based Products for Medicinal Use (CBPMs)
<https://fflm.ac.uk/resources/publications/recommendations-on-the-management-of-detainees-or-prisoners-who-are-prescribed-cannabis-based-products-for-medicinal-use-cbpms/> Accessed 11/07/2026

2.4 Liaison with other agencies

2.4.1 Acute hospital referral

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

The clinician responsible for the discharge of the patient from hospital should ensure that relevant medical information is transferred with the detainee^{112,113} (by letter, copy of electronic discharge summary, or completion of any appropriate forms, e.g. Appendix F).

The police should also be given any necessary information to ensure the safe transfer of the detainee and ongoing care in police custody. Clinicians need to share relevant information with those who have a duty of care for detainees and this includes police officers. Clinical leads for custody should liaise with clinical leads for their local emergency departments to ensure a protocol is in place for sharing information. It is a matter for the custody officer to determine whether further clinical advice should be sought from the HCP on the detainee's return to the custody suite.

2.4.2 Liaison with prison

Remand prisons have GPs and nurses with recognised extended competencies with experience in the management of substance use disorders, and a 24-hour healthcare presence.¹¹⁴ The assessment and treatment of drug and alcohol dependence in this setting tends, therefore, to be more equivalent to that provided in the community rather than the unique short-term environment of police custody, where the period of detention can restrict clinicians in maintaining ongoing medication or managing symptoms of withdrawal. Methadone (first line) and, where clinically appropriate, buprenorphine are opioid substitutes for managing opioid withdrawal in prisons.

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

¹¹² GMC (2024) Good Medical Practice. <https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice> Accessed 11/07/2026

¹¹³ GMC (2017, updated 2018 and 2024) Confidentiality: Good practice in handling patient information. <https://www.gmc-uk.org/professional-standards/the-professional-standards/confidentiality> Accessed 11/07/2026

¹¹⁴ RCGP guide to GP Clinical Extended Roles (GP with Extended Role - GPwER) (2025) <https://www.rcgp.org.uk/your-career/gp-extended-roles/gp-extended-roles-guide> Accessed 07/07/2026

If there is concern that a detainee who is due to be transferred to court may be at risk of suicide or self-harm, the procedure outlined in Section 2.2.1 should be followed. HCPs should, whilst balancing patient confidentiality and appropriate information sharing for the detainee's welfare, provide custody officers with sufficient information to allow them to give the necessary care to the detainee 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 PER). Again, HCPs should ensure that they make a record of any consultation in the police medical record form.

Detainees may arrive in police custody having left 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 controlled drugs are routinely taken under supervised conditions in all prisons. A criminal justice integrated team from a detainee's home area will also hold information on drug services received by their clients in prison, including in relation to prescribed medication.

2.4.3 Community substance use services

All areas have substance use services and entitlement to treatment will be decided by an individual's place of residence. There will be local arrangements for homeless service users and those who may not be entitled to public funds. These are commissioned by local authorities using funds from the public health grant. The services are provided by a range of organisations. In about third of areas the services are run by the local mental health trust but in most areas they are run by voluntary sector organisations. In many areas there are partnerships of the NHS and one or more voluntary sector organisations where organisations work together to provide services. These services will have a range of staff in their teams including senior medical staff (in most cases consultant psychiatrists), prescribers (non-medical prescribers (NMP) and medical) and recovery workers.

Although commissioning arrangements vary, in general services are obliged to provide treatment and interventions which are set out in the clinical guidelines.^{115,116} This includes timely assessment (within a few days) and other interventions such as OAT, alcohol detoxification and needle exchange. Most offer drop in assessments. Services may be offered from a single site or dispersed into the community. In some areas primary care is involved in prescribing OAT although this is becoming less common.

Services targeting those involved in the criminal justice system may be separate and there may be local teams just to work with individuals in police custody. Providing treatment continuity between police custody, prison and the community is imperative to improve outcomes and is monitored locally. Local areas should have arrangements to ensure this system works well.

¹¹⁵ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 10/07/2026

¹¹⁶ Department of Health and Social Care. (2025) Clinical guidelines for alcohol treatment. <https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment> Accessed 10/07/2026

Generally, staff working in police custody should have a comprehensive understanding of local services. Many local services will be actively reaching into custody suites such as by the provision of arrest referral workers. It is good practice to be able to give detailed localised advice on accessing services to substance users (e.g. opening hours) if they are released from custody including for needle exchange and other harm reduction interventions.

3. Management of specific drug problems

3.1 General principles^{117,118}

The increasing likelihood of polysubstance use disorder and associated problems, such as drug interactions and dependence on different drugs, should be borne in mind when considering the management of each individual detainee. There should be a high level of awareness of possible alcohol problems when assessing detainees with other substance use disorders, and a high level of suspicion of co-occurring organic disorder.

The HCP should be aware of, and have access to, the National Poisons Information Service guidance (NPIS)/TOXBASE® (www.TOXBASE.org) for the most up to date guidance and advice on the immediate management of specific drug toxicity and advice regarding ongoing clinical management.

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

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

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

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

Once dependence has been diagnosed, sufficient treatment should be provided for

¹¹⁷ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 10/07/2026

¹¹⁸ Department of Health and Social Care. (2025) Clinical guidelines for alcohol treatment. <https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment> Accessed 10/07/2026

the proposed period of detention. There should be a low threshold for frequent clinical reviews in the early stages of treatment.

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

Wherever possible and where clinically appropriate, OAT with methadone or buprenorphine should be continued for anyone detained in police custody and already stable on such medication in the community. Substantial evidence supports the efficacy of OAT.¹¹⁹ It is unacceptable to have a rule to automatically withhold OAT in police custody. Withholding such treatment from detainees who are compliant with their regime may increase the risk of relapsing or re-offending, and with pregnant detainees there are significant risks to the mother and unborn child.

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

Since the last edition of these guidelines there has been a proliferation in the number of novel psychoactive substances (NPS). NPS are a range of drugs that have been designed to mimic established illicit drugs such as cannabis, cocaine, ecstasy and LSD. NPS have been banned collectively in the UK under the Psychoactive Substances Act 2016 (<https://www.legislation.gov.uk/ukpga/2016/2/contents>).

The chemicals in these drugs are constantly changing, it is possible to receive a very different product from batch to batch, even if the packaging and name are the same. Equally, due to the mechanism of production, dosage of active drug can vary significantly between samples taken from the same package. With so many NPS available, often of variable content, unknown individual tolerance, and intentional and unintentional polydrug use, HCPs should have a low threshold for early referral to an emergency department. Up-to-date specific drug information on NPS is available from the National Poisons Information Service (NPIS/TOXBASE®).

The UK operates a Drug Early Warning System (EWS) that rapidly identifies and communicates risks from NPS and contaminated drug supplies.¹²⁰

Many of these new psychoactive substances may influence a detainee's fitness for interview (see Section 4.1). After being in a stimulated/agitated state for a prolonged period, a detainee may require a period of rest before being interviewed.

¹¹⁹ National Institute for Clinical Excellence (NICE) (2007) Methadone and buprenorphine for the management of opioid dependence Technology appraisal guidance Reference number:TA114 <https://www.nice.org.uk/guidance/ta114/chapter/4-Evidence-and-interpretation> Accessed 10/07/2026

¹²⁰ Department of Health & Social Care. National Drug Treatment Monitoring System (NDTMS) Drug Early Warning System <https://www.ndtms.net/DrugsEarlyWarningSystem> Accessed 09/07/2026

3.2 Opioids

3.2.1 Symptoms and signs of opioid intoxication

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

Intoxication with opioids can lead to hypotension, bradycardia, cyanosis, respiratory depression, loss of consciousness and death. Onset may be rapid with parenteral use and delayed several hours with oral use. Significant intoxication may occur via transdermal route.¹²¹

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 with the presence of hypoxia to maintain target SpO₂. Emergency medicine advice suggests supplemental oxygen or bag-valve-mask ventilation where RR < 10/minute or SpO₂ < 92% (on air).¹²² Interpret saturations with caution in those with pre-existing respiratory disease such as COPD.¹²² Where severe opioid intoxication is suspected, an emergency ambulance must be called immediately, and naloxone given.^{123,124}

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. Naloxone is available via several routes of administration, with additional formulations under development. At the time of publication, licensed preparations were available for intramuscular, intravenous and intranasal administration. Within custody settings, intranasal and intramuscular administration are generally the most practical and commonly used routes because they can be delivered rapidly and safely in emergency situations.

Clinicians and commissioned services should ensure that practice remains aligned with current national guidance, including the latest editions of the BNF and the relevant Summary of Product Characteristics (SmPC) for the product being used. Local policies should be reviewed regularly to ensure they reflect any changes to licensing, formulations, dosing recommendations or routes of administration.

Naloxone has a shorter duration of action than many opioids; close monitoring and repeated injections are necessary according to the respiratory rate and depth of coma.

¹²¹ Sommerfeld-Klatta K, Jiers W, Łukasik-Głębocka M et al. (2023) Severe and Fatal Fentanyl Poisonings from Transdermal Systems after On-Skin and Ingestion Application. *Toxics* 20; 11(10): 872. doi: 10.3390/toxics11100872. PMID: 37888722; PMCID: PMC10610823.

¹²² Royal College of Emergency Medicine and National Poisons Information Service (2024) Best practice Guideline. Guidelines for the Assessment and Management of Acute Opioid Toxicity in Adults in the Emergency Department. <https://rcem.ac.uk/best-practice/acute-opioid-toxicity-best-practice-guideline/> Accessed 10/07/2026

¹²³ NICE. BNF. Naloxone Hydrochloride. <https://bnf.nice.org.uk/drugs/naloxone-hydrochloride/> Accessed 10/07/2026

¹²⁴ [Reversing an adult opioid overdose with naloxone – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#) Accessed 10/07/2026

If naloxone is given in custody the detainee is not fit to be detained in police custody and must be transferred to hospital for further assessment and observation.

Naloxone treatment should be considered to reverse severe respiratory depression in people presenting with signs and symptoms of an opioid overdose where the cause is unknown.¹²⁵

Increasingly police officers are being issued with naloxone, whilst this can be of value in remote and rural forces when police officers may well arrive at the scene of a suspected opiate overdose before clinical first responder teams it does not negate the need for high quality basic life support. Caution should also be used where there may be a risk of mixed use, in particular when an individual has taken both opiates and cocaine as the reversal of the opiate effect may result in unopposed stimulant effect with adverse effects.^{126,127}

NPCC has produced guidance¹²⁸ for police carrying naloxone which advises that officers should receive additional training to their existing First Aid Learning Programme (FALP) in the indications for, and administration of naloxone. This training should highlight that basic life support (BLS) is the mainstay of treatment and that naloxone may be a useful adjunct over and above, but not in place of these core skills. If naloxone is given in the community the individual needs to be assessed in hospital before being taken to custody.

3.2.2 Symptoms and signs of opioid withdrawal

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

Table 3.1 Symptoms and signs of opioid withdrawal	
Symptoms	Signs
Sweating	Dilated pupils
Running nose and eyes	Gooseflesh
Yawning	Flushing
Feeling hot and cold	Sweating
Anorexia and abdominal cramps	Lachrymation and rhinorrhea
Nausea, vomiting, diarrhoea	Tachycardia, hypertension

¹²⁵ [Reversing an adult opioid overdose with naloxone – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#) Accessed 10/07/2026

¹²⁶ Hunter R (2005) Ventricular tachycardia following naloxone administration in an illicit drug misuser. J Clin Forensic Med 12:218–219

¹²⁷ Merigian KS (1993) Cocaine-induced ventricular arrhythmias and rapid atrial fibrillation temporarily related to naloxone administration. Am J Emerg Med 11:96–97

¹²⁸ National Police Chief's Council Supporting clinical guidance to 'The use of intra-nasal Naloxone by Police Officers and Staff' Version 1, August 2025

Tremor	Increased bowel sounds
Restlessness and insomnia	—
Anxiety and agitation	—
Generalised aches and weakness	—
Coughing and sneezing	—

The start of withdrawal symptoms will vary with different opioid drugs. On average, the symptoms of heroin withdrawal start within 8 hours, progress to a peak and then gradually improve within 48–72 hours.^{129,130}

Withdrawal from methadone typically results in a less acutely severe but more prolonged withdrawal syndrome compared to heroin. When assessing severity, greater weight should be given to observable clinical signs, while also taking into account the detainee's reported symptoms and overall clinical presentation.

3.2.3 Symptomatic treatment of opioid withdrawal

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

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

Table 3.2 Symptomatic treatment of opioid withdrawal		
Symptom	Drug	Administration
Vomiting	Metoclopramide	10mg three times daily. Not known to be harmful in pregnancy. Action antagonised by opioid analgesics. Caution, especially in young adults (15-19 yrs), extrapyramidal effects commonly occur.
	Buccal prochlorperazine	3 or 6mg (one or two 3mg tablets) absorbed from buccal cavity twice daily. Useful if unable to retain oral medication.
Abdominal cramps	Mebeverine hydrochloride	135-150mg three times daily, preferably 20 minutes before meals. Antispasmodic, not known to be harmful in pregnancy.
	Hyoscine butylbromide	10-20mg four times daily. Smooth muscle relaxant. Advised to avoid in pregnancy.

