Quality Improvement and Outcome Framework for the Healthcare in Police Custody elements of the Healthcare and Forensic Medical Services for People in Police Care in Scotland

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1. Introduction

1.1 Purpose

This Quality Improvement and Outcome Framework provides a set of evidence informed indicators that can assess outcomes of healthcare delivery within police custody healthcare services and support service planning and quality improvement. The indicators will help NHS Boards, Police Scotland and wider partners understand what impact the services are having for individuals and how this is contributing to common outcomes (short, medium and longer term) as identified in the logic models. Section 4.1 provides more detail on how the Framework can be used.

1.2 Scope

The Framework applies to:

- healthcare and forensic medical services for people in police care in Scotland, whether directly provided by an NHS Board or secured on behalf of an NHS Board
- all people using healthcare and forensic medical services in Scotland with regards to protected characteristics under the Equality Act 2010

The Framework sets out a number of indicators, as agreed nationally by NHS and Police Scotland Senior Leads through the National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care’s Network Board. It in no way constrains NHS, Police Scotland or associated partnerships should they wish to supplement the suite of indicators to reflect specific organisational or local priorities.
2. Background

2.1 Healthcare in Police Custody

In Scotland there has not been a formal health needs assessment of people in police custody therefore we do not currently have a clear picture of the healthcare needs of people in police custody. However, Her Majesties Inspectorate of Constabulary for Scotland’s (HMICS) Thematic Inspection of Police Custody Arrangements in Scotland (2014) found that of the 310 custody records sampled, 68% of detainees declared either medical, mental health or substance misuse issues. UK literature notes high levels of health morbidity in police custody. A study in London estimated that 56% of people in police custody had active medical conditions including asthma, diabetes, epilepsy, alcohol and drug dependence and self reported symptoms related to ‘mental health problems and depression’. From the limited European data available, the estimated prevalence of substance misuse in detainees is approximately 50% of detainees in general police custody, rising to 70% in those seen by a Forensic Physician. Approximately 10% of community police time is spent dealing with incidents concerning those with identified mental health problems. In 2013-14 Police Scotland had 192,848 detainee episodes, of which 68% were classed as vulnerable.

In evaluating the clinical needs of those in police custody, HMICS concluded that had they not been arrested, a significant proportion of those people genuinely in need of medical attention or at least examination would not have sought treatment from a doctor “because of their disorganised or chaotic lifestyle”. Police custody therefore provides an opportunity to engage with those who would not otherwise access healthcare services and therefore this time, albeit limited, needs to be used to maximise health gain.

Evidence suggests that there is a strong link between alcohol and crime, particularly violent crime; 59% of victims of violent crime thought the offender was under the influence of alcohol and 34% thought the offender was under the influence of drugs. 45% of prisoners reported being drunk at the time of their offence (75% of young offenders) and 44% of prisoners reported being under the influence of drugs. The total economic and social cost of illicit drug use in Scotland is estimated at just under £3.5bn. Costs associated with problem drug accounts for 96% of the total cost and this equates to just under £61,000 per problem drug user. Alcohol and drug related crime is estimated to cost Scotland £700 million and £73 million respectively annually. The cost of holding these individuals in police cells is estimated to be around £2.12million per year across Scotland.

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1 Her Majesties Inspectorate of Constabulary for Scotland (2014)
2 McKinnon and Grubin (2013)
4 Rekrup-Lapa, T., Lapa, A (2014)
5 Ceelen, M., Buster, M., Stirbu, I., Doner, G., Das, K., (2012)
8 McKinnon, B., (2014)
9 Her Majesties Inspectorate of Constabulary for Scotland (2014)
10 Her Majesties Inspectorate of Constabulary for Scotland (2008)
11 Scottish Government (2014a)
12 Carnie, J., Broderick, R., McCoard, S., (2013)
There are well established links between health behaviour and crime. By supporting appropriate healthcare interventions, there is the potential to improve health and decrease the potential for further offending. For example, a study on the delivery of Alcohol Brief Interventions in a criminal justice setting found they not only reduced alcohol consumption, but also reduced offending behaviour\textsuperscript{16}. Targeting appropriate healthcare resources in this area could therefore contribute to more effective use of resources across the wider public sector.

Whilst there are international agreements and standards with regards to the care and welfare for people in police custody, such as the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) there are no international, UK or Scottish standards with which to assess the quality of the healthcare delivered in a police custody setting. Public Health England is developing Health and Justice Indicators of Performance which cover police custody healthcare, however these are based on the commissioning model in England and focus on service delivery measures rather than individual health outcomes. With regards to referral from police custody suites to other health services such as addiction or mental health services, or wider services such as agencies who deal with homelessness, there is no national information, and very little local information on the efficacy of these referrals.

2.2 Service Models

Responsibility for the delivery of healthcare to people within police custody sits with NHS Boards\textsuperscript{17}. There are however different service delivery models across Scotland. Some are nurse led with nurses providing the initial triage, assessment and treatment, supported by Forensic Physicians, and others are primarily provided by contracted Forensic Physicians.

In remote and rural areas services are generally provided by General Practitioners. This takes cognisance of the remote and rural geography as well as the infrequent requirement for expert forensic involvement. Support from mainland NHS Boards for forensic medical expertise is provided as required.

2.3 Pathways

High level pathways of the journey through police custody and the interaction with the healthcare and forensic medical services, as well as a patient pathway can be found in Appendix C.


\textsuperscript{17} As per the \textit{NHS (Scotland) Act 1978}
3. National Policy Context

The Scottish Government has five Strategic Objectives which underpin its core purpose to create a more successful country, with opportunities for all of Scotland to flourish through increasing sustainable economic growth. Two strategic objectives, spanning the responsibility of the Health and Social Care, and Justice Directorates, relate specifically to the people in police care:

- Helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.
- Helping communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life\(^{18}\).

3.1 Health and Social Care

A Route Map to the 2020 Vision for Health and Social Care\(^{19}\) sets out the vision for the delivery of healthcare services in Scotland, asserting that “whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.”

Fundamental to the delivery of high quality services are the three quality ambitions:

- **Safe** – There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all time
- **Person-Centred** – Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making
- **Effective** – The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated

Providing care that is equitable and does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status is central to the ethos of the provision of healthcare in Scotland. The report of the Ministerial Task Force on Health Inequalities\(^{20}\) in 2008 noted that offenders and ex-offenders should have access to the health and other public services they need, and benefit from the same quality of service as the rest of the population.

3.2 Justice

The Strategy for Justice in Scotland 2012\(^{21}\) sets out a vision of a justice system that contributes positively to a flourishing Scotland, helping to create an inclusive and respectful society in which all people and communities live in safety and security, individual and collective rights are supported and disputes are resolved fairly and swiftly. Priorities include tackling crime by reducing reoffending and tackling the underlying causes of crime as well as reducing the damaging impact of drug and alcohol problems.

\(^{18}\) Scottish Government (2014b)
\(^{19}\) Scottish Government (2013a)
\(^{20}\) Scottish Government (2008)
\(^{21}\) Scottish Government (2012)
3.3 Indicators, Outcome and Reporting Frameworks

There are a number of other Outcome and Reporting Frameworks that link to healthcare and forensic medical services for people in police custody which have been considered as part of the development of the Framework. A full list can be found in the Bibliography.
4. Development of the Framework

Prior to April 2014, healthcare and forensic medical services for people in police care were delivered by a variety of providers. Police Scotland, NHS Boards and independent contractors used a mixture of paper based and electronic systems to record healthcare and forensic medical encounters depending on location. Use of this information for service management, quality improvement and internal reporting across Police Scotland and NHS Scotland was variable.

The transfer of responsibility to the NHS, the introduction of Adastra as the national IT system, and the establishment of the National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care provided an opportunity to develop this framework.

Initial discussions on the long term outcomes for the healthcare and forensic medical services for people in Police Care across Scotland took place at the Network’s stakeholder day on 1st October 2014. The views of a wide range of stakeholders were captured in the workshop sessions. The information generated was further refined and developed by the Quality Improvement and Outcome Group (QIOG).

The Framework has been developed by the QIOG partnership with relevant Network subgroups. Membership of the QIOG can be found in Appendix A. The Framework was issued for consultation with a wide range of stakeholders, a full list can be found in Appendix B. All comments were considered and changes made as appropriate.

The Framework has been developed based on best current available evidence, as evidence and policy develops, the Framework will be reviewed and updated as required.

4.1 What is the Framework for?

Data relating to healthcare and forensic medical services are collated by NHS Board healthcare and forensic medical services, Police Scotland and Scottish Police Authority. These data and local audit will form the intelligence for the healthcare indicators.

NHS Boards and Police Scotland will work together through local and / or regional partnership groups to develop processes for data collection, reporting and review22. Data can be presented at NHS Board level in a format to be interpreted and used locally to stimulate reflection, understand where services are working and identify opportunities for improving patient care.

