Healthcare in Police Custody- Substance Misuse

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1. Introduction

The health of detainees in police custody is generally poorer than that of the general population. Custody sergeants have a legal duty to ensure the welfare of the detainee, including referring to healthcare staff where required, and detainees should receive the same standard of medical care as any other member of the public.\(^1,2\)

In addition to having a high prevalence of health need detainees in police custody represent a typically ‘hard to reach’ group. Detainees are less likely to have visited their GP in the previous 12 months compared to members of the general population.\(^3\) A considerable proportion of individuals detained in police custody are in need of medical assessment but have not sought health care previously because of their disorganised or chaotic lifestyle.\(^4\)

Substance misuse specifically is associated with chronic ill health.\(^5\) Substance misuse is also associated with crime and particularly for alcohol, violent crime.\(^6,7\) Furthermore, in police custody, substance misuse is known to be a contributory factor in a substantial proportion of detainee deaths.\(^8,9\) A significant proportion of detainees are known, through clinical experience, to misuse substances be it illicit drugs, alcohol or other legal substances such as tobacco.

In the prisoner population the prevalence of substance abuse and dependence is much greater than in the general population.\(^10\) However, comparatively much less is known about the general health and substance misuse of detainees in police custody.\(^11\) This review seeks to summarise the literature published to date with regards to substance misuse in police custody.

2. Methods

The literature review comprises published journal articles and grey literature.

Journal article searches were conducted using Ovid MEDLINE® and EMBASE databases. The following keywords were searched for: police, police custody, detainee, offender, substance misuse, drugs and alcohol. These key words were combined using a mix of search operators (‘AND’ and ‘OR’ as appropriate), resulting in several different search strategies being employed. The results of the search strategies were further augmented by combing the reference lists of the selected citations.

Grey literature was found by: looking at the reference lists of included papers; searching the internet for relevant guidelines, policy and strategy documents; and using the co-authors own knowledge of key documents.

‘Substance misuse’ was considered to the misuse of drugs and/or alcohol. However, where data were published about tobacco use also these were included in the results.
3. Epidemiology

Few published research studies report on the prevalence of substance misuse in police custody (table 1). From the limited data available, the estimated prevalence of any substance misuse in detainees is approximately 50% (of detainees in general police custody) rising to 70% in those seen by a Forensic Physician (FP)/Forensic Medical Examiner (FME). In detainees seen by FP/FME nicotine dependence is most prevalent (range 27% to 63%). Hazardous alcohol intake or alcohol dependency is present in 18% to 34% detainees seen by the medical services and reported cannabis consumption by detainees varies from 21% to 35%. The prevalence of heroin and cocaine use/dependency was greatest in detainees in police custody in London where estimates ranged from 11% to 34% of detainees.

Table 1. Prevalence of substance misuse in detainees in police custody and those seen by an Forensic Physician/FME*

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Location</th>
<th>Nicotine</th>
<th>Alcohol</th>
<th>Heroin/ opioids</th>
<th>Cocaine</th>
<th>Cannabis</th>
<th>Any substance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buster M 2014</td>
<td>264</td>
<td>Netherlands</td>
<td>21%</td>
<td>9%</td>
<td>17%</td>
<td>24%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>*Vincent R 2015</td>
<td>600</td>
<td>France</td>
<td>27%</td>
<td>18%</td>
<td>1%</td>
<td>2%</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>*Chariot P 2014</td>
<td>1000</td>
<td>France</td>
<td>62%</td>
<td>32%</td>
<td>5%</td>
<td>4%</td>
<td>35%</td>
<td>71%</td>
</tr>
<tr>
<td>*Mckinnon I 2013</td>
<td>230</td>
<td>UK (London)</td>
<td>18%</td>
<td>11%</td>
<td>22%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Gahide S 2012</td>
<td>2694</td>
<td>France</td>
<td>49%</td>
<td>34%</td>
<td>1%</td>
<td>3%</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>*Payne-james JJ 2010</td>
<td>201</td>
<td>UK (London)</td>
<td>63%</td>
<td>25%</td>
<td>34%</td>
<td>34%</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