¹²⁹ World Health Organization (2009) [Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings](#). Geneva: World Health Organization. Accessed 10/07/2026

¹³⁰ Stark MM, Payne-James JJ, Scott-Ham M (2025) Symptoms and Signs of Substance Use. Routledge, New York

Diarrhoea	Loperamide	Loperamide 4mg initially followed by one after each loose stool; maximum 16mg daily. An opiate receptor agonist which acts on the gut to reduce peristalsis, increase intestinal transit time and increase tone of the anal sphincter.
Minor aches and pains	Paracetamol	Paracetamol 500mg x 2 up to four times a day (maximum eight per day).
	NSAID such as ibuprofen	Ibuprofen 200-400mg three to four times daily (max 2.4g daily. Avoid in pregnancy especially third trimester.

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

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

Any consideration, and then prescription, of opioid medication must be managed by competent staff, and broadly in line with the Clinical Guidelines 2017.¹³¹ The police custody suite environment is a unique environment due to the acute, unpredictable and relatively short-term detention of detainees and the need to manage symptoms acutely and safely. All HCPs should be aware of the increased risk of overdose and death, particularly in those with opioid use, and this especially with concomitant prescribing and/or administration of other sedative drugs, such as benzodiazepines, gabapentinoids, anti-depressants, and use of illicit drugs and alcohol.

A comprehensive history and clinical examination (which includes the keeping of accurate notes) should be conducted to assess dependence and the objective signs of withdrawal and to correlate these with the subjective symptoms reported by the detainee. Documentation of basic parameters such as pulse, blood pressure, respiratory rate, SpO₂, blood glucose, AVPU and NEWS 2 and size of pupils are essential,¹³² and the use of an opiate withdrawal scale (e.g. COWS¹³³) may be beneficial, particularly when a reassessment is performed. Care must be taken to exclude the presence of intoxication by substances, illicit or prescribed (e.g. benzodiazepines/anti-depressants), and/or alcohol.

¹³¹ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 10/07/2026

¹³² Wall I (2023) Proforma – Fitness for detention and interview. FFLM. <https://fflm.ac.uk/resources/publications/proforma-fitness-for-detention-and-interview/> Accessed 10/07/2026

¹³³ Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9.

Mild opioid withdrawal (COWS < than 12)¹³⁴ can be controlled by symptomatic medications, as described above. There will be cases where significant withdrawal symptoms cannot be managed by symptomatic medication, and opioid drugs may be required to control the symptoms and signs.

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

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

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

Methadone

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

HCPs should be aware that liquid methadone used in the treatment of opioid dependence is available in several strengths. The most commonly used preparation is methadone oral solution 1 mg/ml, typically green in colour, although a colourless formulation is also available. A more concentrated formulation, which is less commonly used, is available as methadone oral concentrate in strengths of 10 mg/ml (blue) and 20 mg/ml (brown).

The effect of a dose of methadone depends on the individual's tolerance to opioids, which can develop within two weeks of commencing daily use. Tolerance disappears as quickly as it develops, and loss of tolerance can lead to previously safe doses proving fatal. Care is required when authorising and supervising self-administration of previously prescribed methadone to ensure that the correct strength is provided, since any confusion could lead to overdose. If supervision and clarity on dispensing cannot be confirmed, then a most cautious approach must be adopted with titration against withdrawal signs. If the prescriber cannot confirm that the detainee has physically taken their methadone within the last 3 days (via confirmation from pharmacy) then

¹³⁴ COWS Scores: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

it shouldn't be prescribed or administered.

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

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

Buprenorphine¹³⁵

Buprenorphine is an opioid with agonist and antagonist properties; it poses less of a risk in overdose when taken alone. The tablets are available in 0.4mg, 2mg and 8mg strengths. Buprenorphine with naloxone is available (as 2mg/0.5mg and 8mg/2mg). Buprenorphine is also available as an oral lyophilizate (Espranor) and a prolonged injectable buprenorphine (Buvidal) given weekly or monthly (various doses).¹³⁶

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

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

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

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

Assessment procedure

On an initial assessment, especially if the detainee is seen soon after arrest, it would be unusual to prescribe any drugs immediately unless there are clear objective signs of opioid withdrawal. This cautious approach is taken because the detainee may have recently taken substances (alcohol, OTC, illicit and prescribed drugs), and the full

¹³⁵ NICE. BNF. Buprenorphine <https://bnf.nice.org.uk/drugs/buprenorphine/> Accessed 10/07/2026

¹³⁶ NICE Evidence review Opioid dependence: buprenorphine prolonged release injection (Buvidal), February 2019 <https://www.nice.org.uk/advice/es19/evidence/evidence-review-pdf-6666819661> Accessed 10/07/2026

effects of this ingestion may not yet be obvious.

If there is evidence of intoxication, NO substitution treatment should be given until the intoxication has resolved. However, it should be remembered that those who are prescribed and are taking OAT (methadone or buprenorphine) regularly may not show signs of withdrawal in short-term police custody situation. Signs of withdrawal will be delayed because of the longer half-life of OAT (compared to heroin for example). Many substances, for example methadone with alcohol, have an additive effect leading to significant morbidity or mortality. Considering whether the detainee is fit for detention is then the priority.

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

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

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

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

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

The decision to prescribe OAT and supervise self-administration is the responsibility of the forensic physician or other appropriately trained HCP, even when the drug is collected from the usual clinic or pharmacist. If there is doubt about the daily dose, then the dose can be divided and given every 6–12 hours (see Table 3.3).

Table 3.3 Dividing the daily dose of OAT

Scenario
• The HCP is looking after a detainee in police custody, and they have obtained the supply of methadone from the detainee's pharmacy to administer, e.g. methadone 60mg once daily. • The HCP is concerned that giving the dose as a single 60mg dose might be harmful and would like to split the dose and give 30mg and then provide the other 30mg in a few hours' time if appropriate. • This situation may also arise if the HCP has access to a stock supply in the police custody suite and a prescriber has prescribed the 30mg dose on a prescription the HCP uses to administer against.
Questions & Answers
Can the HCP lawfully do this without contacting a prescriber either (a) the original prescriber or b) their provider's prescriber? Yes - but see 2019 guidance¹³⁷ (pp5-6) which suggests they should contact the original prescriber or in police custody they could ask their provider's prescriber. This allows the HCP to discuss the basis of their concerns too which may lead to the dose being withheld.
Does the HCP need to have the methadone re-prescribed with the new directions on them? No - the directions are not a legal part of the prescription, but they should document the changes advised by the prescriber in the clinical records and to inform the next HCP who looks after the detainee. The dose administered by whom and when should be clearly documented.
Can the HCP use the current named patient supply to provide the new dose if a new prescription has been written? Yes, the HCP does not have to get a separate supply of the medicine. However, written procedures (Standard Operational Procedures (SOPs)) should describe how to ensure that any other HCP who may use this supply knows that the dose instructions on the label of the current supply have changed. This prevents another or the same HCP supplying 60mg rather than 30mg when the next dose is due.

¹³⁷ Royal Pharmaceutical Society & Royal College of Nursing (2019) Professional Guidance on the Administration of Medicines in Healthcare Settings

Any forensic physician and independent nurse prescriber 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.

Some custody healthcare teams may choose to hold methadone or buprenorphine stock at designated police custody suites so doses can be administered under HCP supervision without the need for a named-patient supply. This works well if there's frequent need for OAT supply and will be easier especially at weekends and BHs when pharmacies may be closed.

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

Where it is determined with the person in police custody that continuing their supply of controlled medication from their community pharmacy is most appropriate, it is important to understand responsibilities to communicate effectively, and to record decisions and actions taken. Further guidance on the mechanics of arranging for such supply to police custody suites in England is contained in 'Access to supervised doses of opioid substitution for people in police custody.'¹³⁸

Managing those not currently on OAT treatment or where OAT cannot be confirmed

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

The evidence base for management of heroin dependence consistently indicates that where a need for opioid substitution is identified, and where safe induction onto methadone or onto buprenorphine is possible, either drug (methadone or buprenorphine) prescribed is the most appropriate intervention for stabilisation and management of the detainee.¹³⁹

¹³⁸ Public Health England (2015) Access to supervised doses of opioid substitution for people in police custody. <https://www.cpcw.org.uk/wp-content/uploads/sites/19/2016/08/Custody-Dispensing.pdf> Accessed 11/07/2026

¹³⁹ Department of Health and Social Care (2024) Guidance: Oral methadone and buprenorphine: recommendations <https://www.gov.uk/government/publications/medicine-choices-in-opioid-substitution-treatment/oral-methadone-and-buprenorphine-recommendations> Accessed 11/07/2026

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

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

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

When deciding on the most appropriate choice of initial opioid agonist therapy (OAT), HCPs should consider the risks and benefits of each treatment option whilst taking into account patient preference, previous treatment response and the potential to facilitate linkage with substance use treatment services and continuation of OAT prescribing.¹⁴⁰

Official UK Government guidance highlights that buprenorphine may be a more suitable option in several clinical scenarios including *"if the patient has significant comorbid cardiac or respiratory disease"* or *"you are concerned about the patient's use of other prescribed sedatives and of non-prescribed drug or alcohol consumption"*.¹⁴¹

Therefore, it may be possible for the police and forensic healthcare providers to initiate treatment or work in partnership with the local community drug and alcohol teams to initiate treatment and follow-up from within police custody. This could involve remote liaison with the local drug and alcohol team, and we are also aware of examples where drug and alcohol team members attended the custody centre in person to assess a detainee and commence treatment, arranging ongoing care for when the detainee leaves custody (see Appendix J for more information on the initiation of buprenorphine in police custody).

Though with little research evidence, the common and long-standing practice of experienced clinicians in police custody is to use non-opioid symptomatic

¹⁴⁰ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 11/07/2026

¹⁴¹ Department of Health and Social Care (2024) Guidance: Oral methadone and buprenorphine: recommendations <https://www.gov.uk/government/publications/medicine-choices-in-opioid-substitution-treatment/oral-methadone-and-buprenorphine-recommendations> Accessed 12/07/2026

medication or dihydrocodeine.^{142,143} Dihydrocodeine tartrate has a short duration of action, so needs to be given several times a day (every 4–6 hours). These drugs have a half-life of 3.5–4.5 hours and reach a peak concentration after 1.5–2 hours.

Dihydrocodeine has perceived safety advantages in short-term use, being a lower potency opioid agonist with a short half-life, with a consequent reduced likelihood of accidental dose accumulation and of overdose.

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

Dihydrocodeine is not licensed for the treatment of opioid withdrawal and should not be routinely used for managing withdrawal in the community.¹⁴⁴ Informed consent includes advising the patient that such use is off-licence as well as discussing the advantages and disadvantages. There is, however, extensive experience of using dihydrocodeine in the unique circumstances of the police custodial environment. It is essential that clinicians working in this setting and using dihydrocodeine off-licence to treat opioid withdrawal have the competencies to do so (see Appendix A).

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

PGDs need to reflect the potential higher doses of dihydrocodeine required in the treatment of opioid dependence to adequately manage withdrawal symptoms and signs.

Any HCPs providing medication by PGD must review the detainee prior to providing this treatment:

'HCPs who supply or administer medicines under a PGD can only do so if they belong to one of the approved classes of HCP designated in writing by or on behalf of the authorising person (Human Medicines Regulations 2012) and identified as named individuals. It follows that delegation to another person of all or part of the process stipulated in a PGD (in effect, deputising for another

¹⁴² Stark MM, 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

¹⁴³ Robertson JR, Raab G, Bruce M, McKenzie JS, Storkey HR (2006) Addressing the efficacy of dihydrocodeine versus methadone as an alternative maintenance treatment for opiate dependence: a randomized controlled trial. *Addiction* 101;1752-1759

¹⁴⁴ GMC (2024) Good practice in proposing, prescribing, providing and managing medicines and devices content Prescribing unlicensed medicines

<https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines>

Accessed 12/07/2026

*HCP to carry out part of the practice), from the assessment of the patient through to the act of supply or administration, is not allowed.*¹⁴⁵

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

Actions to help mitigate the risks include:

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

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

3.2.5 Illicit synthetic opioids

Fentanyl has been implicated in opioid-related deaths.¹⁴⁶ As a medicine fentanyl has analgesic and sedative effects and it is used in the management of severe pain and in anaesthesia. It is available in several formulations. Misuse of fentanyl medications is not new but there has been an increase in the availability of illicit fentanyl, and an increasingly diverse range of illicit fentanyl analogues, some very potent. There are different formulations: powders, liquids (in nasal sprays, e-cigs) and tablets. Overdose may result in vomiting, sedation, respiratory depression, and death. The high potency of fentanyl means only a low dose is required for effect. There are increased toxic effects, especially when mixed with other central nervous system depressant drugs, and where there is lack of tolerance. Injection of the contents of the fentanyl medicinal patch may occur.

Nitazenes are a group of highly potent synthetic opioids with effects similar to heroin but they are much more potent leading to a high risk of fatal overdose. Naloxone is effective but multiple doses may be required due to the high potency of nitazenes. Another reason for naloxone appearing to be less effective in cases of opioid

¹⁴⁵ Cooke C, Payne-James J (2023) Safe and Secure Administration of Medication in Police Custody. FFLM <https://fflm.ac.uk/resources/publications/recommendations-safe-and-secure-administration-of-medication-in-police-custody/> Accessed 10/03/2026

¹⁴⁶ ACMD 2016 Reducing Opioid-related deaths https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf Accessed 12/07/2026

overdose is the presence of additional substances (either known or unknown) such as gabapentinoids, xylazine, and ketamine.