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22 As set out in the Memorandum of Understanding between NHS Boards and Police Scotland for the delivery of Healthcare and Forensic Medical Services
It is anticipated that the Framework will assist NHS Boards and Police Scotland to gain an understanding of the contribution of healthcare and the police to:

- **Healthcare outcomes for individuals**
- **Rehabilitation and personal outcomes for individuals and carers** - e.g. reduction in reoffending, reduction in crime, quality of life and personal functioning/independent living
- **Experience of services** by individuals and carers
- **Adherence to joint police / clinical /professional / care pathways and best practice guidelines** e.g. levels of evidence based interventions; operational processes to deliver shared, jointly owned, care and plans.
- **Comparative understanding about trends within the whole system over time and across Scotland** to highlight and reduce variation in delivering outcomes.
- **Service cost effectiveness and resource use**
- **Position against local and national targets**

The National Coordinating Network has a facilitation role and is able to assist partnerships by providing guidance and support. The Network Board has a potential role in:

- Monitoring service delivery, and ensuring that services meet needs and are delivered clinically, cost effectively and equitably across Scotland
- Monitoring the quality of services delivered and their impact on health and community safety and providing direction on service improvement

Data collected by partnerships would therefore be of interest to the Network Board in fulfilling its role.

The ethos of the Framework is focused on quality improvement. Through interrogating the data, partners can answer questions about service delivery as well as its outcomes, and data can be used to drive quality improvement. The Framework is not primarily designed to be a performance management tool hence no performance thresholds have been incorporated.

It is recognised that the Framework contains a wide range of quality indicators. It is not intended that partnerships necessarily use the Framework in its entirety rather, the Framework is designed to be used flexibly by local and regional partnerships. Partnerships are encouraged to use the Framework to meet local needs depending on their service configuration, service pressures and areas of the service they wish to gain a better understanding of, or they think could be improved.

### 4.2 Data Reporting

It is recognised that NHS Boards, Police Scotland and the Network currently do not have the infrastructure to collect information to demonstrate progress against the quality indicators nationally or between areas and no new resources are at present available for data collection. The indicators are therefore based, wherever possible, on readily accessible existing local and national data sources. The data source for each indicator is defined within the data definition table.

Local or regional partnerships may wish to focus on a specific topic, such as alcohol, or a specific process, such as identification. If data collection and analysis on all episodes of care is not feasible using existing systems then sampling could be attempted. NHS Boards / Police Scotland / partnerships could aim to select a small sample of cases for review.

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23 As set out in the Network Structure document for the National Coordinating Network for Healthcare and Forensic Medical Services
24 Healthcare Improvement Scotland (2013a)
There are a number of resources that can assist NHS Boards with these quality improvement methods and these are contained within the References section.

4.3 Next Steps

The Quality Improvement and Outcomes Group has made a series of recommendations for future work in this area. These will be considered by the Network Board to inform the Network’s workplan.

4.4 Logic Models

A logic model is a graphic representation of a programme, intervention, project or theory of change. It describes what is put in, what is done and what is expected to be achieved, in logical order. It shows the links between intended inputs, activities, outputs and outcomes.26

A useful logic model does the following:
- Identifies the intermediate and ultimate outcomes of the intervention and the pathways through which intervention activities produce those outcomes
- Shows the inter-relationship among intervention components
- Recognises the influence of external contextual factors on the interventions’ ability to produce results
- Helps guide program developers, implementers and evaluators27

Logic Models have been used within the NHS to: capture the essence of an evolving service; inform the development of data indicators to assess the level and quality dimensions of service delivery and care; provide a framework by which to develop a clear and logical evaluation of services and facilitate a co-ordinated and consistent approach to service development, monitoring, evaluation and reporting across the service.28 The high level logic model is included below and others are included in Appendix D.

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26 Alexander, H., (2014)
Healthcare in Police Custody High-Level Logic Model

**INPUTS**
- **What do we invest?**
  - Workforce
    - Police Scotland
    - NHS Scotland
    - Scottish Government
  - Information Technology
  - Models of Care & Integrated Care Pathways
  - Time to develop partnership working
  - Education, training and development for staff
  - Equipment
  - Accommodation

**ACTIVITIES**
- **What do we do?**
  - Identify those with healthcare needs
  - Clinical care underpinned by evidence based guidelines and standards
  - Onward referral to health and social care services
  - Use data to inform service planning / development
  - Staff education and training

**OUTPUTS**
- **Who do we reach?**
  - People in police care
    - Healthcare staff working with people in police care
    - Police who work with people in police care
    - Healthcare staff working in secondary and tertiary care e.g.: Accident and Emergency, specialist treatment services
    - Staff working in the community: Local Authority, NHS and Third Sector
    - Staff working in Criminal Justice setting, Crown Office and Procurator Fiscal Service and Court Service
    - Offender transport service
    - Scottish Prison Service

**OUTCOMES**

**SHORT (1 – 2 years)**
- Most attributable
- Safe, effective and person centred care
- Clinical care based on evidence base
- Police who work with people in police care
- Healthcare staff working in secondary and tertiary care e.g.: Accident and Emergency, specialist treatment services
- Staff working in the community: Local Authority, NHS and Third Sector
- Staff working in Criminal Justice setting, Crown Office and Procurator Fiscal Service and Court Service
- Offender transport service
- Scottish Prison Service

**MEDIUM (2 – 5 years)**
- Least attributable
- Decreased recidivism
- People are seen in the most appropriate environment
- People receive the most appropriate interventions
- Data used to:
  - better understand the healthcare needs of population group
  - develop evidence base for clinical care
- Appropriate information sharing
- Communities are engaged with vulnerable people
- Joined up health and social care partnerships
- Co-location of partners
- National Network includes social care and third sector representatives
- National standards to inform care delivery
- Strong partnership working, including shared understanding of risk

**LONG (25 years)**
- Least attributable
- Safer Scotland
- Healthier Scotland
- Decreased health and socio-economic inequalities
- Better value for money within the system

**PRIORITIES**
- Identification, clinical management and appropriate referral for people requiring healthcare in police custody

**SITUATION**
- High levels of health morbidity within population (long term conditions, alcohol and drug dependence, mental health problems)
- High levels of co-morbidities
- Below average engagement with NHS services
- Inequalities in service delivery across Scotland
4.5 Indicators

An indicator is a measure which demonstrates delivery of person-centred, safe and effective healthcare, and promotes understanding, comparison and improvement of that care. Indicators focus on quality improvement rather than a measure of performance.

The majority of indicators centre on the key areas of alcohol, drugs and mental health. This is due to the high prevalence of mental health disorders and alcohol and drug dependence within police custody, as noted in the literature (see section 2.1) and by members of the Quality Improvement and Outcome Group. It is recognised that this group of patients often have multiple and complex health needs and do not necessarily fit neatly into the defined 3 categories above. Services should take a pragmatic, proportionate and needs led approach to data gathering and recording.

The Framework has been designed to assist those involved in the delivery of healthcare in police custody assess the quality of care delivered. The majority of the indicators therefore focus on the delivery of healthcare within this setting. However, one of the key drivers for integrating the service within the NHS was to improve links and care pathways to other NHS services. The Framework therefore includes a number of indicators which can be used as a proxy measure for service quality more broadly and are not directly attributable to the delivery of care within police custody. They have been included in order to be able to ascertain the denominator for related measures and to act as a catalyst for services to be able to link with community and specialist services.

Other areas such as:

- workforce
- education and training
- long term conditions
- physical injuries
- Appropriate Adults
- tobacco,
- naloxone provision
- adverse events

were considered by the Group and were not included in the Framework for a number of reasons, such as:

- their complexity
- the differing configuration of services across Scotland
- the sensitivity of the data
- national work is currently being undertaken in this area
- capacity within the service to deliver health promotion interventions

Person centred care is one of Scottish Government’s three Quality Ambitions\(^\text{29}\), and is integral to the delivery of all healthcare services. A number of indicators within the Framework take cognisance of qualitative research which has been undertaken with people in police custody (GH3, GH4, A5, D5, MH1, MH4). The Quality Improvement and Outcomes Group concluded that further quality improvement work, such as the development of patient questionnaires would be best undertaken locally.

\(^{29}\) Scottish Government (2013a)
All of the indicators in this Framework follow the same format:

- **Indicator** – what we are trying to achieve

- **Rationale and supporting literature** – the reason this indicator is considered important. The information has been extracted from NHS standards and clinical guidelines, national outcomes frameworks or peer reviewed academic journal articles. The majority are direct quotations and corresponding references can be found in the footnotes at the bottom of each page, with a full reference section at the end of the document.