It should be noted, however, that various factors impact on these prevalence estimates. One factor, as alluded to in the paragraph above, is the origin of detainee recruitment. Some studies comprised only detainees seen by the FP/FME as opposed to all detainees presenting to police custody. Although it is likely that the majority of detainees with substance misuse concerns will be referred to healthcare professionals, not all may be picked up by the screening process at the charge

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1 Definitions:
- Hazardous drinking is synonymous with “at-risk” drinking and concerns drinking which is generally above the recommended guidelines but has not yet caused harm.
- Harmful drinking describes drinking that has caused harm to the physical or mental health of the individual concerned.
- Alcohol dependence is characterised by cravings, tolerance, and/or a preoccupation with alcohol and continued drinking in spite of harmful consequences.
bar, thus potentially underestimating the overall prevalence of detainees with substance misuse. The study by Buster M et al. is the only one to give an indication of overall substance misuse.  

Furthermore, when reviewing the literature, it became apparent that some published studies use denominators other than detainees in police custody or those seen by a healthcare professional. For example one study recruited and used self-reporting drug users as the denominator, others included detainees “who admitted to having taken an intoxicant/s (tobacco, alcohol, drugs or illegal substances)” or detainees seen by arrest referral workers. Given the differences in denominators used these studies have not been included in table 1. Although they can provide robust indications as to which type of substances are most frequently taken by the study population they cannot provide indications of prevalence. In the study by Clement R et al. the most common substances reported were alcohol dependency (47.2%), tobacco dependency (37.7%) and cannabis dependency (24.7%).

A further caveat with the published epidemiological data is the variation in reporting pattern of alcohol and tobacco use in particular. Some articles refer to dependency, with or without an accompanying definition. Others refer to a history of consumption, or hazardous consumption/abuse in relation to alcohol. Similarly there may be variations in the reporting of prevalence (e.g. point prevalence compared to period prevalence (use in last year/lifetime use)). The studies included in table 1 all appeared to report current use prevalence. However, Denis et al. highlighted another study that likely reported lifetime use prevalence of substance misuse in police custody not current use prevalence.

The other significant consideration to take into account is the requirement for detainees to consent to participate in the studies. Inevitably, some individuals will choose not to participate in research and often some individuals are unable to give consent due to intoxication through drugs and or alcohol. The required exclusion of these individuals will likely introduce bias into the results and, particularly where individuals are too intoxicated to consent to the study, this may result in an underestimate of the true prevalence of substance misuse in those in police custody.

Multiple substance misuse is common in detainees in police custody. Combinations of substance misuse are not specifically reported by the majority of studies in table 1. A study by Ogloff et al. found that over half (51%) of detainees in police custody reported abusing multiple substances. Payne-James et al. who recruited self-admitted illicit drug users found that 50% participants reported injecting crack cocaine and heroin simultaneously and Gregory et al. reported that 8% of 103 detainees referred to arrest referral admitted taking a combination of three or more drugs.

Few studies looked at other associated factors but those that did found substance misuse was associated with a high proportion of socioeconomic deprivation.

A couple of studies reported on alcohol consumption in the preceding hours before detention in police custody: McKinnon et al. reported 40% of detainees who were seen by an FME had consumed alcohol in the previous 48 hours; and Payne-James et al. reported 33% in the past 24 hours. There was little reference to the misuse of prescription drugs in the literature, nor reference to new psychoactive substances.
In the grey literature, the NEW-ADAM (New English and Welsh Arrestee Drug Abuse Monitoring) programme interviewed and collected urine specimens from 2,933 arrestees between 1999 and 2001. 69% of detainees tested positive for one or more illicit drug types and 36% tested positive for two or more such substances. 48% tested positive for cannabis, 31% tested positive for opiates and 22% for cocaine. 80% of detainees reported having used at least one illicit drug in the previous 12 months.