A novel class of synthetic opioids, known as “orphines” e.g. buprenorphine, are highly potent μ -opioid receptor agonists with increasing likelihood of rapid-onset overdose.

3.2.6 α_2 -adrenergic receptor agonists

Xylazine is a synthetic α_2 -adrenergic receptor agonist; a non-opioid sedative, painkiller and muscle relaxant used in veterinary medicine as a tranquiliser for animals. Xylazine may be found mixed with opioids, such as heroin or fentanyl, but also with other drugs such as cocaine, in counterfeit codeine and diazepam (Valium) tablets and THC vapes.¹⁴⁷

Medetomidine is a potent synthetic α_2 -adrenergic receptor agonist used primarily in veterinary medicine as a sedative and analgesic. It acts on the central nervous system resulting in sedation, muscle relaxation, and reduced pulse rate and blood pressure. It has been detected in illicit drugs such as fentanyl as it appears to increase the euphoric effects of fentanyl. It is more potent and longer-lasting than xylazine.

The risk of overdose with opioids is increased because of the additive effects of both drugs resulting in more severe respiratory depression.

3.3 Alcohol¹⁴⁸

It is essential that alcohol dependence is recognised in custody; the Alcohol Use Disorders Identification Test (AUDIT)¹⁴⁹ for screening and the Severity of Alcohol Dependence Questionnaire (SADQ) may assist in the diagnosis and measurement of the severity of dependence.¹⁵⁰

3.3.1 Symptoms and signs of alcohol intoxication

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

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

¹⁴⁷ Copeland CS, Rice K, Rock KL, Hudson S, Streete P, Lawson AJ, et al. (2024) Broad evidence of xylazine in the UK illicit drug market beyond heroin supplies: Triangulating from toxicology, drug-testing and law enforcement. *Addiction* 119(7): 1301–1309. <https://doi.org/10.1111/add.16466>

¹⁴⁸ Department of Health and Social Care. (2025) Clinical guidelines for alcohol treatment. <https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment> Accessed 12/07/2026

¹⁴⁹ Office for Health Improvement and Disparities. (2020) Alcohol use screening tests. <https://www.gov.uk/government/publications/alcohol-use-screening-tests> Accessed 12/07/2026

¹⁵⁰ Severity of Alcohol Dependence Questionnaire (SADQ) (2020) <https://www.mdapp.co/severity-of-alcohol-dependence-questionnaire-sadq-calculator-518/> Accessed 12/07/2026

account for the condition (see Section 2.1.2 Table 1).

Signs of intoxication:

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

Signs of severe intoxication/overdose:

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

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

Care should be taken to exclude concurrent medical problems in alcohol-intoxicated detainees, in particular head injuries and hypoglycaemia, which may complicate the picture (see Table 3.4).

Table 3.4 - Differential Diagnosis of Alcohol Intoxication¹⁵¹

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

A breath alcohol measuring device may be a tool to assess the alcohol concentration and facilitate diagnosis and treatment, but any decision regarding whether a suspect who has been drinking alcohol is fit for interview is best made on a full assessment, rather than on arbitrarily defined ‘safe’ breath alcohol levels.¹⁵²

3.3.2 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 (See Table 3.5). It should always be remembered that alcohol use may not be disclosed, and that alcohol withdrawal may mimic other withdrawal syndromes.

¹⁵¹ Stark MM, Holmes J (2014) The Alcohol-Intoxicated Person in Custody: Diagnosis, Differential Diagnosis and Management. *Acad Forensic Pathol* 4(2): 198-205

¹⁵² Rogers DJ, Stark MM, Howitt JB (1995) The use of an alcometer in clinical forensic practice. *Journal of Clinical Forensic Medicine* 2;177–183

Table 3.5 Symptoms and signs of alcohol withdrawal	
Uncomplicated	Complicated
Agitation	Seizures
Mild tremor	Hallucinations auditory and visual
Sweating	Confusion & Disorientation
Fever	Aggressive behaviours
Tachycardia	
Hypertension	Delirium tremens (severe shaking, agitation, fever, tachycardia, profound confusion, delusions and hallucinations)
	Wernicke's encephalopathy (confusion, memory disturbance, impaired eye movements or unsteady walking)

3.3.3 Treatment of alcohol withdrawal

Withdrawal from alcohol in police custody can pose a serious threat to the individual's health, with increased mortality related to delirium tremens (DT), both treated and particularly untreated DT. An attempt should be made to assess the degree of dependence and initiate early treatment to avoid the complications of withdrawal, such as convulsions and DT.

Those who have a history of severe withdrawal and people with other high-risk factors may be at risk of Wernicke's encephalopathy (WE). Incipient WE is characterised in most cases by confusion, in some cases with classical symptoms of ataxia (unsteady walking), memory disturbance and ophthalmoplegia (impaired eye movements), although only a small percentage will show all three of these classical symptoms. People with suspected WE should immediately be transferred to an inpatient setting with 24 hour medical and nursing staffing. People in the high-risk group for developing WE can have a number of conditions:¹⁵³

- significant weight loss
- poor diet
- low body mass index (BMI) (a BMI score of less than 18)
- other signs of malnutrition
- memory disturbance
- peripheral neuropathy
- previous history of complicated withdrawal including WE
- decompensated liver disease

¹⁵³ Department of Health and Social Care. (2025) Clinical guidelines for alcohol treatment. <https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment> Accessed 12/07/2026

- long history of harmful drinking and alcohol dependence.

Clinicians should have a lower threshold for referring more vulnerable groups for specialist inpatient medically assisted withdrawal such as people experiencing homelessness, older people, children and young people and people with established liver disease.¹⁵⁴

Benzodiazepines, for example diazepam,¹⁵⁵ are the treatments of choice.¹⁵⁴ If the detainee is unable to take oral medication, transfer to a general hospital for parenteral treatment should be arranged.

All HCPs should be trained in the use of a validated measure of withdrawal symptoms. Staff should have access to regular clinical supervision and when necessary, consultation from a senior clinician or multidisciplinary team (MDT).

There are different regimes for detoxification, for example fixed dose or symptom triggered.¹⁵⁶ A symptom-triggered regimen involves treatment tailored to the person's individual needs, determined by the severity of withdrawal signs and symptoms. The patient is regularly assessed and monitored, using clinical experience and questioning/assessment alone, or with the use of an alcohol withdrawal tool as an adjunct to clinical judgement. Drug treatment (long-acting benzodiazepine) is provided if the patient needs it and treatment is withheld if there are no symptoms of withdrawal. A symptom-triggered regimen for drug treatment for people in acute alcohol withdrawal is currently recommended for those who are in hospital or in other settings where 24-hour assessment and monitoring are available.¹⁵⁶

In police custody if dependence is diagnosed a fixed and adequate dose regime of a long-acting benzodiazepine should be prescribed, with higher and extra doses given on regular review. If symptoms continue to be severe, or there is onset of severe complications, hospital referral will be required for in-patient treatment. Delirium tremens and Wernicke's encephalopathy are medical emergencies.

3.4 Benzodiazepines & Z-drugs

3.4.1 Symptoms and signs of intoxication with benzodiazepines

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.

¹⁵⁴ Department of Health and Social Care. (2025) Clinical guidelines for alcohol treatment. <https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment> Accessed 12/07/2026

¹⁵⁵ Department of Health and Social Care, NHS England. Medicine Supply Notification MSN/2026/021 Chlordiazepoxide 5mg and 10mg capsules 30/03/2026

¹⁵⁶ NICE (2017) Alcohol-use disorders: diagnosis and management of physical complications Clinical guideline. CG100 <https://www.nice.org.uk/guidance/cg100/chapter/Recommendations#acute-alcohol-withdrawal> Accessed 10/07/2026

The symptoms of toxicity/overdose are mainly an intensification of the therapeutic effects (drowsiness, dysarthria, muscle weakness, profound sleep, hypotension, bradycardia, nystagmus, ataxia) or paradoxical excitation. Paradoxical reactions like restlessness, agitation, irritability, aggressiveness, delusion, rages, nightmares, hallucinations, psychoses, inappropriate behaviour and other adverse behavioural effects are known to occur when using benzodiazepines.^{157,158} In most cases of intoxication observation of vital functions is required.

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

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

3.4.2 Benzodiazepine withdrawal syndrome

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

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

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

In recent years, the regular misuse of very large amounts of benzodiazepines, orally or intravenously, has been more prevalent, especially in combination with opioid and/

¹⁵⁷ NICE. BNF. Drugs. <https://bnf.nice.org.uk/drugs/>

¹⁵⁸ Mancuso CE, Tanzi MG, Gabay M (2004) Paradoxical reactions to benzodiazepines: literature review and treatment options. *Pharmacotherapy* 24(9)1177-85. doi: 10.1592/phco.24.13.1177.38089. PMID: 15460178

or alcohol use disorder. There are marked similarities to alcohol withdrawal symptoms and signs, and careful history-taking and examination are required. However, the use of benzodiazepines is often in binges, and even if huge doses are taken dependence is not common, and may not need pharmacological treatment.

Clonazepam is a second-line or add-on treatment for treatment for myoclonic seizures (not for other seizure types).¹⁵⁹ Detainees may say that they are receiving the drug for this purpose and the diagnosis of epilepsy and current treatment should be confirmed before prescribing further clonazepam.

Treatment of benzodiazepine withdrawal

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

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

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

3.4.3 Z-drugs: zopiclone, zolpidem, zaleplon

These are non-benzodiazepine hypnotic drugs which act on the benzodiazepine receptors. Acute intoxication causes sedation, slurred speech, loss of coordination; they are relatively safe in overdose unless mixed with other drugs and/or alcohol. They may cause impairment of memory and problems with cognition, and somnambulism, and can result in physical and psychological dependence. Withdrawal occurs in a substantial minority of regular users, especially after more than 2–4 weeks of nightly use. This can be treated with diazepam.¹⁶⁰

3.5 Pregabalin and gabapentin

There have been increasing reports of the misuse of both pregabalin and gabapentin in recent years. The Advisory Council for the Misuse of Drugs (ACMD) suggested in 2016 that these drugs be regulated under the Misuse of Drugs Act 1971 and Regulations 2001.¹⁶¹ From April 2019 gabapentin and pregabalin were reclassified as Schedule 3 controlled drugs

¹⁵⁹ [Treating epileptic seizures in children, young people and adults | Epilepsies in children, young people and adults | Guidance | NICE](#) Accessed 07/07/2026

¹⁶⁰ NICE (2024) Benzodiazepine and z-drug withdrawal
<https://cks.nice.org.uk/topics/benzodiazepine-z-drug-withdrawal/> Accessed 09/07/2026

¹⁶¹ ACMD (2016) Pregabalin and Gabapentin advice.
<https://www.gov.uk/government/publications/advice-on-the-anticonvulsant-drugs-pregabalin-and-gabapentin> Accessed 12/07/2026

under the Misuse of Drugs Regulations 2001, and Class C of the Misuse of Drugs Act 1971. They are exempted from the safe custody requirements under the Misuse of Drugs (Safe Custody) Regulations 1973.¹⁶¹

These drugs are indicated for the treatment of epilepsy (adjunct only¹⁶²), generalized anxiety disorder, for the relief of neuropathic pain, postherpetic neuralgia, diabetic peripheral neuropathy, fibromyalgia, and as an adjunct therapy for partial seizures.

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

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

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

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

3.6 Stimulants

Problem cocaine users include users of powder cocaine or crack cocaine. Powder cocaine users commonly also use alcohol problematically. Many heroin users may also use crack cocaine as an integral part of their drug-using repertoire. Amphetamine and methamphetamine users may seek treatment (with methamphetamine being increasingly seen among men who have sex with men and are involved in 'chemsex'¹⁶³).

Ecstasy (3,4-methylenedioxymethamphetamine) MDMA is the most commonly used stimulant responsible for acute toxicity. It 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.

¹⁶² NICE. BNF. Drugs <https://bnf.nice.org.uk/drugs/pregabalin/> Accessed 12/07/2026

¹⁶³ Chemsex is used in the UK to describe intentional sex under the influence of psychoactive drugs (mephedrone, γ-hydroxybutyrate (GHB), γ-butyrolactone (GBL), and crystallised methamphetamine) mostly among men who have sex with men

3.6.1 Intoxication with stimulants

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

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

Users of stimulant drugs such as cocaine, methamphetamine and amphetamine may present with Acute Behavioural Disturbance (ABD). ABD is not a diagnosis.¹⁶⁴ It is the 'umbrella' term for a presentation of severe agitation, hence the importance of considering the differential diagnosis.^{164,165} It may occur secondary to substance use (both intoxication and withdrawal), physical illness (such as post head injury, hypoglycaemia, sepsis) and psychiatric conditions (including psychotic and personality disorders).

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

Presentations of suspected ABD should be taken directly to the Emergency Department (ED) of the local hospital. If the detainee is taken to custody HCPs need to be aware of the guidance issued by the FFLM¹⁶⁴ and RCEM¹⁶⁶ regarding management.