The rationale has been developed using the following hierarchy of information:
1. NHS standards and clinical guidelines (where these exist)
2. national outcomes frameworks
3. peer reviewed academic journal articles
4. agreed best practice, including discussion at national meetings

- **Operational Definition** – how information is collected to demonstrate progress measurement against the indicator
  - **Numerator** - number of episodes where people experienced the outcome of interest
  - **Denominator** - number of episodes where people could potentially have experienced that outcome

- **Exclusions** – what is not included for measurement

- **Data source** – where to obtain data for measurement

The indicators have been devised to cover the following areas:
- **Identification** – Are the correct people being correctly identified as in need of healthcare? How many are there?
- **Management** – Are people being managed according to best practice? What interventions are being delivered?
- **Referral** – Are people being referred to appropriate specialists if required? How many?
- **Outcome** – Are people attending specialist services? What are the consequences of treatment?

### 4.6 Summary of Indicators

A summary of the indicators can be found below

<table>
<thead>
<tr>
<th>Indicator No.</th>
<th>Indicator</th>
<th>Page No.</th>
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<tbody>
<tr>
<td>GH1</td>
<td>Outcome % of deaths in police custody</td>
<td>17</td>
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<tr>
<td>GH2</td>
<td>Management % of episodes where people are transferred from police custody to Accident and Emergency by Scottish Ambulance Service <em>as an emergency</em> during their custody episode</td>
<td>18</td>
</tr>
<tr>
<td>GH3</td>
<td>Management % of episodes where people are transferred from police custody to Accident and Emergency by Police Scotland during their custody episode <em>for routine care</em></td>
<td>19</td>
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<tr>
<td><strong>GH4</strong></td>
<td>Management</td>
<td>% of episodes where people are maintained on existing prescribed medications 20</td>
</tr>
<tr>
<td><strong>GH5</strong></td>
<td>Outcome</td>
<td>% of complaints that are made by people in police custody relating to the delivery of healthcare and forensic medical services 21</td>
</tr>
<tr>
<td><strong>GH6</strong></td>
<td>Outcome</td>
<td>% of complaints that are made by people in police custody relating to the delivery of healthcare and forensic medical services <em>that are upheld</em> 22</td>
</tr>
<tr>
<td><strong>GH7</strong></td>
<td>Outcome</td>
<td>% of people who complete suicide in the 28 days following release from police custody 23</td>
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### Alcohol

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<table>
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<tr>
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</table>
| **A1** | Identification | % of episodes where people in police custody are seen by a healthcare professional and meet the following triggers:  
* In line with SIGN Guideline 74 *The management of harmful drinking and alcohol dependence in primary care*  
* Individuals where alcohol is thought to be a contributory factor in the offence and are then screened using a validated alcohol screening tool (such as AUDIT or FAST) in order to detect Alcohol Use Disorders with hazardous or harmful patterns of alcohol consumption or alcohol dependency* 24 |
| **A2** | Management | % of episodes where people identified as having an Alcohol Use Disorder with hazardous or harmful patterns of alcohol consumption receive an Alcohol Brief Intervention (ABI) 26 |
| **A3** | Management | % of episodes where people identified through the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar) as being at risk of alcohol withdrawal are managed according to local guidelines 28 |
| **A4** | Identification | % of episodes where people identified as having an Alcohol Use Disorder are currently engaged with specialist alcohol treatment services 29 |
| **A5** | Referral | % of episodes where people identified as having an Alcohol Use Disorder of alcohol dependency are referred to specialist alcohol treatment services 30 |
| **A6** | Referral | % of episodes where people identified as having an Alcohol Use Disorder of alcohol dependency are signposted to specialist alcohol treatment services 32 |
| **A7** | Outcome | % of episodes where people referred to specialist alcohol treatment services take up the referral 33 |
| **A8** | Outcome | % of episodes where people detained for an alcohol related offence are identified as having previously attended police custody for an alcohol related offence in the past 12 months 35 |

### Drugs

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</thead>
<tbody>
<tr>
<td><strong>D1</strong></td>
<td>Identification</td>
<td>% of episodes where people seen by a healthcare professional report problematic drug use, including use of new psychoactive substances 36</td>
</tr>
<tr>
<td><strong>D2</strong></td>
<td>Management</td>
<td>% of episodes where people identified through the Clinical Opiate Withdrawal Scale (COWS) as being at risk of drug withdrawal are managed according to local guidelines 38</td>
</tr>
<tr>
<td><strong>D3</strong></td>
<td>Management</td>
<td>% of episodes where people who receive an opioid substitution therapy in the community have their prescription continued while in police custody 39</td>
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<tr>
<td><strong>D4</strong></td>
<td>Identification</td>
<td>% of episodes where people identified as having problematic drug use are currently engaged with specialist drug treatment services</td>
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<tr>
<td><strong>D5</strong></td>
<td>Outcome</td>
<td>% of episodes where people identified as having problematic drug use are referred to specialist drug treatment services</td>
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<tr>
<td><strong>D6</strong></td>
<td>Outcome</td>
<td>% of episodes where people identified as having problematic drug use are signposted to specialist drug treatment services</td>
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<tr>
<td><strong>D7</strong></td>
<td>Outcome</td>
<td>% of episodes where people referred to specialist drug treatment services take up the referral</td>
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<tr>
<td><strong>D8</strong></td>
<td>Outcome</td>
<td>% of episodes where people detained for a drug related offence are identified as having previously attended police custody for a drug related offence in the past 12 months</td>
</tr>
<tr>
<td><strong>D9</strong></td>
<td>Outcome</td>
<td>% of new patients at specialist drug treatment services who report funding their drug use through crime</td>
</tr>
<tr>
<td><strong>D10</strong></td>
<td>Outcome</td>
<td>% of people who die of a drug related death who have been detained in police custody in the preceding 14 days</td>
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</table>

**Mental Health**

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<tbody>
<tr>
<td><strong>MH1</strong></td>
<td>Management</td>
<td>% of episodes where people are detained in police custody premises as a ‘Place of Safety’ as defined by section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003</td>
</tr>
<tr>
<td><strong>MH2</strong></td>
<td>Identification</td>
<td>% of episodes where people, after coming into police custody, are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003</td>
</tr>
<tr>
<td><strong>MH3</strong></td>
<td>Identification</td>
<td>% of episodes where people identified as having a mental health disorder are currently engaged with specialist mental health services</td>
</tr>
<tr>
<td><strong>MH4</strong></td>
<td>Referral</td>
<td>% of episodes where people identified as having a mental health disorder are referred to mental health specialist services</td>
</tr>
<tr>
<td><strong>MH5</strong></td>
<td>Outcome</td>
<td>% of episodes where people referred to mental health specialist services take up the referral</td>
</tr>
<tr>
<td><strong>MH6</strong></td>
<td>Outcome</td>
<td>% of episodes where people identified as having a mental health disorder are detained in police custody and are identified as having previously attended police custody more than once in the past 12 months</td>
</tr>
</tbody>
</table>
5. Indicators

5.1 General

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>GH1</td>
<td>% of deaths in police custody</td>
</tr>
</tbody>
</table>

Rationale & supporting literature

The rationale behind this indicator is to reduce avoidable deaths through the delivery of optimal healthcare.

The evaluation of the Tayside pilot found evidence that a clear and unambiguous set of benefits had arisen through the introduction of the pilot model of police custody healthcare service delivery in Tayside. Benefits were shown across policing practice, healthcare practice, and healthcare outcomes. The report concluded that the most significant benefits have accrued to the end users of the service: those detained in Tayside Police custody. The study also found evidence that the pilot was actively contributing in perhaps the most significant way of all: the prevention of deaths in police custody\(^3\). It should however be noted that numbers in Scotland are very small therefore it is difficult to draw robust conclusions.

Operational definition

Numerator: number of deaths in Police Custody

Denominator: number of episodes of people in Police Custody

Police Custody is defined as the period from when someone is bought to the custody charge bar to when they are released from custody. This is different from the official definition used by Crown Office and Procurator Fiscal Service (COPFS) and Police Scotland.

Exclusions

People who have had contact with Police who are not in custody.

Data source

COPFS

Police Investigations and Review Commissioner

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<table>
<thead>
<tr>
<th>Indicator GH2</th>
<th>Management</th>
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<tbody>
<tr>
<td>% of episodes where people are transferred from police custody to Accident and Emergency by Scottish Ambulance Service as an emergency during their custody episode</td>
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**Rationale & supporting literature**

The rationale behind this indicator is to ensure appropriate use of resources and reduce inappropriate referrals.

During the Nurse led pilot in Tayside, referrals from the custody suites to the Accident and Emergency departments across Tayside showed a Tayside-wide decrease of around 15% from the pre-pilot period.

**Operational definition**

Numerator: number of episodes where people are transferred from police custody to Accident and Emergency by Scottish Ambulance Service as an emergency

Denominator: number of episodes where people are detained in police custody

**Exclusions**

Individuals who have been transferred to A&E suspected of having drugs concealed internally, as per the Management Guidelines for Persons Suspected of Having Drugs Concealed Internally (version 2).