The Arrestee survey, conducted in 2005 and 2006, comprised 8530 respondents interviewed in police custody in England and Wales and found that 52% of all respondents reported having taken one or more drugs in the month previous to arrest. Cannabis was the most widely taken drug with 41% having taken it in the last month, followed by heroin (13%), cocaine (13%) and crack (11%). 57% of respondents were dependent drinkers.

The Arrestee survey also explored the association of substance misuse with the likelihood of crime and detention in police custody. The authors found that among respondents who took heroin or crack at least once a week, 79% had been arrested in the previous year compared to 48% among those who did not take heroin/crack weekly. 57% of arrestees who took heroin/crack regularly reported they had committed crimes whilst high on drugs with 43% saying that they would not have committed the crimes had they not been high. 12% of respondents said they had committed crimes in the last 12 months in order to buy or access drugs. 38% of respondents said that they had got into a fight or used violence against someone after drinking alcohol and 17% reported having caused damage or vandalised a vehicle, house or some other building after drinking alcohol.

The Scottish Prisoner Survey conducted in 2013 found that 45% or respondents reported being drunk at the time of their offence and 39% reported being under the influence of drugs. 16% of the respondents who reported being under the influence of drugs said that they had committed their offence in order to obtain money to pay for drugs.

Nationally reported statistics reporting on substance misuse in relation to crime were also reviewed. The Recorded Crime in Scotland publication reported that there were 5,218 offences of drunk driving, equating to a rate of 10 per 10,000 population, in Scotland in 2014/15. The Scottish Crime and Justice Survey reported that in 2012/13, the victim said the offender was under the influence of alcohol in 59% of cases of violent crime and in 29% of cases the offender was thought to be under the influence of drugs. With regards to fatalities, 29 of 77 (38%) persons accused in homicide cases in 2014/15 were reported to have been drunk and/or under the influence of drugs at the time of the homicide. Of the 77, 11 (14%) were under the influence of alcohol, 2 (3%) were under the influence of drugs and 16 (21%) were under the influence of both. For 38 of the 77 (49%) accused persons the alcohol and drug status was unknown.

**4. Identifying detainees with substance misuse**

National guidelines recommend that healthcare professionals should be involved in the management of detainees with substance misuse or dependence. In order to provide healthcare, detainees with substance misuse need to be identified and, with regards to alcohol, The National Institute for Health and Clinical Excellence (NICE) has stipulated that “staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be
competent to identify harmful drinking and alcohol dependence”. Through the proactive identification of detainees with substance misuse early intervention, healthcare and health improvement can be provided.

The two most commonly used screening tools for the determination of substance misuse by researchers in police custody are the Drug Abuse Screening Test (DAST) and the AUDIT alcohol questionnaire.

The DAST is a screening tool whereby the extent of problem drug use can be quantified. Although used by researchers in police custody suites little comment has been made in the literature as to its clinical application in the police custody setting.

The AUDIT screening tool has been shown to be feasible to use in prisons and community justice settings and can provide valuable information to detect and understand alcohol problems in detainees. As a result of the AUDIT score obtained respondents can be categorised into low risk, hazardous, harmful or dependent drinkers.

AUDIT is regarded as the ‘gold standard’ screening questionnaire for detecting hazardous and harmful drinking with 92% sensitivity and 93% specificity. However, where time is pressed the FAST tool can be used to perform an initial screening. The FAST tool is a cut down 30 second version of the AUDIT screening tool and has been recommended for use where alcohol is a possible or confirmed contributory factor in a person’s presentation to services in order to detect a hazardous drinking pattern.

NICE advocates the use of screening tools, preferably AUDIT or an abbreviated version (e.g. FAST) where time is limited, to identify people who may be at risk of harm from the amount of alcohol they drink, including in the criminal justice setting. In addition to using the AUDIT to identify the nature and severity of alcohol misuse, NICE recommends the use of the CIWA-AR tool to assess severity of alcohol withdrawal.