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

¹⁶⁴ FFLM (2024) Acute behavioural disturbance (ABD): guidelines on management in police custody. <https://fflm.ac.uk/resources/publications/acute-behavioural-disturbance-abdguidelines-on-management-in-police-custody/> Accessed 12/07/2026

¹⁶⁵ Humphries C, Kelly A, Sadik A, Walker A, Smith J. (2023) Consensus on acute behavioural disturbance in the UK: a multidisciplinary modified Delphi study to determine what it is and how it should be managed. *Emerg Med J* 41(1):4-12. doi: 10.1136/emmermed-2023-213335. PMID: 37739766; PMCID: PMC10804037

¹⁶⁶ RCEM (2023) Best Practice Guideline Acute Behavioural Disturbance in Emergency Departments <https://rcem.ac.uk/best-practice/acute-behavioural-disturbance-in-emergency-departments/> Accessed 12/07/2026

3.6.2 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 BNF for the use of CNS stimulant drugs for the treatment of substance use disorder.

3.7 Hallucinogens

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

LSD is usually taken orally and results in sympathomimetic effects such as tachycardia, hypertension, pyrexia and dilated pupils within 10–30 minutes, with psychological effects after 30–60 minutes. There is a recovery period of up to 12 hours, during which there may be periods of normal perception and cognition alternating with degrees of intoxication that may affect fitness for interview (see Section 4.1). Emotional lability, euphoria and anxiety, visual and auditory illusions (although true hallucinations can occur) and synaesthesia (a mixing of the sensory input: ‘seeing’ sounds or ‘hearing’ smells) may all occur. Polydrug users may use benzodiazepines to alleviate anxiety and panic attacks.

3.8 Volatile substances

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

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

HCPs are reminded that sudden death is a recognised hazard of volatile substance misuse and may occur during exposure or in the subsequent hours,¹⁶⁷ especially during struggling or arousal. No specific management is required, even after abrupt discontinuation. There is no physical withdrawal syndrome.

¹⁶⁷ Shepherd RT (1989) Mechanisms of sudden death associated with volatile substance abuse. *Human Toxicology* 8; 287–292.

3.9 Nitrous oxide¹⁶⁸

Nitrous oxide has widespread legitimate medical, dental and veterinary uses but there has been an increase in recreational use. On inhalation the gas results in a brief period of euphoria. The use of nitrous oxide, a central nervous system depressant in combination with other drugs including alcohol, opioids, benzodiazepines, or GHB/GBL increase the potential for harm.

Heavy use of nitrous oxide can lead to the inactivation of vitamin B12 and neurological disorders including myeloneuropathy with damage to spinal cord tract and peripheral nerves. There has been an apparent rise in cases of nitrous oxide-induced subacute combined degeneration of the spinal cord. HCPs should provide advice to detainees regarding treatment which can be provided which involves the cessation of nitrous oxide use alongside vitamin B12 supplementation.

3.10 Cannabis and synthetic and semi-synthetic cannabinoid receptor agonists (SCRA)

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

Synthetic cannabinoid receptor agonists (SCRA)¹⁶⁹ are often sold in herbal products such as the smoking mixture 'Spice' or sheets of paper sprayed with SCRA solution, which is then smoked by the user. Other methods of administration include vaporising ('vaping') SCRA liquid solutions or ingestion of pills or powders.

The acute effects are dependent on how the drugs are taken. It is difficult to inhale very substantial doses but when the drugs are ingested as edible materials, or vaping cartridges are used, the dose may be higher and the effects more severe. The ingestion of edibles makes dose titration more challenging and may result in users re-dosing before the full effects of the original dose have been experienced.

Adverse effects include dizziness, somnolence, trembling, agitation, headaches, dysarthria, confusion, euphoria, paraesthesia or muscle contractions, tachycardia, palpitations or chest pain, vomiting, nausea, or abdominal pain, anxiety, hallucinations, or delirium, dilated pupils and/or or blurred vision.

¹⁶⁸ ACMD (2023) Nitrous Oxide– Updated Harms Assessment
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1140251/ACMD_Nitrous_Oxide_Report_06_March.pdf Accessed 12/07/2026

¹⁶⁹ ACMD (2020) Synthetic cannabinoid receptor agonists (SCRA)
<https://www.gov.uk/government/publications/synthetic-cannabinoid-receptor-agonists> Accessed 12/07/2026 and
ACMD (2025) 'Semi-synthetic' Cannabinoids: Cannabinoids related to tetrahydrocannabinol and cannabidiol <https://www.gov.uk/government/publications/semi-synthetic-cannabinoids-related-to-tetrahydro-cannabinol-and-cannabidiol> Accessed 12/07/2026

Concerns with the increasingly potent THC and synthetic preparations include acute arrhythmias, respiratory failure, psychosis and ABD. These can be medical emergencies.

3.11 Diversion and illicit supply of medicines (DISM)^{170,171}

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

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

It is essential in the custody environment that there is safe disposal of unused or expired medicines to prevent diversion or misuse.¹⁷¹

3.12 Alkyl nitrites – 'poppers'¹⁷²

Alkyl nitrites are volatile, yellowish, clear liquids that have vasodilatory properties, used as a euphoric relaxant in the dance culture and to relax the anal sphincter and enhance sexual experience. The effect of inhaling the vapour is instantaneous and very short-lived, resulting in a 'rush', a sense of euphoria, 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. Methaemoglobinemia may occur with swallowing of volatile nitrites as opposed to inhaling.¹⁷³

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

¹⁷⁰ ACMD report on Diversion and Illicit Supply of Medicines (2016)

<https://www.gov.uk/government/publications/diversion-illicit-supply-of-medicines>

Accessed 12/07/2026

¹⁷¹ UNODC (2026) Minimizing the risk of diversion of pharmaceuticals containing controlled substances from the regulated supply chain. A practitioner's handbook for effective operational practice <https://www.unodc.org/unodc/drug-prevention-and-treatment/publications/data/2026/march/minimizing-the-risk-of-diversion-of-pharmaceuticals-containing-controlled-substances-from-the-regulated-supply-chain.html>

Accessed 12/07/2026

¹⁷² ACMD (2024) Alkyl nitrites: ACMD exemption consideration.

<https://www.gov.uk/government/publications/alkyl-nitrites-acmd-exemption-consideration/alkyl-nitrites-acmd-exemption-consideration-accessible#harms-in-the-uk> Accessed 12/07/2026

¹⁷³ Stambach T, Haire K, Soni N, Booth J (1997) Saturday night blue—a case of near fatal poisoning from the abuse of amyl nitrite. J Accid Emerg Med 14:339–340 [CrossRef](#) [PubMed](#) [PubMedCentral](#)

3.13 Gamma-hydroxybutyrate (GHB), gamma-butyrolactone (GBL), 1,4-butanediol (BD)

GHB is structurally related to gamma-aminobutyric acid (GABA). It is a naturally occurring substance in the human brain and may be a neurotransmitter. Gamma-butyrolactone (GBL) is inactive but is rapidly converted to GHB when ingested. It is available as a colourless, odourless liquid, powder or capsules, taken orally, and rarely injected. Both GHB and GBL are controlled under Class B of the Misuse of Drugs Act 1971.

Initial effects include: euphoria, sedation, confusion, agitation and amnesia; nausea, vomiting and diarrhoea; ataxia, seizures, hypotonia and tremor; vertigo and dizziness; bradycardia, hypotension, hypothermia; and coma and respiratory collapse. There is a narrow margin between intoxication and coma. The clinical effects are potentiated by use of other CNS depressants such as alcohol, opioids, benzodiazepines and antipsychotics. GHB is often taken with methamphetamine which can cause a psychotic state.

Dependence may occur rapidly, resulting in a withdrawal syndrome, with wide individual variation of anxiety, sweating, tachycardia, tremor and eventually delirium (especially in frequent users) similar to the symptoms and signs of alcohol withdrawal. Withdrawal may develop rapidly, 3-4 hours after the last use of the drug, and there may be a rapid deterioration into agitated delirium in those that are severely dependent.

Withdrawal may be treated with high-dose benzodiazepines and require admission to an intensive care unit.

3.14 Khat

Khat consists of the young leaves of the *Catha edulis* plant. It is a central nervous system stimulant and its main components are cathine and cathinone, with effects similar to those of amphetamine. It is usually chewed for its stimulant effect, resulting in euphoria, increased alertness and anorexia; anxiety and insomnia may occur. Khat is a Class C drug (since 2014).

3.15 Ketamine¹⁷⁴

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, as well as orally, intramuscularly or intravenously. It has analgesic properties; the onset of its effects depends on the route of administration.

Ketamine is a prescription-only medicine Schedule 2 of the Misuse of Drugs Regulations 2001 (MDR), controlled under Class B (since 2014) of the Misuse of Drugs Act 1971.

Ketamine is a dissociative anaesthetic with analgesic, psychedelic and central nervous system depressant properties. It has a wide margin of safety therapeutically. In higher

¹⁷⁴ Morgan CJ, Curran HV (2012) Independent Scientific Committee on Drugs. Ketamine use: a review. *Addiction* 107(1):27-38. doi: 10.1111/j.1360-0443.2011.03576.x. Epub 2011 Jul 22. PMID: 21777321

doses physical effects may include a cocaine-like rush, increased pulse and blood pressure, arrhythmias, nausea and vomiting, slurred speech, nystagmus, lack of coordination, and seizures. Mild respiratory depression may occur. Use with other drugs, such as benzodiazepines and alcohol, increases the risk of central nervous system and respiratory depression. Methoxamine may be encountered with increased toxicity compared with ketamine.

There is increasing recognition of SUD in those that regularly consume high doses of ketamine. Significant adverse effects on the bladder, upper urinary tract, kidneys, abdomen, liver and bile ducts have been found.¹⁷⁵ Ketamine-induced uropathy is a condition associated with damage to the urinary tract, including the bladder with increased daytime urinary frequency, urgency, incontinence, nocturia, dysuria, haematuria and bladder pain. Pain may require treatment whilst in custody and the HCP should provide advice regarding harm reduction and onward referral for adverse health effects.¹⁷⁵

3.16 Hallucinogenic mushrooms

These mushrooms grow wild in many areas of Europe and the USA, although more commonly they are cultivated. Their use has been increasing in recent years but the statistics for the year end March 2025 showed there was no statistically significant change in the overall prevalence of hallucinogens (lysergic acid diethylamide and magic mushrooms).¹⁷⁶ 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, disorientation, confusion, delusions, paranoia and psychosis, limit their recreational popularity.

3.17 Nicotine

Individuals who use nicotine products (e.g., tobacco cigarettes, oral nicotine pouches or electronic nicotine vaping devices) are likely to experience nicotine withdrawal symptoms if they are detained in settings in which they are required to temporarily abstain. Withdrawal symptoms can manifest within a few hours as intense cravings, restlessness, irritability and constipation. Inadequate control of withdrawal symptoms may contribute to agitated behaviour and impact the ability of a detainee to appropriately participate in interviews. Nicotine Replacement Therapy (NRT) should be rapidly available for all detainees in police custody.¹⁷⁷ NRT is licenced for any individual over twelve years of age, including pregnant women, and can be provided by custody staff without a prescription.

The simultaneous combined use of two NRT products (i.e., typically a longer acting patch + a quicker-acting oral or nasal formulation) is the most effective strategy.

¹⁷⁵ ACMD (2026) Ketamine: an updated review of use and harms.

<https://www.gov.uk/government/publications/ketamine-an-updated-review-of-use-and-harms/ketamine-an-updated-review-of-use-and-harms-accessible> Accessed 12/07/2026

¹⁷⁶ ONS (2025) Drug misuse in England and Wales: year ending March 2025.

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2025#overall-trends-in-drug-misuse> Accessed 12/07/2026

¹⁷⁷ PHE. HCSCT. ASH. (2016) Joint briefing: Managing nicotine withdrawal in police custody. <https://ash.org.uk/resources/view/joint-briefing-managing-nicotine-withdrawal-in-police-custody> Accessed 12/07/2026

Where local policies allow, detainees could also be permitted to use an electronic nicotine vaping device¹⁷⁸ to minimise nicotine withdrawal.¹⁷⁹

3.18 Serotonin syndrome (SS)

Serotonin syndrome may be caused by the use of one serotonergic agent; using two or more serotonergic agents together increases the risk. It is a predictable consequence of excess serotonin acting on the central nervous system. The degree of symptoms can range from mild to severe, and they include hyperthermia, agitation, hyperreflexia, tremor, sweating, dilated pupils, hypertension, rapid heart rate and diarrhoea. Complications may include seizures and rhabdomyolysis.

The combination of serotonin-boosting antidepressants, such as citalopram and fluoxetine, with stimulants such as MDMA, cocaine and amphetamines, as well as NPS substances,¹⁸⁰ has been implicated in serotonin syndrome. Additionally other drugs such as tramadol, MAOIs and triptans, as well as the 'herbal preparation' St John's Wort, have been associated with it when combined with antidepressants. This is a serious and potentially fatal condition that warrants admission to hospital when suspected.

3.19 Neuroleptic malignant syndrome

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

Any medications within the neuroleptic family can cause the condition, though typical antipsychotics, e.g. haloperidol, chlorpromazine, thioridazine appear to have a higher risk than atypicals, e.g. olanzapine, risperidone, quetiapine. This is a serious, albeit rare, condition with a mortality of about 10%; any individual suspected of suffering from NMS should be referred to hospital without delay.

¹⁷⁸ Electronic nicotine-vaping devices must be examined prior to use in custody to confirm they are safe, undamaged, compliant with UK regulations, and free from counterfeit or tampered components.