Individuals who are taken straight to A&E by Police Scotland who do not enter a police custody building

**Data source**

Police Scotland
Scottish Ambulance Service
Accident and Emergency
Adastra

Currently would need to manually link Police and A&E data

---

32 National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (2015)
<table>
<thead>
<tr>
<th>Indicator GH3</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes where people are transferred from police custody to Accident and Emergency by Police Scotland during their custody episode for routine care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale &amp; supporting literature</th>
<th>The rationale behind this indicator is to ensure appropriate use of resources and reduce inappropriate referrals.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>During the Nurse led pilot in Tayside, referrals from the custody suites to the Accident and Emergency departments across Tayside showed a Tayside-wide decrease of around 15% from the pre-pilot period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operational definition</th>
<th>Numerator: number of episodes where people are transferred from police custody to Accident and Emergency by Police Scotland for routine care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denominator: number of episodes where people are detained in police custody</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
<th>Those who have been transferred to A&amp;E suspected of having drugs concealed internally, as per the Management Guidelines for Persons Suspected of Having Drugs Concealed Internally (version 2).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People who are transferred to Accident and Emergency by Scottish Ambulance Service as an emergency.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data source</th>
<th>Police Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Scottish Ambulance Service</td>
</tr>
<tr>
<td></td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td></td>
<td>Adastra</td>
</tr>
<tr>
<td></td>
<td>Currently would need to manually link Police and Accident and Emergency data</td>
</tr>
</tbody>
</table>

34 National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (2015)
<table>
<thead>
<tr>
<th>Indicator GH4</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes where people are maintained on existing prescribed medications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale &amp; supporting literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rationale behind this indicator is to help ensure that people are managed effectively whilst in police custody and do not come to avoidable harm.</td>
</tr>
<tr>
<td>A qualitative report by Support in Mind found that people detained in police custody were not always maintained on existing medications causing distress and confusion.</td>
</tr>
<tr>
<td>Detainees have the right to have prescribed medication continued while in custody, as long as it is clinically safe to do so.</td>
</tr>
<tr>
<td>Focus groups undertaken with people who had been in police custody by the third sector organisation ‘Revolving Doors Agency’ in England found that a major concern for detained people who are on medication is the length of time they have to wait to receive medication when they are in custody.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operational definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: number of episodes where people are maintained on existing prescribed medications</td>
</tr>
<tr>
<td>Denominator: number of episodes where people are on existing prescribed medications</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who are started on medication whilst in police custody who are not on existing prescribed medications</td>
</tr>
<tr>
<td>Police custody episodes where the detention of the individual is sufficiently short that existing prescribed medication do not need to be administered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adastra</td>
</tr>
<tr>
<td>Local audit</td>
</tr>
</tbody>
</table>

---

36 Report of a Medical Working Group (2011)  
37 Revolving Doors Agency (2013)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>GH5</td>
<td>% of complaints that are made by people in police custody relating to the delivery of healthcare and forensic medical services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale &amp; supporting literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rationale behind this indicator is to monitor access to complaints systems. It is not an indicator of the quality of care per se, rather it is around ensuring patients know how they can make a complaint if they wish to do so.</td>
</tr>
</tbody>
</table>

Complaints about the NHS are valued alongside all other forms of feedback. They are a helpful way of identifying issues and areas in need of change within the service. Acknowledging these issues and taking steps to rectify associated problems is vital in creating an open and honest NHS and in maintaining the quality and safety of NHS services 📌.

The Patient Rights (Scotland) Act 2011 introduced a right to give feedback, make comments, raise concerns or make complaints about the health care received from the NHS in Scotland 📌.

<table>
<thead>
<tr>
<th>Operational definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: number of complaints made by people in police custody relating to the delivery of healthcare and forensic medical services</td>
</tr>
</tbody>
</table>

| Denominator: total number of episodes where people in police custody are seen by the NHS healthcare and forensic medical service |

Information Services Division has developed Definitions document for new NHS Complaints dataset which can be used a reference tool 📌.

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints made against the Police</td>
</tr>
<tr>
<td>Complaints made by other organisations.</td>
</tr>
<tr>
<td>Complaints made against the healthcare and forensic medical service in relation to the delivery of forensic medical services for victim sexual assault examinations or victim child sexual abuse or child non accidental injury examinations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Boards complaints systems</td>
</tr>
</tbody>
</table>

---

38 Information Services Division (2015a)
39 Information Services Division (2015a)
40 Information Services Division (2015b)
<table>
<thead>
<tr>
<th>Indicator GH6</th>
<th>Outcome</th>
<th>% of complaints that are made by people in police custody relating to the delivery of healthcare and forensic medical services that are upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale &amp; supporting literature</td>
<td>The rationale behind this indicator is to assist services in monitoring legitimate complaints or concerns that have been raised within the service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complaints about the NHS are valued alongside all other forms of feedback. They are a helpful way of identifying issues and areas in need of change within the service. Acknowledging these issues and taking steps to rectify associated problems is vital in creating an open and honest NHS and in maintaining the quality and safety of NHS services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Patient Rights (Scotland) Act 2011 introduced a right to give feedback, make comments, raise concerns or make complaints about the health care received from the NHS in Scotland.</td>
<td></td>
</tr>
<tr>
<td>Operational definition</td>
<td>Numerator: number of complaints made by people in police custody relating to the delivery of healthcare and forensic medical services that are upheld</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denominator: total number of episodes where people in police custody are seen by the NHS healthcare and forensic medical service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information Services Division has developed Definitions document for new NHS Complaints dataset which can be used a reference tool.</td>
<td></td>
</tr>
<tr>
<td>Exclusions</td>
<td>Complaints made against the Police</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complaints made by other organisations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complaints made against the healthcare and forensic medical service in relation to the delivery of forensic medical services for victim sexual assault examinations or victim child sexual abuse or child non accidental injury examinations</td>
<td></td>
</tr>
<tr>
<td>Data source</td>
<td>NHS Boards complaints systems</td>
<td></td>
</tr>
</tbody>
</table>

41 Information Services Division (2015a)  
42 Information Services Division (2015a)  
43 Information Services Division (2015b)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>GH7</td>
<td>% of people who complete suicide in the 28 days following release from police custody</td>
</tr>
</tbody>
</table>

**Rationale & supporting literature**

The rationale behind this indicator is to help ensure that detention in police custody does not have a significantly detrimental impact on health and wellbeing.

Police forces should agree with partner agencies exit and aftercare strategies for mentally vulnerable detainees on release from custody. Consideration should be given to a more formalised pre-release process to assure, as far as possible, that detainees will be safe after release from police custody.

The issue of those who complete suicide following forensic evidence being taken for historical rape cases was raised at the Operational Support Group 17/3/2014.

**Operational definition**

Numerator: number of people who complete suicide in the 28 days following release from police custody

Denominator: number of episodes where people are detained in police custody

**Suicides, including those classed as probable suicides** is defined as deaths resulting from:

- intentional self harm (codes X60–X84, Y87.0 of the International Classification of Diseases, Tenth Revision (ICD10))
- events of undetermined intent (ICD10 codes Y10-Y34, Y87.2).

‘Events of undetermined intent’ are cases where it is not clear whether the death was the result of intentional self-harm, an accident or an assault. It is thought that most of these deaths are likely to be suicides and therefore NRS combine these with the ‘intentional self-harm’ deaths to produce their statistics. As some ‘undetermined intent’ deaths will not have been suicides, including these cases may over estimate the ‘true’ ( unknowable) number (The National Records of Scotland (NRS).

**Exclusions**

Data source

- Police Scotland
- Scottish Suicide Information Database (ScotSID)
- Healthcare Improvement Scotland Suicide Review Team

*Currently would need to record link Police ISD ScotSID*

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44 Her Majesty’s Inspectorate of Constabulary for Scotland (HMICS) (2014)
45 Information Services Division (2012)
5.2 Alcohol

<table>
<thead>
<tr>
<th>Indicator</th>
<th>A1</th>
<th>Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes where people in police custody are seen by a healthcare professional and meet the following triggers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- In line with SIGN Guideline 74 <em>The management of harmful drinking and alcohol dependence in primary care</em> (^{46})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individuals where alcohol is thought to be a contributory factor in the offence and are then screened using a validated alcohol screening tool (such as AUDIT or FAST) in order to detect Alcohol Use Disorders with hazardous or harmful patterns of alcohol consumption or alcohol dependency</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note that although SIGN Guideline 74 has been withdrawn, in the absence of an updated version, the broad key principles of SIGN apply.*

<table>
<thead>
<tr>
<th>Rationale &amp; Supporting literature</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The rationale behind this indicator is to appropriately detect people in police custody who may benefit from support for their alcohol consumption – e.g.: through the delivery of an Alcohol Brief Intervention or through support from specialist alcohol treatment services. It will also provide an indication of prevalence in order to assist in the quantification of service demand.</td>
<td></td>
</tr>
</tbody>
</table>

Her Majesties Inspectorate of Constabulary for Scotland *Thematic Inspection of Police Custody Arrangements in Scotland* (2014) found that of the 310 custody records sampled, 68% of detainees declared either medical, mental health or substance misuse issues \(^{47}\).