5. Complications of substance misuse requiring hospital care

Healthcare provision in police custody varies across the country with some police custody settings having 24 hour healthcare provision on-site and others being supported by off-site healthcare professionals who will attend to review detainees where required. As a result there may be varying thresholds as to who can be managed in police custody and when to transfer detainees for healthcare provision in hospital. That said, two specific presentations resulting directly from substance misuse were highlighted by the literature as requiring the detainee to be transferred to hospital for assessment and management: significant alcohol intoxication and acute behavioural disturbance. (Of note other health complications may also require the detainee to be transferred to hospital but these were the two specifically referred to in the substance misuse literature.)

The management of detainees dependent on, or under the influence of alcohol in police custody is associated with considerable risk (such as inhalation of vomit) and it is often not appropriate to keep such detainees in a police cell. However, it can often be difficult to identify where the best place for individuals who are drunk and incapable to be looked after is. The Royal College of Emergency Medicine guidelines suggest that it may be appropriate for detainees who are ‘drunk and incapable’
to be seen in the Emergency Department whereas detainees who are ‘drunk and disorderly’ should remain in police custody but the guidelines also acknowledge that this distinction is often subjective.\(^{37}\)

Individuals with acute behavioural disturbance should ideally be taken directly to an emergency department and not detained in police custody.\(^{38}\) The Faculty of Forensic and Legal Medicine guidelines highlight excited delirium as one of the most extreme forms of acute behavioural disturbance and it is potentially life-threatening. Excited delirium is a condition that can be caused by physical illness or psychiatric conditions or secondary to substance misuse (both intoxication and withdrawal). Clinical features include a state of high mental and psychological arousal, agitation, hyperpyrexia associated with sweating, violence, aggression and hostility with insensitivity to pain. Treatment with short-acting oral benzodiazepines, with appropriate medical observation, in order to reduce further distress for the patient may be appropriate whilst transfer to an emergency department is arranged.

6. Substitution therapy and management of withdrawal

When detained in police custody there is a recognised risk that continuity of medication and healthcare support may be disrupted.\(^{39}\) However, as long as it is safe and appropriate to do so, detainees should have prescribed medication continued whilst in police custody including the consideration of opiate substitution therapy such as methadone.\(^{1,40}\) This is of particular importance to pregnant women for whom there could be potential complications to their foetus in the event of sudden cessation of opioid use.\(^{1}\)

To treat symptoms of withdrawal from alcohol, benzodiazepines such as chlordiazepoxide or diazepam are recommended.\(^{1}\) For opioids, if a detainee takes opioid substitution therapy this should be continued where safe and appropriate to do so but if not available or the detainee is not prescribed opioid substitution therapy consideration should be given to treating opioid withdrawal symptoms with opioid agonist medication e.g. dihydrocodeine.\(^{41}\) The initiation of methadone substitution therapy in custody should rarely be considered and only in the event of “an exceptional necessity”\(^{1}\) and there is no recognised indication for prescribing amphetamine, cocaine or injectable benzodiazepines for the treatment of dependence in police custody.\(^{40}\) However, if the time in custody is brief, a substitute drug may not be required to be prescribed.\(^{1}\)

NICE recommends that a symptom-triggered regimen for drug treatment for people in acute alcohol withdrawal should be done for people in hospital or in other settings where 24-hour assessment and monitoring are available.\(^{42}\) Alternatively a ‘fixed dosing’ schedule may be used. Healthcare professionals who care for people in acute alcohol withdrawal should be skilled in the assessment and monitoring of withdrawal symptoms and signs. Locally specified protocols to assess and monitor patients in acute withdrawal should be followed e.g. CIWA-AR.

NICE and the Scottish Intercollegiate Guidelines Network (SIGN) also recommend that thiamine should be offered to people with a chronic alcohol problem whose diet may be deficient and are therefore at high risk of developing Wernicke’s encephalopathy.\(^{36,42}\) Thiamine should be given orally to harmful or dependent drinkers if they are malnourished/at risk of malnourishment, have decompensated liver disease or are in acute withdrawal. Parental thiamine followed by oral...
thiamine is recommended for harmful or dependent drinkers with these characteristics who attend an emergency department or are admitted to hospital with an acute illness or injury. The guidance notes that “there is some theoretical and trial evidence to suggest that parenteral replacement elevates blood levels more quickly than oral replacement, however it is not known if this is clinically significant, and there is no convincing clinical evidence to suggest which route and dose of thiamine is most effective at preventing Wernicke’s encephalopathy”. NICE reflects that this is important to consider given that parenteral dosing uses additional resources, is unpleasant for the patient and has a very small risk of anaphylaxis.42