¹⁷⁹ ASH and Cancer research UK. (2025) Space to Breathe <https://ash.org.uk/resources/view/space-to-breathe-findings-from-a-survey-of-smokefree-policies-and-tobacco-dependence-treatment-services-in-nhs-mental-health-trusts-in-england-2024> Accessed 12/07/2026

¹⁸⁰ Schifano F, Chiappini S, Miuli A, et al. (2021) New psychoactive substances (NPS) and serotonin syndrome onset: A systematic review. *Exp Neurol.* 2021 May;339:113638. doi: 10.1016/j.expneurol.2021.113638. Epub 2021 Feb 8. PMID: 33571533.

4.1 Fitness for interview^{181,182,183}

4.1.1 General considerations

An opinion may be requested of an HCP as to the detainee's fitness for interview. The HCP should ask the custody officer about the probable period of detention and the likelihood and timing of any proposed interview. Withdrawal or intoxication may affect a detainee's fitness to be interviewed, and symptoms and signs may vary with time, so a finding of fitness for interview is potentially time limited. The HCP should ensure that an accurate record is made of the examination conducted, including the reasoning behind their decision regarding fitness for interview. A proforma may be of assistance in documenting the assessment.¹⁸⁴

Co-occurring substance use and mental health disorders are common and frequently under-identified and can complicate both the assessment of the detainee and the safe management of withdrawal.¹⁸⁵

4.1.2 Definition¹⁸⁶

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

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

When HCPs identify risks, they should attempt to quantify the risk (definite, major risk, some risk, no discernible risk).¹⁸⁷ 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

¹⁸¹ Stark MM, Rix KJB. Fitness to Be Interviewed & Charged. Chapter 11. In Clinical Forensic Medicine – A Physician's Guide. Ed. Stark MM. Humana Press, Totowa, New Jersey, 2026. Fifth edition, in press. Springer, New York

¹⁸² Ventress MA, Rix KJB, Kent JH (2008) Keeping PACE: fitness to be interviewed by the police. *Advances in Psychiatric Treatment* 2008:14;369-381

¹⁸³ Rix KJB, Nathan R (2021) Reports for Criminal Proceedings and in Prison Cases. Chapter 7. In *Rix's Expert Psychiatric Evidence*. Eds. Rix K & Powers M. Cambridge University Press. Second edition. pp 105 -115

¹⁸⁴ Wall I (2023) Proforma. Fitness for detention and interview. FFLM <https://fflm.ac.uk/resources/publications/proforma-fitness-for-detention-and-interview/> Accessed 11/07/2026

¹⁸⁵ Royal College of Psychiatrists (2025) Co-occurring substance use and mental health disorders (CoSUM) College Report 243 [https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2025-college-reports/co-occurring-substance-use-and-mental-health-disorders-\(cosum\)-\(cr243\)](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2025-college-reports/co-occurring-substance-use-and-mental-health-disorders-(cosum)-(cr243)) Accessed 10/07/2026

¹⁸⁶ Home Office (2023) Code C Revised. Code of Practice for the detention, treatment and questioning of persons by Police Officers. Annex G. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 10/07/2026

¹⁸⁷ Home Office (2001) The report of the Home Office Working Group on Police Surgeons.

- how long it may take for any improvement to take effect.

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

- how the detainee's physical or mental state might affect their ability to understand the nature and purpose of the interview, to comprehend what is being asked, and to appreciate the significance of any answers given, and to make rational decisions about whether they want to say anything
- the extent to which the detainee's replies may be affected by their physical or mental condition, rather than representing a rational and accurate explanation of their involvement in the offence
- how the nature of the interview, which could include particularly probing questions, might affect the detainee.

Therefore, the HCP must consider the various vulnerability factors that render an individual more likely to provide an unreliable confession. These factors include the personality traits that increase vulnerability – suggestibility, acquiescence and compliance; the health of the individual (physical and mental, including substance use disorders, intoxication, withdrawal states), the likely demand characteristics of the interview, and the totality of the circumstances – (personality/health/interview/totality of the circumstances: PHIT).¹⁸⁸

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

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

The definition of fitness for interview is distinct from the definition of fitness to plead.¹⁸⁹

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

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

¹⁸⁸ Norfolk GA (2001) Fit to be interviewed by the police – an aid to assessment. *Medicine, Science and the Law* 41; 5–12

¹⁸⁹ In assessing fitness to plead and fitness to stand trial, medical witnesses are asked whether the accused can participate effectively in the trial process which means having the ability to (1) understand the nature and effect of the charges; (2) decide whether to plead guilty or not; (3) exercise their right to challenge jurors; (4) instruct solicitors and counsel so as to prepare and make a proper defence in their case, which includes understanding the details of the evidence which can reasonably be expected to be given in their case, and advise their solicitor and counsel in relation to that evidence (this applies to their ability to instruct their legal advisers before and/or during his trial; (5) follow the course of the proceedings; and (6) give evidence in their own defence.

4.1.3 False confessions^{190,191}

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

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

False confessions have been divided into:

- voluntary
- coerced–compliant or pressured–compliant
- coerced–internalised or pressured–internalised (memory distrust)
- accommodating–compliant¹⁹²
- coerced–reactive.¹⁹³

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

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

A coerced–internalised false confession happens when the suspect comes to believe, at least temporarily, that they may have committed the crime of which they are accused. Suspects may do this even though they have no actual memory of committing the crime. A history of alcohol and substance use disorder 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.¹⁹⁴

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

¹⁹⁰ Kassir SM, Wrightsman LS (1985) *The Psychology of Evidence and Trial Procedure*. Sage Publications, London

¹⁹¹ Gudjonsson GH (2018) *The Psychology of False Confessions. Forty Years of Science and Practice*. John Wiley & Sons Ltd, West Sussex

¹⁹² Shepherd E (2004) *Police station skills for legal advisors: becoming skilled*, 3rd edn. Law Society, London

¹⁹³ McCann JT (1998) A conceptual framework for identifying various types of confessions. *Behavioural sciences and the Law* 16; 441-453

¹⁹⁴ Gudjonsson GH, MacKeith JAC (1982) False confessions. Psychological effects of interrogation. A discussion paper. In: Trankell A, (Ed) *Reconstructing the Past: The Role of Psychologists in Criminal Trials*. Deventer, The Netherlands, Kluwer pp 253-269.

happened. In such circumstances, a false confession is borne out of a strong need for approval and to be liked.

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

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

Vulnerability factors

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

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

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

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

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

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

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

Healthcare professionals and the treatment of withdrawal

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

Symptoms and signs of mild opioid withdrawal may be no barrier to interview, whereas severe withdrawal may render a detainee unfit to be interviewed until the peak of withdrawal subsides after 2–3 days or is brought under control with OAT.

The Court of Appeal (Criminal Division) in *R v Crampton*¹⁹⁵ has ruled that the mere fact that an individual is withdrawing and might have a motive for confession does not necessarily make the confession unreliable. Whether an individual is fit to be interviewed, in the sense that his or her answers can be relied on as being true, is a matter for those present at the time. Considerable weight is likely to be given to the evidence provided by the HCP. However, the admissibility of any statement will be decided in court by the judge and its credibility decided by the jury.

Withdrawal from alcohol and other sedative/hypnotic drugs can be very severe and distressing, with a risk of delirium tremens and convulsions. Fitness to be interviewed may be seriously impaired and the detainee may first need to be stabilised on sedative medication, preferably a long-acting drug such as diazepam.¹⁹⁶ Their mental state will then need re-examination to assess their fitness for interview. Polysubstance use, which is increasingly common, will complicate matters further, particularly where drugs and alcohol have been taken.

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

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

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

¹⁹⁵ *R v Crampton Court of Appeal (Criminal Division) (1990)* The Times Law Report, 22 November 1990

¹⁹⁶ Department of Health and Social Care (2025) Clinical guidelines for alcohol treatment. 10. Pharmacological Interventions <https://www.gov.uk/guidance/clinical-guidelines-for-alcohol-treatment/10-pharmacological-interventions> Accessed 11/07/2026

the intoxication has cleared before commencing questioning.

However, NPS, in particular hallucinogenic substances, may give rise to difficulties in this respect. For example, the mental state may fluctuate in the recovery stages of a lysergic acid diethylamide (LSD) experience and, although the apprehension and distraction that this causes may not be immediately evident to onlookers, it may have a bearing on suggestibility and resistance to questioning. HCPs should be aware of this possibility and be prepared to advise the police accordingly.¹⁹⁷

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

4.2 Intimate searches¹⁹⁸

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

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

The Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM) and the British Medical Association (BMA) have issued comprehensive guidelines for doctors asked to perform intimate body searches¹⁹⁹ (with a flowchart see Figure 2). An intimate search should be performed by an HCP, i.e. a registered medical practitioner or registered nurse.

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

¹⁹⁷ NEPTUNE (Novel Psychoactive Treatment: UK Network) <https://www.cnwl.nhs.uk/neptune> Accessed 12/07/2026

¹⁹⁸ Police and Criminal Evidence Act 1984 (PACE) – Code C Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers December 2023 Annex A Intimate and Strip Searches <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 11/07/2026

¹⁹⁹ Stark MM, Gorton A, Offiah C (2024) Recommendations for healthcare professionals asked to perform intimate body searches Guidance for doctors from the British Medical Association and the Faculty of Forensic & Legal Medicine. <https://fflm.ac.uk/resources/publications/recommendations-healthcare-professionals-asked-to-perform-intimate-body-searches/> Accessed 12/07/2026

hospital (in an emergency department) or other medical premises concerned. It is recommended that an emergency department with full resuscitation facilities is used because of the potential dangers involved.

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

The doctor or nurse will be guided by the authorities as to which orifice(s) to search. It is essential that the doctor or nurse has the appropriate knowledge and skills and is competent to perform the required clinical examination. Intimate searches of the vagina and rectum are not recommended but any of the following orifices may be used to conceal drugs/weapons and should be examined in the following manner:²⁰⁰

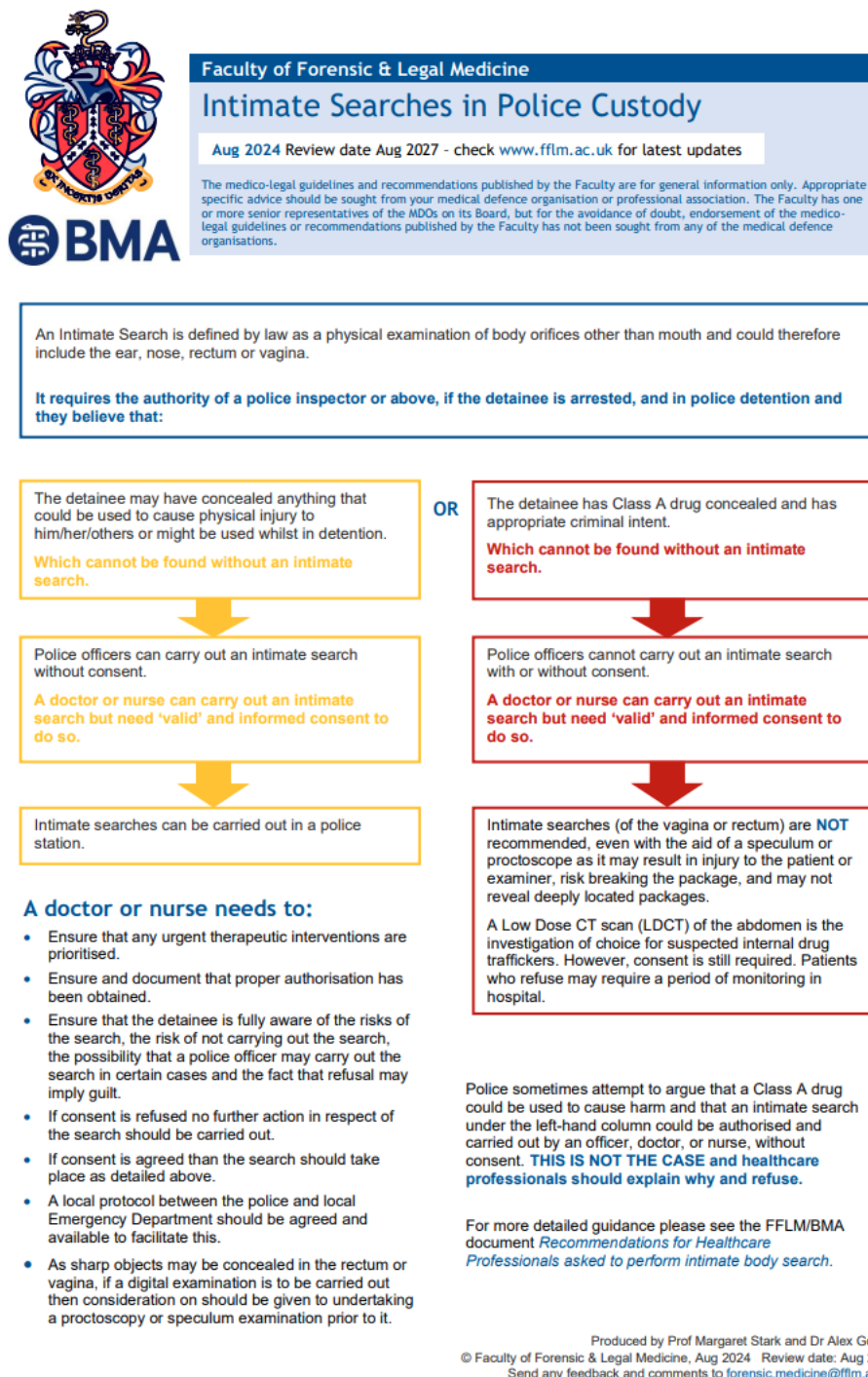
- mouth: visual inspection with light source
- nostrils: visual inspection with auroscope
- ears: visual inspection with auroscope
- umbilicus: visual inspection with light source
- foreskin: visual inspection with light source