A study of healthcare issues of detainees in police custody in London found that 25% of the custody population were dependent on alcohol \(^{48}\).

A survey in Scotland by MacAskill *et al* suggested that 73% of male prisoners have an Alcohol Use Disorders Identification Test (AUDIT) score indicating problematic alcohol use and 36% have alcohol dependence \(^{49}\).

Identifying individuals with alcohol problems is a necessary step to address the links between alcohol and offending by aiming to intervene in the often cyclical process of prison admissions where alcohol plays a major part. Effective identification is needed to signpost individuals to appropriate intervention, treatment and support options \(^{50}\). The Alcohol Use Disorders Identification Test (AUDIT) was one of three screening tools which emerged as having good reliability with adult prisoners \(^{51}\).

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\(^{46}\) Scottish Intercollegiate Guidelines Network (2004)  
\(^{47}\) Her Majesties Inspectorate of Constabulary for Scotland (2014)  
\(^{48}\) Payne-James, J., Wall, I. J., and Bailey, C., (2005)  
\(^{50}\) MacAskill, S., Parkes, T., Brooks, O., Graham, L., McAuley, A. and Brown, A., (2011)  
Screening and brief interventions targeted towards those in a criminal justice setting have the potential not only for health gain and reductions in reoffending and the associated economic costs but also for reducing wider societal impact of offending\(^{52}\).

Even if not directly requested, screening for risky drinking and associated interventions are acceptable to detainees\(^{53}\). Brief interventions and screening for addictive behaviours in police custody are feasible in the majority of cases.

The frequent link between addictive behaviours and the suspected crime highlights the value of such interventions, which could be incorporated into the public health mission of the physician in police custody\(^{54}\).

<table>
<thead>
<tr>
<th>Operational definition</th>
<th>Numerator: number of episodes where people are seen by a healthcare professional and meet the relevant triggers and are screened using a validated screening tool (e.g.: AUDIT or FAST)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denominator: number of episodes where people are seen by a healthcare professional and meet the relevant triggers</td>
</tr>
<tr>
<td></td>
<td>\textit{Currently engaged with specialist alcohol treatment services} is defined as: \begin{itemize} \item self reported \item identified (with consent) as being in contact with alcohol services through existing local systems \end{itemize}</td>
</tr>
</tbody>
</table>

| Exclusions | Individuals not seen by a healthcare professional  |
|            | Individuals currently engaged with specialist alcohol treatment services |

| Data source |

\(^{53}\) Newbury-Birch D., Coulton S., Bland M. \textit{et al.} (2014)  
**Indicator A2**

**Management**

% of episodes where people identified as having an Alcohol Use Disorder with hazardous or harmful patterns of alcohol consumption receive an Alcohol Brief Intervention (ABI) in line with SIGN Guideline 74

*Note that although SIGN Guideline 74 has been withdrawn, in the absence of an updated version, the broad key principles of SIGN apply.*

**Rationale / supporting literature**

The rationale behind this indicator is to ensure that appropriate people receive a short, evidence-based, structured conversation about alcohol consumption that seeks, in a non-confrontational way, to motivate and support the individual to think about and/or plan a change in their drinking behaviour, in order to reduce their consumption and/or their risk of harm.

This is an NHS Board Local Delivery Plan (LDP) standard, with NHS Boards expected to deliver 20% of ABIs in 'wider settings' which includes police custody. ABI delivery for people in police custody should be reported to local Alcohol and Drug Partnerships in line with the National Guidance. NHS Boards and the Scottish Government monitor NHS Boards performance against the national LDP standards and progress is published on the Scottish Government Scotland Performs website and in the Information Services Division ABI Annual Report.\(^{55}\)


Alcohol Brief Interventions (ABI) are practices that aim to indentify a real or potential alcohol problem and provide motivation an individual to do something about it.

The National Institute for Health and Care Excellence advocates the use of ABIs in the criminal justice system.\(^{56}\) There is a strong evidence base for ABIs to reduce problematic alcohol use in a variety of health and non health settings opportunistically.\(^{57}\)

Evaluation of the delivery of ABIs has been reported in the (non-prison) custody setting. One study reported no difference in alcohol use or offending, but did find a reduction in injury and an increase in readiness to change drinking behaviour at three months. Another found a decrease in both offending and drinking, again at three months follow up.\(^{58}\)

Reducing alcohol problems in offenders by ABI screening and delivery also has the potential for wider outcomes in hard to reach populations. The delivery of ABIs in a criminal justice setting have been found to reduce offending behaviour and criminal recidivism (indicated by convictions) by 50%.\(^{59}\)

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\(^{55}\) Scottish Government (2015a)

\(^{56}\) National Institute for Health and Care Excellence (2010)


\(^{59}\) Newbury-Birch D., Coulton S., Bland M. *et al.* (2014)
Quality and Outcomes Framework
National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care

| Operational definition | Numerator: number of episodes where people identified as having an Alcohol Use Disorder with hazardous or harmful patterns of alcohol consumption receive an Alcohol Brief Intervention in line with SIGN guideline 74

Denominator: number of episodes where people are identified as having an Alcohol Use Disorder with hazardous or harmful patterns of alcohol consumption

*Alcohol Use Disorder with hazardous and harmful patterns of alcohol consumption* is defined as FAST +ve (score of 3 or more) or an AUDIT score between 8-19

*A brief intervention* is defined in 'Sign Guideline 74 as:
- Feedback: about personal risk or impairment
- Responsibility: emphasis on personal responsibility for change
- Advice: to cut down or abstain if indicated because of severe dependence or harm
- Menu: of alternative options for changing drinking pattern and, jointly with the patient, setting a target. Intermediate goals of reduction can be a start
- Empathic interviewing: listening reflectively without cajoling or confronting; exploring with patients the reasons for change as they see their situation
- Self efficacy: an interviewing style which enhances peoples' belief in their ability to change.

| Exclusions | Individuals who are alcohol dependent
Individuals who have had an ABI within previous 12 months
Individuals who are incapacitated either through alcohol or other conditions
Individuals who are engaged with specialist alcohol treatment services

| Data source | ABI can be recorded on Adastra

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60 Babor, T., Higgins-Biddle, J. C., Saunders, J. B., Monteiro, M. B., (2001)
<table>
<thead>
<tr>
<th>Indicator A3</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes where people identified through the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar) as being at risk of alcohol withdrawal are managed according to local guidelines</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale &amp; supporting literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rationale behind this indicator is to help ensure that people are managed effectively whilst in police custody and do not come to avoidable harm.</td>
</tr>
</tbody>
</table>

The CIWA scale has well documented reliability, reproducibility and validity, based on comparison to ratings by expert clinicians. From 30 signs and symptoms, the scale has been carefully refined to a list of 10 signs and symptoms in the CIWA-Ar. It is thus easy to use and has been shown to be feasible to use in a variety of clinical settings\(^\text{61}\). |

The overriding principle of care for offenders who are substance misusers, including alcohol, and who are in custody must be their safety and the treatment of suffering that occurs as a result of substance intoxication or withdrawal\(^\text{62}\). |

Alcohol withdrawal complicates other presenting symptoms and signs and carries a significant morbidity and mortality if untreated\(^\text{63}\). |

Detainees should be assessed for signs of intoxication and/or withdrawal and prompt attention paid to any acute medical needs\(^\text{64}\). |

<table>
<thead>
<tr>
<th>Operational definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: number of episodes where people identified through the CIWA-Ar as at risk of alcohol withdrawal are managed according to local guidelines</td>
</tr>
<tr>
<td>Denominator: number of episodes of people identified through the CIWA-Ar as at risk of alcohol withdrawal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIWA-Ar is in Adastra</td>
</tr>
<tr>
<td>Local audit</td>
</tr>
</tbody>
</table>

---

\(^{61}\) Clinical Institute Withdrawal Assessment of Alcohol Scale

\(^{62}\) Report of a Medical Working Group (2011)

\(^{63}\) Report of a Medical Working Group (2011)