7. Healthcare and health improvement interventions

The identification of detainees with substance misuse provides an opportunity to deliver health improvement interventions. The Scottish Government recognises that by maximising opportunities to engage detainees who are in the criminal justice system with health improvement interventions benefits are accrued not only for detainees with alcohol problems but also for their families and friends as well as potentially contributing more widely to safer communities through the reduction of re-offending.39

With regards to drug misuse, healthcare professionals can provide detainees advice on:1, 2

- local services (eg community drug and alcohol teams, treatment centres, needle exchange and sexual health services)
- blood borne viruses and hepatitis B vaccination
- safe injection techniques
- harm reduction advice in general (e.g. graduated dosing, increased risks associated with multiple substances and loss of tolerance following a period of abstinence)

For detainees with alcohol misuse in police custody opportunities for health improvement include the delivery of alcohol brief interventions and/or referral to local services.2

Alcohol brief interventions (ABIs) have been shown to be effective for individuals with a harmful alcohol intake who are seen in primary care and are not necessarily seeking treatment for alcohol-related problems.43, 44 However, there has been little research to date looking at the effectiveness of interventions, alcohol brief interventions or otherwise, in police custody even though the possibility of delivering brief interventions in the police custody suite in order to reach a “target group who doctors have failed to have an impact on” was recognised in the literature nearly two decades ago.45

Evidence suggests that screening for addictive behaviours and the delivery of brief interventions and screening in police custody is feasible. Chariot et al. managed to deliver brief interventions to 77% of 708 selected cases where an addictive disorder was found.7 However, the main challenges to effective brief intervention delivery were aggressive behaviour, drowsiness or “fanciful statements by the detainee”.7 Brief interventions were more frequently given and more successful when delivered by a specialist in addiction medicine compared to other physicians.7

In Scotland, a pilot study that randomised offenders who were given Probation/Community Service Orders to either alcohol brief interventions or information only found that screening and alcohol brief interventions can be used in the community justice setting “with reasonable levels of
acceptability”. The study comprised small numbers and the follow-up data were limited such that the effectiveness of ABIs could be not be determined, however, it echoes the results of the study by Chariot et al. indicating that the delivery of ABIs is feasible in the police custody setting.

A second, larger study conducted in the probation setting in England recruited 525 offenders who were randomized to a client information leaflet, brief advice or brief lifestyle counselling as part of multicentre factorial cluster randomized controlled trial. Offenders were willing and able to participate in the study and although brief advice or brief lifestyle counselling provided no additional benefit in reducing hazardous or harmful drinking compared with the client information leaflet, those in the brief advice and brief lifestyle counselling intervention groups were statistically less likely to reoffend in the year following intervention.

This study by Newbury-Birch et al. was conducted in the probation setting and not in police custody. A previous exploratory study by the same authors determined that the probation setting was preferable to the police custody setting as many detainees were intoxicated when in police custody and could not consent to the study. The authors also noted that “police custody suites were busy and often chaotic environments and screening at busy times was difficult in these environments”. However, this exploratory study was conducted in England in 2007. The change in Scotland to provision of healthcare by the NHS last year recognised the importance of proactive preventative healthcare thus starting to shift the ethos of healthcare delivery in police custody and potentially start to create a more conducive environment for intervention work to be delivered.

Guidelines issued by NICE concerning ABIs advocate the delivery of brief interventions to hazardous or harmful drinkers in the criminal justice setting. If this cannot be done immediately NICE recommends an appointment should be offered as soon as possible thereafter. If a detainee is a dependent drinker then he/she should be referred for specialist treatment unless they are reluctant to accept a referral in which case they should be offered an extended brief intervention.