In Scotland Section 14 of the Criminal Procedure Act 1995 allows a healthcare professional to perform an intimate search if a Class A drug or object which may cause physical harm is suspected by police of being concealed. Where an intimate search is considered necessary in Scotland in the interests of justice and in order to obtain evidence, this may lawfully be carried out under the authority of a sheriff's warrant. As with searches authorised under PACE, however, the BMA and FFLM consider that such searches should be carried out by a doctor or nurse only when the individual has given consent. If consent is not given, the doctor or nurse should refuse to participate and have no further involvement in the search.²⁰¹

²⁰⁰ Stark MM. Body cavity searches, practical issues, and consent. *Encyclopaedia of Forensic and Legal Medicine*. © 2024 Elsevier Ltd. This is an update of M.M. Stark, *Body Cavity Searches: Practical Issues and Consent*, Editor(s): Jason Payne-James, Roger W. Byard, *Encyclopedia of Forensic and Legal Medicine* (Second Edition), Elsevier, 2016, Pages 433e436, ISBN 9780128000557, <https://doi.org/10.1016/B978-0-12-800034-2>

²⁰¹ Stark MM, Gorton A, Offiah C (2024) Recommendations for healthcare professionals asked to perform intimate body searches Guidance for doctors from the British Medical Association and the Faculty of Forensic & Legal Medicine. <https://fflm.ac.uk/resources/publications/recommendations-healthcare-professionals-asked-to-perform-intimate-body-searches/> Accessed 12/07/2026

Figure 2 - Intimate Searches in Police Custody Flowchart



4.3 Management of detainees suspected of having drugs concealed internally

It is essential that clear and consistent terminology is used in relation to the clinical management of persons suspected of having drugs concealed internally.²⁰²

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

If police officers know or suspect that a detainee has swallowed or packed drugs, either for the purpose of trafficking or to avoid imminent arrest or detention by the police, they must treat the person as being in need of urgent medical attention and transfer them straight to hospital.²⁰³

A review of the limited literature on the subject provides evidence to suggest that a blanket policy of observation for only 6 hours is insufficient for the asymptomatic cocaine body stuffer.²⁰⁴ (see below RCEM Guidelines)

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

Body packers ('drug couriers' or 'surgical mules') is the term commonly used to describe people who swallow packets of illicit drugs or put them into body orifices (using condoms or other containers, often purposely designed to escape detection) as they pass through customs checks. Increasingly, these are sophisticated, factory produced items²⁰⁵ with the packets designed to retain their contents as the individual crosses frontiers and therefore the risk of leakage is lower. However, should the packets leak or rupture at any stage the risk of severe and potentially fatal toxicity is much higher.

²⁰² Department of Health & Social Care. The Medical Care of Suspected Internal Drug Traffickers – Independent Report of the Chief Medical Officer's Expert Group. January 2013
<https://www.gov.uk/government/publications/report-on-the-care-of-suspected-internal-drug-traffickers-published> Accessed 12/07/2026

²⁰³ College of Policing. Authorised Professional Practice. Detention in Custody (Alcohol and Drugs) (2021) <https://www.college.police.uk/app/detention-and-custody/detainee-care/alcohol-and-drugs> Accessed 12/07/2026 and see:
Template Protocol for the Management of Detainees who are Suspected of Swallowing or Having Packed Drugs or Foreign Objects into Body Orifices or Cavities
<https://library.college.police.uk/docs/NPIA/Protocol-for-the-Management-of-Detainees.pdf> Accessed 12/07/2026

²⁰⁴ Norfolk GA (2007) The fatal case of a cocaine body-stuffer and a literature review – towards evidence-based management. *Journal of Forensic and Legal Medicine* 14; 49–52

²⁰⁵ Cappelletti S, Piacentino D, Ciallella C (2019) Systematic Review of Drug Packaging Methods in Body Packing and Pushing: A Need for a New Classification. *The American Journal of Forensic Medicine and Pathology* 40(1):pp 27-42

Facilitated by the introduction of long-distance flights from the 1970s onwards, the number of cases of body packing reported in the literature count more than 6,000 recorded across the world. These include both men and women. Body packaging has also been documented amongst pregnant women and in children. Typically, the substances concerned are cocaine or heroin, but other drugs may be involved including methamphetamine, cannabis, ecstasy and prescription opioids. Diagnosis is often based on the presence of symptoms and signs on clinical examination. Signs of toxicity may be apparent, and packages may sometimes be incidentally felt through the abdominal wall during palpation of the abdomen. Intimate searches of the vagina and/or rectum are not recommended (see Section 4.2 Intimate searches).²⁰⁶ However, many body packers are asymptomatic.

Urinalysis has a low sensitivity in detection of drug packages and should therefore play a limited role in primary diagnosis of body packing.^{207,208} However, it has a very high sensitivity in instances of package leak. A near-patient urine or oral-fluid test can be helpful to confirm the presence of drugs, but it does not differentiate between smugglers and users. 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 concealed. Other investigations may be required to confirm the presence of packages, including abdominal X-ray, abdominal ultrasound or computed tomography scanning.

The Police may request X-rays and/or an ultrasound scan under section 55A of PACE if:²⁰⁹

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

If a detainee states that they have swallowed drugs before arrest, or if the arresting officer reasonably believes they have done so, they should be conveyed without delay to the Emergency Department (ED) of an NHS hospital with full resuscitation facilities and treated for a drug overdose until this is shown to be otherwise.

²⁰⁶ Stark MM, Gorton A, Offiah C (2024) Recommendations for healthcare professionals asked to perform intimate body searches Guidance for doctors from the British Medical Association and the Faculty of Forensic & Legal Medicine. <https://fflm.ac.uk/resources/publications/recommendations-healthcare-professionals-asked-to-perform-intimate-body-searches/> Accessed 12/07/2026

²⁰⁷ Bogusz MJ, Althoff H, Erkens M, Maier R-D, & Hofmann R (1995) Internally concealed cocaine: analytical and diagnostic aspects. *Journal of Forensic Sciences* 40(5); 811-815

²⁰⁸ RCEM, FFLM, RCR, NPCC (2020) Management of Suspected Internal Drug Trafficker (SIDT) https://rcem.ac.uk/wp-content/uploads/2021/10/Management_of_Suspected_Internal_Drug_Trafficker_December_2020.pdf Accessed 12/07/2026

²⁰⁹ Home Offic. (2023) Police and Criminal Evidence Act 1984 (PACE) – Code C Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers. Annex K X-rays and ultrasound scans. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 12/07/2026

If an HCP is contacted in this scenario, they should undertake a risk assessment and the custody officer should be advised accordingly. If the detainee is symptomatic, immediate transfer to hospital should be made. The HCP should be aware of, and have access to, the National Poisons Information Service guidance (NPIS)/TOXBASE® (www.TOXBASE.org) for the most up to date guidance and advice on the immediate management of specific drug toxicity and advice re ongoing clinical management

In cases of doubt, early and repeated examinations must be undertaken documenting changes to the detainee's symptoms and clinical signs. Basic physical observations should include temperature, heart rate, respiratory rate, blood pressure, pupil size and Glasgow Coma Score. For healthcare staff NEWS2 could be used to monitor the detainee. For non-clinical staff the 4Rs observations model can be used (see Appendix B).

The CMO report²¹⁰ recommended the development of a custodial early warning system (CEWS). However, the results of a three-month trial based in a police custody suite concluded that the scoring systems assessed were not sensitive enough to identify health needs in the detainee population, due to frequent, altered physiological parameters²¹¹ and so this is no longer recommended.

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

Detainees who swallow or conceal drugs in their body cavities have various motives. Some are simply seeking to dispose of evidence of the offence (possession of drugs); others may have an explicit intention of self-harm of varying degree of intensity. Suicides by re-ingesting cocaine from excreted packages are reported in the literature,²¹² highlighting the need to implement steps to prevent re-ingestion.

Sometimes this arises from the belief that the claimed suicidal behaviour will lead to transfer to a psychiatric service and an avoidance of criminal charges. If there is evidence that suicidal or other self-harming intent lies behind the disposal of drugs in this way, the HCP should liaise as appropriate with the responsible psychiatric service provider for the custody suite.

²¹⁰ Department of Health & Social Care. The Medical Care of Suspected Internal Drug Traffickers – Independent Report of the Chief Medical Officer's Expert Group. January 2013
<https://www.gov.uk/government/publications/report-on-the-care-of-suspected-internal-drug-traffickers-published> Accessed 12/07/2026

²¹¹ Miles T, Webb V, Kevern P, Shibchurn R, Bird T, Finch G (2020) Custody early warning scores; Do they predict patient deterioration in police custody? Journal of Forensic & Legal Medicine 76; 102069 <https://doi.org/10.1016/j.jflm.2020.102069> Accessed 12/07/2026

²¹² Stichenwirth M, Stelwag-Carion C, Klupp N, et al. (2000) Suicide of a body packer. Forensic Science International 108(1);61-66

If deliberate smuggling is suspected, an initial assessment by a suitably trained HCP is recommended. This should include a full A-E examination including abdominal assessment as tenderness or signs consistent with obstruction will require expedited transfer to hospital. Further detention should occur only under suitable conditions, which include enhanced training of all custody staff, the ready availability of suitable resuscitation equipment, and rapid and easy access to a hospital emergency department with 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.²¹³ Most body packers can be managed conservatively; however, should a package rupture or cause obstruction prompt and often complicated medical treatment will be required, for instance IV administration of naloxone to reverse respiratory depression following an opioid overdose caused by leaks from packages in the stomach, or surgical intervention in the case of stasis of the packages inside the body. Indications for surgical removal include intestinal obstruction, suspected rupture, and drug overdose.

The RCEM guidance states that:

- Body stuffers and pushers should be observed for 8 hours post ingestion if asymptomatic or longer if symptomatic
- Asymptomatic body packers can be safely discharged to the police/Border Force (BF)
- All patients transferred to police custody should receive a letter of discharge, including Suspected Internal Drug Traffickers.
- Medical information should be provided to the police in a sealed envelope for attention of the custody healthcare professional in line with Good Medical Practice and Caldicott Principles.

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

²¹³ RCEM, FFLM, RCR, NPCC (2020) Management of Suspected Internal Drug Trafficker (SIDT) https://rcem.ac.uk/wp-content/uploads/2021/10/Management_of_Suspected_Internal_Drug_Trafficker_December_2020.pdf Accessed 12/07/2026

4.4 Forensic samples

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

The Police and Criminal Evidence Act 1984 (PACE), as amended by the Criminal Justice and Public Order Act 1994, together with the Police and Criminal Evidence (Northern Ireland) Order 1989, imposes statutory constraints on the police regarding the taking of forensic samples from detained persons.

In England and Wales, and under the corresponding PACE (NI) framework in Northern Ireland, intimate samples may only be taken where the procedure is authorised by a police officer of at least the rank of Inspector and the detained person provides written consent. For detainees held under the Terrorism Act 2000 (TACT), authorisation for intimate samples must be given by a Superintendent, and the sample must be taken by a Registered Medical Practitioner.²¹⁴

The rules for taking forensic samples from detainees are set out in the Criminal Procedure (Scotland) Act 1995 (CPSA), as amended, and associated Codes of Practice.

In deciding the appropriateness of the sampling, the police and the HCP need to be aware of the latest FFLM recommendations²¹⁵ and the evidence²¹⁶ for the taking of the forensic samples, in particular for toxicology (blood, urine and hair). These are updated every six months.

²¹⁴ Gorton A (2023) Medical Care of Persons Detained Under the Terrorism Act 2000. FFLM. <https://fflm.ac.uk/resources/publications/recommendations-medical-care-of-persons-detained-under-the-terrorism-act-2000/> Accessed 12/07/2026

²¹⁵ FFLM. Recommendations for the Collection of Forensic Specimens from Complainants and Suspects <https://fflm.ac.uk/resources/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects/> Accessed 12/07/2026

²¹⁶ FFLM. Recommendations for the Collection of Forensic Specimens from Complainants and Suspects – the evidence <https://fflm.ac.uk/resources/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-the-evidence/> Accessed 12/07/2026

4.5 Examination and samples under the Road Traffic Act

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

- assessing whether there is a medical reason for failing to provide a breath, blood or urine sample
- taking blood samples for alcohol or drug analysis
- performing a comprehensive examination under section 4 of the RTA.²¹⁷

It is essential the HCPs have the knowledge and skills for this role²¹⁸ and have received initial training along with continuing professional development training,²¹⁹ including awareness of the need to have an appropriate adult where required (see Section 2.2.1).²²⁰

HCPs should advise the detainee on the impact of their medical condition on safe driving ability, and on the legal requirement that the detainee notify the DVLA of any relevant condition.²²¹ The GMC's guidance states that a doctor should explain to a patient that a condition may affect their ability to drive and that they have a legal duty to inform the DVLA or DVA about the condition.²²²

²¹⁷ Stark MM, Wall I (2023) Proforma - Assessments (alcohol & drugs) under the RTA. FFLM. <https://fflm.ac.uk/resources/publications/assessments-alcohol-drugs-under-the-rta/> Accessed 12/07/2026

²¹⁸ Gorton A, Stark MM (2024) Drug-driving competencies. FFLM. <https://fflm.ac.uk/resources/publications/fflm-drug-driving-competencies/> Accessed 12/07/2026

²¹⁹ Stark MM (2016) Driving Impairment – the main risk factors. In Current Practice in Forensic Medicine, Eds Gall J. & Payne-James JJ. Volume 2, John Wiley & Sons Ltd, West Sussex.