\(^{64}\) Report of a Medical Working Group (2011)
<table>
<thead>
<tr>
<th>Indicator A4</th>
<th>Identification</th>
<th>% of episodes where people identified as having an Alcohol Use Disorder are currently engaged with specialist alcohol treatment services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale &amp; supporting literature</td>
<td>The rationale behind this indicator is to identify people who are not already in contact with alcohol specialist services in order to ensure they are signposted or referred to appropriate treatment or support services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Her Majesties Inspectorate of Constabulary for Scotland Thematic Inspection of Police Custody Arrangements in Scotland (2014) noted that “With the increasing vulnerability of detainees n police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. A detainee will often present with complex and multiple needs and already be known to a number of agencies. Local community planning partners will have community safety and health and social care partnerships set up to address many of these needs, but may not necessarily focus on police custody as a referral or delivery point for these services. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely.”</td>
<td></td>
</tr>
<tr>
<td>Operational Definition</td>
<td>Numerator: number of episodes where people identified as having an Alcohol Use Disorder are currently engaged with specialist alcohol treatment services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denominator: number of episodes where people are identified as having an Alcohol Use Disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol use disorder is defined as FAST +ve (score of 3 or more) or an AUDIT score of 8 or over</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Currently engaged with specialist alcohol treatment services is defined as:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• self reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• identified (with consent) as being in contact with alcohol services through existing local systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist alcohol treatment services are defined as Tier 3 and 4 services.</td>
<td></td>
</tr>
<tr>
<td>Exclusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source</td>
<td>Adastra</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In the future DAISy will be in operation</td>
<td></td>
</tr>
</tbody>
</table>

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65 Her Majesties Inspectorate of Constabulary for Scotland (2014)
66 Babor, T., Higgins-Biddle, J. C., Saunders, J. B., Monteiro, M. B., 2001
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>A5</td>
<td>% of episodes where people identified as having an Alcohol Use Disorder of alcohol dependency are referred to specialist alcohol treatment services</td>
</tr>
</tbody>
</table>

### Rationale & supporting literature

The rationale behind this indicator is to ensure that people are provided with an opportunity to engage with appropriate support services if desired.

SIGN Guideline 74 – *The Management of Harmful Drinking and Alcohol Dependency in Primary Care* found that specialist treatments for alcohol problems are effective. A health technology assessment from NHS Quality Improvement Scotland concluded that specialist services are effective for relapse prevention if offering behavioural self control training, motivational enhancement therapy, family therapy/community reinforcement approach and/or coping/communication skills training. *Note that although SIGN Guideline 74 has been withdrawn, in the absence of an updated version, the broad key principles of SIGN apply.*

One of the recommendations in *Changing Scotland’s Relationship with Alcohol: A Framework for Action (2009)* is to “work with partners to encourage the development of integrated care pathways for offenders and information sharing to ensure they receive continuity of alcohol support and treatment both in custody and in the community”.

With the increasing vulnerability of detainees in police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. A detainee will often present with complex and multiple needs and already be known to a number of agencies. Local community planning partners will have community safety and health and social care partnerships set up to address many of these needs, but may not necessarily focus on police custody as a referral or delivery point for these services. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely. At best, there is a coherent model of provision, with formalised referral and liaison (e.g. Tayside).

In light of the well-established links between chaotic and or chronic substance/alcohol misuse and multiple re-offending the notion of integrating NHS care with custody brings with it certain prima facie advantages. A more direct form of integration between custody healthcare and the local NHS board also brings the potential for joined-up access to critical service areas, such as mental health and substance misuse services.

Results from a study by Needham et al note that assigning male offenders to 1 of 3 possible programmes - Alcohol Specified Activity Requirement (ASAR), Addressing Substance-Related Offending (ASREO) and Low Intensity Alcohol Programme (LIAP) - was associated with a significant reduction in the likelihood of being charged or reconvicted.

Scottish Government’s NHS Scotland Local Delivery Plan Standards 2015-16 has as a standard that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%). Services

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68 The Scottish Government (2009)
69 Her Majesties Inspectorate of Constabulary for Scotland (2014)
for people are recovery focused, good quality and can be accessed when and where they are needed. A focus group undertaken by the Revolving Doors Agency in England with people who had been in police custody found that participants would like the community services to be described to them and made aware of what these can provide so that they can give informed consent to the healthcare professionals in the police station to contact the services on their behalf.

A focus group undertaken by the Revolving Doors Agency in England with people who had been in police custody found that participants would like the community services to be described to them and made aware of what these can provide so that they can give informed consent to the healthcare professionals in the police station to contact the services on their behalf.

**Operational definition**

| Numerator: number of episodes where people identified as having an Alcohol Use Disorder of alcohol dependency are referred to specialist alcohol treatment services |
| Denominator: number of episodes where people are identified as having an Alcohol Use Disorder of alcohol dependency |
| *Alcohol use disorder of alcohol dependency* is defined as FAST +ve (score of 3 or more) or an AUDIT score of 19 or over.
| *Specialist alcohol treatment* services are defined as Tier 3 and 4 services. |

**Exclusions**

Individuals already in contact with specialist alcohol treatment services

Individuals who are signposted to services rather than referred directly – see A6

**Data source**

Adastra Drug and Alcohol Waiting Times Database

*In the future DAISy will be in operation*

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72 Scottish Government (2015c)

73 Revolving Doors Agency (2013)

74 Babor, T., Higgins-Biddle, J., C., Saunders, J., B., Monteiro, M. B., 2001
Indicator A6
Referral
% of episodes where people identified as having an Alcohol Use Disorder of alcohol dependency are signposted to specialist alcohol treatment services

Rationale & supporting literature
The rationale behind this indicator is to ensure that people are provided with an opportunity to engage with appropriate support services if desired.

SIGN Guideline 74 – The Management of Harmful Drinking and Alcohol Dependency in Primary Care found that specialist treatments for alcohol problems are effective. A health technology assessment from NHS Quality Improvement Scotland concluded that specialist services are effective for relapse prevention if offering behavioural self control training, motivational enhancement therapy, family therapy/community reinforcement approach and/or coping/communication skills training\(^75\). Please note that although SIGN Guideline 74 has been withdrawn, in the absence of an updated version the broad key principles of SIGN apply.

One of the recommendations in Changing Scotland’s Relationship with Alcohol: A Framework for Action (2009)\(^76\) is to “Work with partners to encourage the development of integrated care pathways for offenders and information sharing to ensure they receive continuity of alcohol support and treatment both in custody and in the community”.

With the increasing vulnerability of detainees in police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. A detainee will often present with complex and multiple needs and already be known to a number of agencies. Local community planning partners will have community safety and health and social care partnerships set up to address many of these needs, but may not necessarily focus on police custody as a referral or delivery point for these services. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely. At best, there is a coherent model of provision, with formalised referral and liaison (e.g. Tayside)\(^77\).

In light of the well-established links between chaotic and or chronic substance/alcohol misuse and multiple re-offending the notion of integrating NHS care with custody brings with it certain prima facie advantages. A more direct form of integration between custody healthcare and the local NHS board also brings the potential for joined-up access to critical service areas, such as mental health and substance misuse services\(^78\).

Results from a study by Needham et al note that assigning male offenders to 1 of 3 possible programmes - Alcohol Specified Activity Requirement (ASAR), Addressing Substance-Related Offending (ASREO) and Low Intensity Alcohol Programme (LIAP) - was associated with a significant reduction in the likelihood of being charged or reconvicted\(^79\).
The Scottish Government’s NHS Scotland Local Delivery Plan Standards 2015-16 has as a standard that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%). Services for people are recovery focused, good quality and can be accessed when and where they are needed.\textsuperscript{80}

A focus group undertaken by the Revolving Doors Agency in England with people who had been in police custody found that participants would like the community services to be described to them and made aware of what these can provide so that they can give informed consent to the healthcare professionals in the police station to contact the services on their behalf.\textsuperscript{81}

This indicator is different from A5 in that some services choose not to proactively refer directly, rather they signpost, as an individual taking the initial step to self refer is seen to be an important part of the recovery journey.

<table>
<thead>
<tr>
<th>Operational definition</th>
<th>Numerator: number of episodes where people identified as having an Alcohol Use Disorder of alcohol dependency are signposted to specialist alcohol treatment services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator: number of episodes where people are identified as having an Alcohol Use Disorder of alcohol dependency</td>
<td></td>
</tr>
</tbody>
</table>

\textit{Alcohol use disorder of alcohol dependency} is defined as FAST +ve (score of 3 or more) or an AUDIT score of 19 or over\textsuperscript{82}

\textit{Specialist alcohol treatment services} are defined as Tier 3 and 4 services.

<table>
<thead>
<tr>
<th>Exclusions</th>
<th>Individuals who are already in contact with specialist alcohol treatment services Individuals who are actively referred to services – see A5</th>
</tr>
</thead>
</table>

\textit{Currently engaged with specialist alcohol treatment services} is defined as:
- self reported
- identified (with consent) as being in contact with alcohol services through existing local systems

<table>
<thead>
<tr>
<th>Data source</th>
<th>Adastra Drug and Alcohol waiting times database \textit{In the future DAISy will be in operation}</th>
</tr>
</thead>
</table>

\textsuperscript{80} Scottish Government (2015c)  
\textsuperscript{81} Revolving Doors Agency (2013)  
\textsuperscript{82} Babor, T., Higgins-Biddle, J., C., Saunders, J., B., Monteiro, M., B., (2001)
<table>
<thead>
<tr>
<th>Indicator A7</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes where people referred to specialist alcohol treatment services take up the referral</td>
<td></td>
</tr>
</tbody>
</table>

**Rationale & supporting literature**

*The rationale behind this indicator is to ascertain to what extent people are taking up referral opportunities / entering into treatment. This will assist services in determining potential enablers / barriers to attendance.*

This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.