In addition to brief interventions, other health improvement interventions reported in the literature include Arrest Referral schemes and cognitive behavioural alcohol treatment programmes. The recent study by Needham et al. suggested a beneficial effect of cognitive behavioural alcohol treatment programmes in terms of reducing recidivism. However, the authors used as their control group offenders who refused to participate in a treatment programme which is likely to have introduced bias into their findings.

With regards to Arrest Referral schemes Hunter et al. reported on their evaluation of the schemes in 2005 when in their relative infancy. They found that while Arrest Referral schemes were considered a useful resource, police were often sceptical as to the ultimate benefit Arrest Referral schemes may deliver in terms of reducing crime. The paper also highlighted practical difficulties in delivering Arrest Referral schemes including lack of training and preparation for both police and Arrest Referral workers and the lack of integration of the schemes with community-based drug services. It should be noted, however, that Arrest Referral schemes have evolved since this work was done and, for example, have started delivering alcohol brief interventions.

The Home Office summarised the findings of two evaluations of Home Office alcohol arrest referral pilot concluding that overall alcohol arrest referral schemes did not appear to reduce re-arrests.
There was a caveat to this, however, which was that there were relatively low numbers of arrests in the six months either side of the index arrest meaning it was difficult to detect small changes in arrest rates. There was, however, some evidence of reduced alcohol consumption among those who received alcohol brief interventions. The Home Office concluded that delivering interventions in a custody setting was possible, but required good co-operation between custody staff and alcohol workers.\textsuperscript{50}

Overall, evidence concerning effective interventions in police custody is extremely limited. It should be noted that this review has specifically concentrated on healthcare provision for substance misuse in police custody. As a result, published literature concerning the effectiveness of interventions delivered in the prison setting has not been considered. Although there will be some crossover in the characteristics of individuals detained in police custody and in prison there are differences in terms of applicability of interventions in each of the two settings. For example, prison represents a largely abstinent environment for alcohol where the impact of hazardous drinking is less at the forefront of detainees’ minds whereas alcohol misuse is a more immediate issue for detainees in police custody.\textsuperscript{46}

In addition to the health improvement interventions available to healthcare professionals there are various options available to the wider criminal justice system to address substance misuse. For example, there is the provision for courts to impose Community Payback Orders (CPOs) with additional requirements such as treatment for alcohol or drugs. However Audit Scotland noted that these are being imposed in only a small minority of cases with fewer than 5% of CPOs in 2011/12 having a requirement for alcohol treatment.\textsuperscript{51} Drug courts and drug treatment orders are also available justice interventions.\textsuperscript{52}

8. **Throughcare**

The British Medical Association (BMA) notes that, as with other areas of medical practice, it is important for healthcare professionals in police custody to share information with other providers of health care.\textsuperscript{2} This includes ensuring that the confidential record of any medical treatment provided, or requested, by the healthcare professional while the individual is in police custody, accompanies the individual when he/she is transferred elsewhere. Healthcare professionals in police custody, GPs and prison medical officers are encouraged to communicate with each other, with the detainee’s consent, to obtain confirmation of the detainee’s medical history. The BMA also recommends that appropriate procedures are in place for exchanging information when handing over the care of detainees if healthcare professionals are working in a group or rota situation.

Her Majesty’s Inspectorate of Constabulary in Scotland expects that detainees with substance misuse in police custody are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred to community drugs/alcohol teams or prison drug workers as necessary. Also, detainees who are known to inject drugs and are to be released into the community should be offered clean needles by drug referral workers.\textsuperscript{53}

From the literature searched there was no reference to the provision of take-home naloxone kits to detainees on release from police custody.
9. **Challenges to engaging with healthcare**

Detainees in police custody have a high level of unmet need and represent an otherwise ‘hard to reach group’ for whom there could be significant potential benefit resulting from healthcare intervention. Furthermore there is the opportunity to reduce re-offending as a result. However, studies highlighted various challenges encountered when trying to engage detainees with healthcare in police custody including:

1. Screening by the police custody sergeant of detainees at the charge bar is not always sufficiently sensitive or specific to pick up relevant physical, mental health, drug or alcohol problems.\(^\text{14, 54}\)

2. Detainees who are dependent upon illicit substances often do not want to divulge this to the police sergeant.\(^\text{14}\) The authors of this English-based study noted that “Information obtained during screening is not treated confidentially by the police sergeants, but may be used as part of any police investigation”. As a result it may be that this has the potential to impact on the accuracy with which detainees are responding to the screening questionnaires administered by police custody sergeants. It was also noted that those with heroin use tended to declare their use more frequently than if they were taking crack cocaine. This may be due to the anticipated requirement for treatment to manage opioid withdrawal symptoms.

3. Leading on from the point above, it can depend on what substance a detainee takes as to how keen they are to access support. For example, Buster et al. noted that detainees who are accustomed to taking opioids are generally more open to seeking support for addiction problems compared to other substances.\(^\text{12}\)

4. Detainees’ self-reporting history of drug use is not always accurate. Stark et al. found 7% of people reporting heroin use tested negative on urine screening and 25% of people who denied heroin use tested positive.\(^\text{16}\) Furthermore, when considering methadone use, 25% people who reported taking methadone on a daily basis had this contradicted by the urinalysis result.

5. Not all detainees are registered with a GP. One study in England found that 29.8% detainees where not registered.\(^\text{15}\)

6. Detainees are often from an ethnic minority, unemployed with no permanent address and with financial concerns.\(^\text{15, 55}\) In addition to accessing help for substance misuse addictions, many would like housing and or financial support.\(^\text{12}\)

7. In some cases detainees with substance misuse may not want advice on harm reduction measures.\(^\text{18}\)

8. Services can be overburdened and this is one of the reasons that there has been a move to support FMEs with custody nurses in recent years.\(^\text{56}\)
9. Lastly, lack of interpreter was a common reason cited in studies for not recruiting participants. Whether this translates into a barrier in practice for detainees to access healthcare, and not specifically confined to research, was not specified.

10. Substance misuse and mental health disorders

There is an overlap in reporting between substance misuse and mental health disorders and often detainees will present with a combination of conditions. Scott et al. identified that many detainees with mental health illnesses often consume harmful levels of alcohol and or drugs. In a prospective study of illicit drug users who were assessed by forensic physicians in London, 18% were found to have concurrent significant mental health issues such as schizophrenia. An audit of service provision by FMEs in the North East of England found that mental health comorbidity was seen in 13% of detainees with alcohol dependence and 5% of detainees with drug dependence. The authors also commented, however, that these may have been underestimates due to the difficulty in assessing mental health when a high degree of concurrent intoxication is present.

In terms of the literature review, the searches have focused on identifying articles reporting on substance misuse. However, on occasion the data on substance misuse may be reported as part of a paper predominantly concerned with mental health illnesses, as in the example by Dorn et al. It is possible that an article has inadvertently been missed for inclusion in this literature review as a result but by cross-checking the reference lists of the articles obtained as a result of the search strategies it is hoped that the risk of this happening is minimised.

11. Conclusions

From the literature, substance misuse is prevalent in a considerable proportion of detainees in police custody. Accurate estimates are difficult but approximately 50% of detainees in police custody and 70% of those seen by an FME engage in substance misuse. Various challenges exist in facilitating healthcare improvement delivery to detainees whilst in police custody, however, screening and the delivery of interventions and support in police custody has been shown to be feasible and police custody provides as opportune time to reach an otherwise hard to reach group of the population.

Research into the effectiveness of interventions delivered in police custody is limited. In particular there are few Scottish studies published. This may be in part due to the evolving nature of healthcare provision in police custody, with only a relatively recent shift to recognising and emphasising the potential preventative and therapeutic interventions that can be delivered in this setting. The accurate monitoring and evaluation of encounters in police custody with detainees who misuse substances is integral to continuing to understand and develop the service further in future.
12. References


36. The management of harmful drinking and alcohol dependence in primary care. SIGN Guideline 74. 2003