²²⁰ *Miller v Director of Public Prosecutions* [2018] EWHC 262 (Admin) (15 February 2018) <https://www.bailii.org/ew/cases/EWHC/Admin/2018/262.html> Accessed 12/07/2026

²²¹ DVLA (2025) Assessing fitness to drive – a guide for medical professionals. www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals Accessed 12/07/2026

²²² Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA (2025) <https://www.gmc-uk.org/professional-standards/the-professional-standards/confidentiality---patients-fitness-to-drive-and-reporting-concerns-to-the-dvla-or-dva> Accessed 12/07/2026

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

As has been discussed earlier in this guidance, individuals in police custody have specific needs and vulnerabilities in addition to those encountered when managing substance use disorder in other settings. It is therefore vital that clinicians managing this patient group have specific training, competencies, and support. Concerns have been raised about the quality of training following a survey of clinicians²²³ and in recent coronial prevention of future deaths reports.^{224,225,226}

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

Nurses and paramedics working within custody must have a minimum of three years' post registration experience in a patient-facing role within a relevant field (General Practice, Emergency Medicine, Walk in Centres, Community Substance use Services, Prison Healthcare, Mental Health, or Ambulance Service).²²⁷

Doctors working within the custody setting must have a minimum of three years' experience (post satisfactory completion of FY2) in a relevant field. For general forensic medicine relevant fields would include Emergency Medicine, General Practice, Community Substance Use Services, or Psychiatry.²²⁸

All clinicians practicing clinical forensic medicine must.^{227,228}

- attend an FFLM accredited Introductory Training Course in General Forensic Medicine²²⁹ prior to starting work unsupervised
- have training in at least Immediate Life Support via a Resuscitation Council UK approved course

²²³ Gorton AJ, Stark MM (2022) Quality standards in forensic medicine. *Journal of Forensic and Legal Medicine* 92; 102436 <https://doi.org/10.1016/j.jflm.2022.102436> Accessed 12/07/2026

²²⁴ Courts and Tribunals Judiciary (2023) Jack Zarrop: Prevention of future deaths report <https://www.judiciary.uk/prevention-of-future-death-reports/jack-zarrop-prevention-of-future-deaths-report/> Accessed 12/07/2026

²²⁵ Courts and Tribunals Judiciary (2024) Mark Pryor: Prevention of future deaths report <https://www.judiciary.uk/prevention-of-future-death-reports/mark-pryor-prevention-of-future-deaths-report/> Accessed 12/07/2026

²²⁶ Courts and Tribunals Judiciary (2026) Josh Tarrant: Prevention of future deaths report <https://www.judiciary.uk/prevention-of-future-death-reports/josh-tarrant-3-prevention-of-future-deaths-report/> Accessed 12/07/2026

²²⁷ Smith J, Stark MM, Wall I (2024) Quality Standards for Nurses and Paramedics General Forensic Medicine (GFM). FFLM. <https://fflm.ac.uk/resources/publications/fflm-quality-standards-for-nurses-and-paramedics-general-forensic-medicine-gfm/> Accessed 12/07/2026

²²⁸ Wall I., Stark MM. (2025) Quality Standards in Forensic Medicine General Forensic Medicine (GFM) and Sexual Offence Medicine (SOM). FFLM. <https://fflm.ac.uk/resources/publications/fflm-quality-standards-in-forensic-medicine/> Accessed 12/07/2026

²²⁹ Recommendations – Introductory Training Courses in General Forensic Medicine (GFM) <https://fflm.ac.uk/resources/publications/recommendations-introductory-training-courses-in-general-forensic-medicine-gfm/> Accessed 12/07/2026

- complete training in Safeguarding of Children and Young People to at least Level 3
- complete training in Safeguarding of Vulnerable Adults to at least Level 3
- have training in Equality, Diversity and Inclusion (EDI)
- have shadowed and been supervised by an experienced forensic clinician prior to sign-off to work unsupervised

Competency Framework

All clinicians working with detainees with substance use disorders must have the following competencies:

Consent and Confidentiality

- be able to explain consent, capacity, confidentiality, and safeguarding duties in custody
- understand information sharing rules within healthcare and criminal justice settings

Clinical Assessment Skills

- be competent to take a comprehensive and complete medical history, which must include past medical, surgical, psychiatric, and substance use history
- be skilled in eliciting information on patterns of use, dependence, tolerance, withdrawal, and risk behaviours
- be able to gather collateral information when appropriate (e.g., from custody staff, ambulance crews, family, friends)
- be competent to undertake a full clinical examination of the detainee as and when required relevant to acute and chronic substance related presentations and exclude other co-morbid medical conditions, including sepsis and trauma
- recognise and manage physical health issues common in substance-using populations (e.g., liver disease, respiratory illness, wounds, infections)
- be competent to assess the detainee's mental state and identify co-occurring substance use and mental health disorders (CoSUM) including acute behavioural disturbance, suicidality, neurodiversity, and cognitive impairment
- be competent to identify and manage the symptoms and signs of illicit drug use, intoxication and withdrawal across major substance groups (opioids, stimulants, depressants, NPS, alcohol)
- be competent in the management of a detainee following a suspected overdose; including familiarity with emergency interventions (e.g., airway management, naloxone administration protocols (ILS certification))
- recognise when urgent medical transfer is required

Pregnancy Related Substance Use

- be aware of the special precautions to be taken managing detainees who are pregnant with drug and/or alcohol dependence
- understand the risks of withdrawal, intoxication, and medication use in pregnancy
- be aware of safeguarding, obstetric referral pathways, and required precautions for pregnant detainees

Harm Reduction

- be able to deliver harm reduction interventions, on overdose prevention, safer use, infection prevention, and continuity of care
- be able to deliver brief interventions: motivational, non-judgmental advice tailored to detainees

Risk Assessment and Risk Management

- be competent in risk assessment including identifying acute risks: self-harm, suicide, violence, clinical deterioration, toxicity and withdrawal complications.
- be competent in the assessment of safeguarding concerns, exploitation, and vulnerability
- be aware of the observation levels, monitoring plans, and escalation procedures
- be aware of, and have access to, relevant information resources such as the National Poison Information Service (NPIS) TOXBASE, Summary Care Records or equivalent, and NSPIS or equivalent

Medicines Management

- demonstrate safe and effective medicines management including the administration of medication in police custody²³⁰ and prescribing (where appropriate)²³¹
- knowledge of medications used in withdrawal management, symptom control, and emergency care
- application of safe prescribing principles in a custodial environment (e.g., diversion risk, observation requirements)
- understand contraindications, interactions, and monitoring requirements

²³⁰ Cooke C, Payne-James J (2023) Safe and Secure Administration of Medication in Police Custody. FFLM <https://fflm.ac.uk/resources/publications/recommendations-safe-and-secure-administration-of-medication-in-police-custody/> Accessed 11/07/2026

²³¹ Royal College of Pharmacy (2022) A Competency Framework for all Prescribers <https://www.rcpharm.org/professional-standards/a-competency-framework-for-all-prescribers/> Accessed 12/07/2026

Criminal Justice and Referral Pathways

- recognise the interplay between substance use and the criminal justice system and how substance use intersects with offending, vulnerability, and custody processes
- understand the roles of custody officers, Liaison & Diversion teams, and criminal justice drug workers
- knowledge of local referral pathways for support of detainees with substance use disorders in the community including community drug and alcohol services, crisis mental health pathways, safeguarding routes, and social support agencies.
- Be able to facilitate continuity of care on release or transfer

Forensic Aspects

- be competent to deliver forensic aspects of management including the assessment of fitness to be interviewed by the police, the management of detainees who may have concealed drugs, requests for intimate searches, and the taking of forensic samples including those under the Road Traffic Act
- in relation to forensic samples understand the chain of evidence principles and medico-legal responsibilities.
- be able to provide clear, objective, contemporaneous detailed clinical records suitable for legal scrutiny

Communication and Cultural competence

- be able to communicate clearly both verbally and in writing with custody staff and other clinicians
- use trauma informed, non-judgmental, and culturally competent approaches
- staff should be trained in cultural competence and data on ethnicity should be collected²³²
- complete appropriate handover documentation when transferring between services

²³² ACMD (2026) Drug use in ethnic minority groups: a review and recommendations.
<https://www.gov.uk/government/publications/drug-use-in-ethnic-minority-groups-a-review-and-recommendations> Accessed 12/07/2026

Appendix B

PACE Code C Annex H²³³ – Detained Person: Observation List

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

When assessing the level of rousability, consider:

Rousability – can they be woken?

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

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

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

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

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

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

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

²³³ Home Office (2023) Police and Criminal Evidence Act 1984 (PACE) – Code C Revised Code of Practice for the detention, treatment and questioning of persons by Police Officers
<https://www.gov.uk/government/publications/pace-code-c-2023>
Accessed 11/07/2026

Appendix C: Levels of observation²³⁴

Level 1 – General observation

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

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

Level 2 – Intermittent observation

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

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

Level 3 – Constant observation

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

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

²³⁴ College of Policing. Authorised Professional Practice. Detainee Care. Levels of Observation <https://www.college.police.uk/app/detention-and-custody/detainee-care/detainee-care#levels-of-observed> Accessed 12/07/2026

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

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

Level 4 – Close proximity

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

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

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

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

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



**METROPOLITAN
POLICE**

Working together for a safer London

To the duty Pharmacist,

at

.....

Chemists

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

Age:

DOB:

Custody number:

C/O [address of police station]

Duty Pharmacist,

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

[Insert exact requirements]

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

Signed:

Dated:

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

Name:.....

Signed:.....

Dated:.....

At... ..Police station (insert as applicable)

Contact telephone number(s) of police station:

Contact number for FME/CNP:

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

	METROPOLITAN POLICE	Working together for a safer London
Name of Forensic Medical Examiner (Doctor):		
GMC Number:		
Contact number for FME:		
Address of police station:		
Date:		
Re: [Title, Forename, Surname, & Address of detainee]		
Age		
DOB		
Custody number:		
C/O [address of police station]		
		
Number of day's treatment		
Signature of Prescriber		
Date		
N.B. This form is not suitable for prescribing Schedule 1, 2 or 3 Controlled Drugs		

Appendix F: Letter to hospital



Hospital

Custody to Emergency Department Transfer

Demographics													
Name						DOB							
Custody Ref						Date/Time of Arrest							
Issues Necessitating Transfer to ED													
Past Medical History and medications prescribed (if known)													
Diabetes	Epilepsy	Asthma	IHD	BBV	Pregnancy	Allergies:							
Relevant Examination Findings (include date and time of observations)													
Pulse		BP	/	Temp	°C	SpO ₂	%	BM		Ketones if ↑BM		Alertness	ACVPU
Treatment Given in Custody (including doses, dates and times of any medications given)													
Any additional specific issues to be addressed prior to returning to custody?													
Referrer Details													
Name					Signature					Professional Reg #			
Role					Contact Telephone					Custody			
Date & time form completed													

Hospital



Emergency Department to Custody Discharge Summary

Affix addressograph here		Date & Time Seen																		
		Date & Time Discharged																		
Summary of management in ED			Or Capacity to Refuse Treatment																	
Medications Administered in ED <table border="1"> <thead> <tr> <th>Medications Administered in ED</th> <th>Dose</th> <th>Time</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> Results of Relevant Investigations and/or Imaging			Medications Administered in ED	Dose	Time													They have refused treatment & I confirm I have assessed that they can do all of the following: 1. Understand the information we have given them about our proposed treatment 2. Retain the information sufficiently to allow them to make a decision 3. Demonstrate ability to use or weigh up the information about medical treatment/lack of medical treatment risks and benefits 4. Communicate their decision to me They therefore have mental capacity to make this decision & have refused treatment I have completed the following (limited) assessment & or treatment despite this:		
			Medications Administered in ED	Dose	Time															
Follow up arranged/advised for patient to organise post release from custody																				
NB If patient requires crisis team or liaison psychiatry this should usually be arranged in department prior to discharge as with other patients					Additional paperwork attached?															
					Yes / No															
Discharging Clinician		(Please note, patients should not be discharged to custody unless you would be happy to discharge them into the care of a non-medically trained relative)																		
Name		Signature		Hospital																
Role		Contact Telephone																		