Supporting literature as per A5.

**Operational definition**

| Numerator: number episodes where people referred to specialist alcohol treatment services take up the referral |
| Denominator: number episodes where people are referred to specialist alcohol treatment services |

*Specialist alcohol treatment services* are defined as Tier 3 and 4 services

*Take up referral* is defined as an individual having completed wait for services

**Exclusions**

Individuals who are currently engaged with specialist alcohol treatment services

*Currently engaged with specialist alcohol treatment services* is defined as:

- self reported
- identified (with consent) as being in contact with alcohol services through existing local systems

**Data source**

Measure referrals within Adastra

Drug and Alcohol Waiting Times Database

*DAISy will be used in the future*

Uptake measure requires liaison with NHS / Third sector services

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83 Information Services Division (2015c)
<table>
<thead>
<tr>
<th>Indicator A8</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes where people detained for an alcohol related offence are identified as having previously attended police custody for an alcohol related offence in the past 12 months</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale / supporting literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rationale behind this indicator is to understand the number of people who frequently attend police custody for a specific offence.</td>
</tr>
<tr>
<td>This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.</td>
</tr>
<tr>
<td>The proportion of young Scottish offenders who believed that alcohol had contributed to their offending increased from 48% in 1979 to 80% in 2007.</td>
</tr>
<tr>
<td>In 2007-08 there were 5,502 charges made by Scottish police forces to individuals who were “drunk and incapable”. This is equivalent to approximately 106 charges per week. The cost of holding these individuals in police cells is estimated to be around £2.12million per year across Scotland.</td>
</tr>
<tr>
<td>In 59% of violent crime the victim said the offender was under the influence of alcohol. Overall costs of alcohol misuse in Scotland are estimated to be £3.5bn with alcohol related crime accounting for over £700m.</td>
</tr>
<tr>
<td>Data for Scotland from 2007 indicated that the estimated cost associated with alcohol-specific offences (‘drunkenness’ and ‘drink driving’) was £8.2 million. It was estimated that there were 303,668 incidents of alcohol-related crime (all other crimes and offences that result as a consequence of alcohol misuse, police recorded and unrecorded). The estimated cost in anticipation of alcohol-related crime was between £14.1 million and £28.5 million. The estimated cost as a consequence of alcohol-specific crime was between £354.0 million and £757.7 million. The estimated cost to the Criminal Justice System in response to alcohol specific crime is between £86.2 million and £197.3 million. The overall estimate for the cost of alcohol-specific offences and alcohol specific crimes and offences is between £462.5 million and £991.7 million.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operational definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: number of episodes where people detained for an alcohol related offence are identified as having previously attended police custody for an alcohol related offence in the past 12 months</td>
</tr>
<tr>
<td>Denominator: number of episodes where people are detained in police custody for an alcohol related offence</td>
</tr>
<tr>
<td>Alcohol related offence is defined as:</td>
</tr>
<tr>
<td>- an alcohol specific offence e.g.: drunk and incapable or drink driving or</td>
</tr>
<tr>
<td>- where alcohol is a contributory factor in the offence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Scotland</td>
</tr>
</tbody>
</table>

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86 Scottish Government (2014a)
87 Health Scotland (2015)
88 York Health Economics Consortium (2010)
### 5.3 Drugs

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>% of episodes where people seen by a healthcare professional report problematic drug use, including use of new psychoactive substances</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale &amp; supporting literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rationale behind this indicator is to detect people appropriately in police custody in order to identify clinical risk, as well as those who may benefit from support for their drug use e.g. through support from specialist drug treatment services. It will also provide an indication of prevalence in order to assist in the quantification of service demand.</td>
</tr>
</tbody>
</table>

A study of patterns of illicit drug use of people in police custody in London in 2010 found that 34% of detainees were dependent on heroin, 34% on crack cocaine and 17% on benzodiazepines.\(^{89}\)

The Scottish Crime and Justice Survey 20012/13 reported that in 29% of violent crime the victims perceived offenders to be under the influence of drugs.\(^{90}\) 31% of those who died of a drug related incident had been in police custody at some point in the six months prior to death. 51% of those who died of a drug related death had been in prison at some point in their lives.\(^{91}\)

Her Majesties Inspectorate of Constabulary for Scotland *Thematic Inspection of Police Custody Arrangements in Scotland (2014)* found that of the 310 custody records sampled, 68% of detainees declared either medical, mental health or substance misuse issues.\(^{92}\)

<table>
<thead>
<tr>
<th>Operational definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: number of episodes where people seen by a healthcare professional report problematic drug use, including use of new psychoactive substances</td>
</tr>
<tr>
<td>Denominator: number of episodes where people are seen by a healthcare professional</td>
</tr>
</tbody>
</table>

**Problem drug use** can be defined as:
- ‘injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines’. This definition specifically includes regular or long-term use of prescribed opioids such as methadone but does not include their rare or irregular use nor the use of ecstasy or cannabis (The European Monitoring Centre for Drug and Drug Misuse\(^{93}\)).
- the problematic use of opiates (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use (Information Services Division).\(^{94}\)

**New Psychoactive Substances** can be defined as:
- ‘psychoactive drugs which are not prohibited by the United Nations Single Convention on Narcotic Drugs or by the Misuse of Drugs Act 1971, and which people are seeking for intoxicant use’ (Advisory Council of the Misuse of Drugs\(^{95}\)).

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\(^{89}\) Payne-James, J. J., Wall, I. J., and Bailey, C., (2005)  
\(^{90}\) Scottish Government (2014a)  
\(^{92}\) Her Majesties Inspectorate of Constabulary for Scotland (2014)  
\(^{93}\) European Monitoring Centre for Drug and Drug Misuse (2015)  
\(^{94}\) Information Services Division (2014)  
\(^{95}\) Advisory Council of the Misuse of Drugs (2015)
- “any substance which is capable of producing a psychoactive effect in a person who consumes it, and is not an exempted substance (i.e. alcohol, tobacco, medicines and controlled drugs, caffeine and foodstuffs such as nutmeg and chocolate). A substance produces a psychoactive effect in a person if, by stimulating or depressing the person’s central nervous system, it affects the person’s mental functioning or emotional state” (The Psychoactive Substances Bill – UK Parliament)96.

Report defined as one of the following criteria:
- self reported
- where the use of controlled substances is thought to be a contributory factor in the individual’s offence
- individuals who screen positive for drugs through locally agreed protocols

Where possible, data should be broken down by illegal drugs, illicit prescription drugs and New Psychoactive Substances

<table>
<thead>
<tr>
<th>Exclusions</th>
<th>Those who are not seen by a healthcare professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data source</td>
<td>Adastra</td>
</tr>
</tbody>
</table>

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96 UK Parliament (2014)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2</td>
<td>% of episodes where people identified through the Clinical Opiate Withdrawal Scale (COWS) as being at risk of drug withdrawal are managed according to local guidelines</td>
</tr>
</tbody>
</table>

**Rationale & Supporting Literature**

*The rationale behind this indicator is to help ensure that people are managed effectively whilst in police custody and do not come to avoidable harm.*

The overriding principle of care for offenders who are substance misusers and who are in custody must be their safety and the treatment of suffering that occurs as a result of substance intoxication or withdrawal. Detainees should be assessed for signs of intoxication and/or withdrawal and prompt attention paid to any acute medical needs. It should be remembered that the onset of signs of overdose with certain substances (for example, methadone or other substances swallowed immediately before arrest in order to escape detection) may not be immediately obvious and may occur later.

**Definition**

* Numerator: % of episodes where people identified through the Clinical Opiate Withdrawal Scale (COWS) as being at risk of drug withdrawal are managed according to local guidelines
* Denominator: % of episodes where people are identified through the Clinical Opiate Withdrawal Scale (COWS) as being at risk of drug withdrawal

**Exclusions**

**Data source**

Local audit

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97 Report of a Medical Working Group (2011)
98 Report of a Medical Working Group (2011)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3</td>
<td>% of episodes where people who receive an opiate substitution therapy (OST) in the community have their prescription continued while in police custody</td>
</tr>
</tbody>
</table>

**Rationale & Supporting Literature**

The rationale behind this indicator is to help ensure that people are managed effectively whilst in police custody and do not come to avoidable harm.