Appendix G: Glossary

AA	Appropriate Adult
ABD	Acute Behavioural Disturbance
ACMD	Advisory Council for the Misuse of Drugs
AMHP	Approved Mental Health Professional
APP	Authorised Professional Practice
AUD	Alcohol Use Disorder
AUDIT	Alcohol Use Disorders Identification Test
BAME	Black, Asian and Minority Ethnic
CIWA	Clinical Institute Withdrawal Assessment
CJLDS	Criminal Justice Liaison and Diversion Services
CJIT	Criminal Justice Integrated Team
CJS	Criminal Justice System
CNP	Custody Nurse Practitioner
CoSUM	Co-occurring substance use and mental health disorders
COWS	Clinical Opiate Withdrawal Scale
CRHT	Crisis resolution and home-based treatment service
CSEW	Crime Survey for England and Wales
DOB	Date of Birth
DHSC	Department of Health and Social Care
DIP	Drug Intervention Programme
DVA	Driver & Vehicle Agency Northern Ireland
DVLA	Driver and Vehicle Licensing Agency
ED	Emergency department
FP	Forensic physician (forensic medical examiner, forensic medical officer)
FFLM	Faculty of Forensic and Legal Medicine
GFM	General Forensic Medicine
GMC	General Medical Council
HCP	Healthcare professional
HCPC	Health and Care Professions Council
HIV	Human Immunodeficiency Virus
HMICFRS	His Majesty's Inspectorate of Constabulary Fire & Rescue Services
IOPC	Independent Office for Police Conduct previously the Independent Police Complaints Commission (IPCC)
IPCC	Independent Police Complaints Commission, now superseded by IOPC
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MHA	Mental Health Act 1983
MSE	Mental State Examination
OAT	Opiate Agonist Therapy
OHID	Office for Health improvement and Disparities
OST	Opiate Substitution Therapy
OTC	Over-the-counter
PR	Parental Responsibility
NPCC	The National Police Chiefs Council
NICE	National Institute for Health and Care Excellence
NDTMS	National Drug Treatment Monitoring System
NPS	Novel Psychoactive Substances

NMC	Nursing and Midwifery Council
NPCC	National Police Chiefs' Council
NSPIS	National Strategy for Police Information Systems
PACE	Police and Criminal Evidence Act 1984
PAF	Police effectiveness, efficiency and legitimacy (PEEL) Assessment Framework (PAF)
PGD	Patient Group Direction
POS	Place of safety
PRRA	Pre-Release Risk Assessment
SADQ	Severity of Alcohol Dependence Questionnaire
SUD	Substance Use Disorder
UKAFNP	UK Association of Forensic Nurses and Paramedics

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Appendix H: Useful Websites/Resources

Addiction to Medication: Improving Care (ATOMIC)	https://addiction-to-medication.org/atomic/ Free, evidence-based, mobile-learning application aimed at clinicians and other practitioners who want to improve their knowledge of the acute and chronic clinical harms of non-medical prescription drug use
Addiction Professionals	https://addictionprofessionals.org.uk/ Previously Substance Misuse Management in General Practice (SMMGP) and the Federation of Drug and Alcohol Practitioners (FDAP)
The Advisory Council on the Misuse of Drugs (ACMD)	https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs
Driver and Vehicle Licensing Agency (DVLA)	https://www.gov.uk/government/organisations/driver-and-vehicle-licensing-agency
European Union Drugs Agency	https://www.euda.europa.eu/index_en
Faculty of Forensic & Legal Medicine	https://fflm.ac.uk/about/
Frank	talktofrank.com
General Medical Council	gmc-uk.org
Health and Care Professions Council (HCPC)	hcpc-uk.co.uk
National Institute for Health and Care Excellence (NICE)	nice.org.uk
Nursing & Midwifery Council (NMC)	nmc.org.uk
Royal College of Pharmacy	https://www.rcpharm.org/
National Drug Treatment Monitoring System (NDTMS)	ndtms.net
National Poisons Information Service	npis.org
NEPTUNE	https://www.cnwl.nhs.uk/neptune Training eLearning modules to improve clinical practice in the management of harms resulting from the use of club drugs and novel psychoactive substances are available open access (free of charge). https://elearninghub.rcpsych.ac.uk/catalog?pagename=neptune

The Royal College of Psychiatrists	rcpsych.ac.uk
The Royal College of Emergency Medicine	rcem.ac.uk
Royal College of General Practitioners	rcgp.org.uk
United Nations Office on Drugs and Crime (UNODC)	https://www.unodc.org/

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APPENDIX I - Feedback from volunteers with Lived Experience

1. Access to healthcare staff can be limited. Police and police staff have basic first aid knowledge only. There is a need for experienced and knowledgeable healthcare professionals (HCP) *on site* in the custody centre to assess and manage those detained. Often there are delays before treatment is provided because there is no HCP on site in the police station.
2. Concerns re confidentiality – never sure what information is confidential and what information would be provided to the police. This may limit the discussion between HCP and the detainee.
3. Cells and custody centres are not the most comfortable of places. Often there is a lack of facilities and access to reading materials, for example, to help pass the time. Time in custody is increasingly prolonged for a variety of reasons.
4. HCPs caring for detainees with issues with drugs and alcohol should be more empathic. Understanding the effects that intoxication and withdrawal have on an individual and therefore their behaviour.
5. Many police officers were found to be kind and custody officers well trained but improved training for police and police staff would be good to ensure they understand the types of drugs used and the complications that may occur if the detainee is not managed appropriately and provided with treatment.
6. Cell checks could be improved, more frequent, with those checking showing concern for the detainee and speaking to them (being more interactive).
7. Appropriate administration of medication does not always occur – whether that be continuation of prescribed medicines, e.g. methadone and buprenorphine (Subutex), or providing medicines for the treatment of withdrawal from drugs and/or alcohol.
8. All staff should be aware of referral pathways. Whilst there maybe arrest referral workers on site this is not universal. There is poor communication from one agency to another which doesn't help with a long-term management plan for a detainee.
9. Detainees should be asked specifically – do you need help? (short and long term)
10. Urine testing should be available to check what has been taken by the detainees.

APPENDIX J - Initiation of buprenorphine in police custody²³⁵

As mentioned above (Section 3.2) it may be possible for the police and forensic healthcare provider to work in partnership with the local community drug and alcohol teams to initiate treatment and follow-up from within police custody.

As an example, a pilot has been run using this model where the drug & alcohol teams attended the custody centre and assessed eligible detainees and initiated community OAT while in custody. This included either buprenorphine (which was given on site by the drug & alcohol teams) or a prescription for methadone which could be filled by the detainee on release. In this instance, the drug & alcohol team were responsible for the initial assessment of the detainee prior to the initiation of OAT as well as the purchase, safe storage and prescription of any medication and then the ongoing care post release.

Buprenorphine is a high affinity partial opioid agonist, with transmucosal formulations commonly used first line treatment option in the management of opioid use disorder.²³⁵ When used in this context, buprenorphine has been shown to have a favourable safety profile when compared to full opioid agonists (e.g., methadone).²³⁶ Newer long-acting injectable depot formulations of buprenorphine are becoming increasingly available.

Individuals in police custody at risk of opioid withdrawal should be monitored with an appropriate structured withdrawal assessment scale (e.g., the Combined Opiate Withdrawal Scale (COWS)). Administration of buprenorphine in the presence of a full opioid agonist can potentially lead to the development of buprenorphine precipitated opioid withdrawal (BPOW). This is operationally defined as a substantial increase in opioid withdrawal symptoms (typically an increase in COWS score of ≥ 6) within one to two hours of buprenorphine administration. The overall incidence of BPOW is low and should not be a barrier to prescribe buprenorphine.²³⁷

To minimise the risk of precipitated withdrawal, buprenorphine should be given following the emergence of opioid withdrawal symptoms, with a recommended COWS score of ≥ 8 prior to initiation.

UK guidance currently recommends doses of up to 8 milligrams of buprenorphine in the first 24 hours in most cases. Table 3.3 suggests a typical induction schedule.

²³⁵ Clinical Guidelines on Drug Misuse and Dependence Update. Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management> Accessed 12/03/2026

²³⁶ Department of Health and Social Care (2024) Guidance: Oral methadone and buprenorphine: recommendations <https://www.gov.uk/government/publications/medicine-choices-in-opioid-substitution-treatment/oral-methadone-and-buprenorphine-recommendations> Accessed 12/03/2026

²³⁷ Gregory C, Yadav K, Linders J, Sikora L, Eagles D (2025) Incidence of buprenorphine-precipitated opioid withdrawal in adults with opioid use disorder: A systematic review. *Addiction* 120(1):7-20

Table J.1 Induction schedule for buprenorphine

Dose	Route	Frequency	Additional information
2-4mg	Sublingual	STAT	COWS ≥ 8 give 2- 4mg stat then PRN 2-4mg up to a max of 8mg total in 24 hours
Then: 2-4mg	Sublingual	PRN 6-8 hours	

In the event of the development of precipitated withdrawal the most appropriate management strategy is to provide additional doses of transmucosal buprenorphine (up to a recommended maximum of 16mg within 24 hours) with consideration given to the need for transfer to an acute care setting.

APPENDIX K - Capacity Assessments Examples in Police Custody

1. A 16-year-old boy has been arrested on suspicion of murder. The police believe that drugs are involved and the Inspector has given authority for an intimate sample of blood to be taken. The HCP on site is asked to assess the detainee to see if he is fit to be detained, fit to be interviewed, and to take the sample of blood.

Table K.1

Question	Example
1. Can the individual understand the information?	The HCP would need to explain what the blood test is for (toxicological analysis for drugs and alcohol) and that the police have the authority to request this sample. The HCP needs to explain that the sample will only be taken with the detainee's consent. Possible outcomes from the procedure include minor, short-lived effects at the sampling site - most commonly a small bruise, mild tenderness, or slight bleeding. Consideration should also be given to the potential results of the blood test. The HCP could ask: <i>'Can you just explain to me why I need to take this blood sample?'</i>
2. Can the individual retain the information?	This needs to be only for as long as the capacity assessment takes.
3. Can they weigh up the information?	Can they tell you the benefits and risks of having the blood test, including the consequences of not having it. A question like, <i>'Can you tell me what might happen if you have this blood test and what might happen if you decline the blood test?'</i>
4. Are they able to communicate the answers back?	This can be spoken or written.

In this case consent should be sought from the person with parental responsibility even though the MCA 2005 comes into force at 16 years of age.²³⁸

The detainee advised that his mother would be at home and contactable by phone. The HCP telephoned the mother, explaining the situation and request for the assessment and sample of blood and obtained consent to proceed.

2. A 79-year-old man was arrested for shoplifting. The custody sergeant asked the HCP on site to assess the detainee to see if he was fit to be detained and interviewed.

It was clear to the HCP that the detainee was cognitively impaired. The HCP considered the four questions outlined in Table K-1 and the detainee was not able to respond appropriately to any of them.

Information was obtained from the Care Home that the detainee suffered with a form of dementia and had wandered from the Care Home without supervision.

Whilst there were no other health issues, the detainee was not fit to be interviewed. The HCP advised the custody officer that there was a definite risk of unreliability and that the person's condition was not likely to improve or be amenable to treatment.²³⁹ The detainee lacked the capacity to understand that he has committed an offence – the need to pay for the goods he had taken.

The police liaised with the Care Home and social services to ensure that the man was returned home and supervised more closely.

3. A 26-year-old male Adult A has been arrested on suspicion of rape and on arrival in custody he appeared to be under the influence of alcohol. The HCP on site was asked to assess the detainee to see if he was fit to be detained and interviewed and to have the appropriate forensic samples taken. The HCP performed an assessment (see Table K-1) and recorded in the clinical notes:

'I assessed Adult A's capacity at 18.45 hours, and he was intoxicated with alcohol and unable to communicate with me regarding the reason for his arrest, and the request for forensic samples, due to the level of intoxication.'

²³⁸ Green P, Paul S, Teebay L, Stark MM, Butler B, Gifford J, Gorton A (2023) Consent from Children and Young People in Police Custody in England and Wales for Medical Examinations. FFLM & RCPCH <https://fflm.ac.uk/resources/publications/recommendations-consent-from-children-and-young-people-in-police-custody-in-england-and-wales/> Accessed 12/07/2026

²³⁹ Home Office. PACE Code C (2023) Annex G Fitness to be Interviewed. <https://www.gov.uk/government/publications/pace-code-c-2023> Accessed 12/07/2026

He did not have the capacity to make the decision regarding the forensic samples.'

After a rest period at 22:45 hours the HCP reassessed the detainee and recorded:

'I reassessed Adult A's capacity to make the decision about the forensic samples. I gave him the following information, (enter the information in the record you gave Adult A). He was able to tell me in his own words what the samples were being taken for and how the results would be used, demonstrating that he had retained the information and was able to weigh up the consequences of having the samples taken.'

It is important to remember that capacity is time and decision specific.

4. A 32-year-old woman is arrested for assault of a stranger at a bus stop. The HCP has been asked to assess the detainee to see if she is fit to be detained and interviewed as well as to take a blood sample for toxicology. The detainee has a diagnosis of bipolar affective disorder with previous episodes of detention in hospital.

The HCP performs a mental state examination and a capacity assessment. The HCP finds that the detainee appears mildly elated, engages in conversation and appears distracted. When asked the detainee denies this and has some grandiose interpretation around the assault.

At the conclusion of the assessment the HCP is not sure if the detainee has capacity to consent to the provision of forensic samples and thinks that a formal Mental Health Act (MHA) assessment should be requested.

The HCP would need to contact a senior HCP for advice as whilst a MHA assessment might be required, it does not prevent, and should not prevent, a capacity assessment being undertaken. The detainee may not need to be detained under the MHA and detention does not mean a capacity assessment is not required.