Patients who are on opiate maintenance therapy prior to admission to prison should have their medication continued inside prison. However there are many barriers to such continuity of care. The most significant barrier is that many patients have their maintenance therapy interrupted if they spend time in police custody prior to prison. This can result in significant loss of opiate tolerance. Wherever possible users should have their opiate maintenance therapy continued at their prescribed dose whilst held in police custody.\(^9\)

Substitution maintenance therapy is one of the most effective treatment options for opioid dependence. It can decrease the high cost of opioid dependence to individuals, their families and society at large by reducing heroin use, associated deaths, HIV risk behaviours and criminal activity. Substitution maintenance therapy is a critical component of community-based approaches in the management of opioid dependence. Provision of substitution maintenance therapy – guided by research evidence and supported by adequate evaluation, training and accreditation – should be considered as an important treatment option in communities with a high prevalence of opioid dependence.\(^1\)

The overriding principle of care for offenders who are substance misusers and who are in custody must be their safety and the treatment of suffering that occurs as a result of substance intoxication or withdrawal.\(^2\)

To the greatest extent possible, arrangements to continue methadone should be made for people upon entering institutions (such as police detention, arrest house, hospital or prison) or returning from them to the community.\(^3\)

Some detainees may be part of an existing substitution treatment programme at the time of their arrest and substitution treatment should be continued if, in the doctor’s judgement, it is safe to do so.\(^4\)

It is particularly important to know whether the detainee is currently receiving treatment and medication as part of an opioid substitution detoxification or maintenance programme.\(^5\)

**Definition**

Numerator: number episodes where people who receive an opiate substitution therapy in the community have their prescription continued while in police custody

Denominator: number of episodes where people receive an opiate substitution therapy in the community

**Exclusions**

Individuals who are in custody for a short period of time such that OST is not required.

**Data source**

Adastra

Local audit

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\(^2\) Report of a Medical Working Group (2011)

\(^3\) Kastelic, A., Pont, J., Stöver, H., (2008)

\(^4\) British Medical Association and Faculty of Forensic and Legal Medicine (2009)

\(^5\) Report of a Medical Working Group (2011)
**Indicator D4**

% of episodes where people identified as having problematic drug use are currently engaged with specialist drug treatment services

**Rationale & Supporting Literature**

The rationale behind this indicator is to identify people who are not currently engaged with drug specialist services in order to ensure that they are signposted or referred to appropriate treatment or support services.

This indicator is not an indicator of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.

Her Majesties Inspectorate of Constabulary for Scotland *Thematic Inspection of Police Custody Arrangements in Scotland* (2014) stated that “with the increasing vulnerability of detainees in police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. A detainee will often present with complex and multiple needs and already be known to a number of agencies. Local community planning partners will have community safety and health and social care partnerships set up to address many of these needs, but may not necessarily focus on police custody as a referral or delivery point for these services. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely”.

MacAskill et al’s 2011 study identified the need for a rapid response and pathways providing links with community-based services (within a prison context) for people with problematic drug use.

**Operational Definition**

Numerator: number of episodes where people identified as having problematic drug use are currently engaged with specialist drug treatment specialist services

Denominator: number of episodes where people are identified as having problematic drug use

For definition of *problematic drug use* see D1.

Currently engaged with specialist drug treatment services is defined as either:

- self reported
- identified (with consent) as being in contact with drug specialist services through existing local systems.

Specialist drug treatment services are defined as Tier 3 or 4.

**Exclusions**

Data source

Adastra

DAISy in the future

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105 Her Majesties Inspectorate of Constabulary for Scotland (2014)

<table>
<thead>
<tr>
<th>Indicator D5</th>
<th>Outcome</th>
<th>The rationale behind this indicator is to ensure that people are provided with an opportunity to engage with appropriate support services if desired.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale &amp; supporting literature</td>
<td>With the increasing vulnerability of detainees in police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. A detainee will often present with complex and multiple needs and already be known to a number of agencies. Local community planning partners will have community safety and health and social care partnerships set up to address many of these needs, but may not necessarily focus on police custody as a referral or delivery point for these services. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely. At best, there is a coherent model of provision, with formalised referral and liaison (e.g. Tayside)\textsuperscript{107}.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In light of the well-established links between chaotic and or chronic substance/alcohol misuse and multiple re-offending the notion of integrating NHS care with custody brings with it certain prima facie advantages. A more direct form of integration between custody healthcare and the local NHS board also brings the potential for joined-up access to critical service areas, such as mental health and substance misuse services\textsuperscript{108}.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Scottish Government’s NHS Local Delivery Plan Standards 2015-16 has a standard that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%). Services for people are recovery focused, good quality and can be accessed when and where they are needed\textsuperscript{109}.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A focus group undertaken by the Revolving Doors Agency in England with people who had been in police custody found that participants would like the community services to be described to them and made aware of what these can provide so that they can give informed consent to the healthcare professionals in the police station to contact the services on their behalf\textsuperscript{110}.</td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>Numerator: number of episodes where people identified as having problematic drug use are referred to specialist drug treatment services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denominator: number of episodes where people are identified as having problematic drug use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For definition of \textit{problematic drug use} see D1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>\textit{Specialist drug treatment services} are defined as Tier 3 or 4.</td>
<td></td>
</tr>
<tr>
<td>Exclusions</td>
<td>Individuals who are already in contact with drug specialist services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individuals who are signposted to services rather than actively referred directly - see D6.</td>
<td></td>
</tr>
<tr>
<td>Data source</td>
<td>Adastra</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DAISy in the future</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{107} Her Majesties Inspectorate of Constabulary for Scotland (2014)  
\textsuperscript{109} Scottish Government (2015b)  
\textsuperscript{110} Revolving Doors Agency (2013)
**Indicator D6**

**Outcome**

% of episodes where people identified as having problematic drug use are signposted to specialist drug treatment services

**Rationale & supporting literature**

The rationale behind this indicator is to ensure that people are provided with an opportunity to engage with appropriate support services if desired.

With the increasing vulnerability of detainees in police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. A detainee will often present with complex and multiple needs and already be known to a number of agencies. Local community planning partners will have community safety and health and social care partnerships set up to address many of these needs, but may not necessarily focus on police custody as a referral or delivery point for these services. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely. At best, there is a coherent model of provision, with formalised referral and liaison (e.g. Tayside)\(^{111}\).

In light of the well-established links between chaotic and or chronic substance/alcohol misuse and multiple re-offending the notion of integrating NHS care with custody brings with it certain prima facie advantages. A more direct form of integration between custody healthcare and the local NHS Board also brings the potential for joined-up access to critical service areas, such as mental health and substance misuse services\(^{112}\).

The Scottish Government's NHS Local Delivery Plan Standards 2015-16 has a standard that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%). Services for people are recovery focused, good quality and can be accessed when and where they are needed\(^{113}\).

A focus group undertaken by the Revolving Doors Agency in England with people who had been in police custody found that participants would like the community services to be described to them and made aware of what these can provide so that they can give informed consent to the healthcare professionals in the police station to contact the services on their behalf\(^{114}\).

This indicator is different from D5 in that some services choose not to actively refer but rather signpost. This is because taking the initial step to self refer is often seen to be an important part of the recovery journey.

**Definition**

Numerator: number of episodes where people identified as having problematic drug use are signposted to specialist drug treatment services

Denominator: number of episodes where people are identified as having problematic drug use

*Problematic drug use* is defined in section D1.

*Specialist drug treatment services* are defined as Tier 3 or 4.

**Exclusions**

Individuals who are already in contact with specialist drug treatment services

Individuals who are referred to services - see D5.

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\(^{111}\) Her Majesties Inspectorate of Constabulary for Scotland (2014)


\(^{113}\) Scottish Government (2015b)

\(^{114}\) Revolving Doors Agency (2013)
| **Data source** | Adastra  
*DAISy in the future* |
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7</td>
<td>% of episodes where people referred to specialist drug treatment services take up the referral</td>
</tr>
</tbody>
</table>

**Rationale & supporting literature**

The rationale behind this indicator is to ascertain to what extent people are taking up referral opportunities / entering into treatment. This will assist services in determining potential enablers / barriers to attendance.

This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.

Treatment offers the best alternative for interrupting the drug use/criminal justice cycle for offenders with drug problems. Untreated substance using offenders are more likely to relapse into drug use and criminal behavior, jeopardizing public health and safety and taxing criminal justice system resources. Additionally, treatment consistently has been shown to reduce the costs associated with lost productivity, crime, and incarceration caused by drug use\(^{115}\).

As per indicator D5.

**Operational definition**

Numerator: number of episodes where people referred to specialist drug treatment services take up the referral

Numerator: number of episodes where people are referred to specialist drug treatment services

*Problematic drug use* is defined in D1.

*Specialist drug treatment services* are defined as Tier 3 or 4.

*Take up referral* is defined as an individual having completed a wait for services\(^{116}\).

**Exclusions**

Individuals currently engaged in specialist drug treatment services

*Currently engaged with specialist drug treatment services* is defined as:
- self reported
- identified (with consent) as being in contact with drug services through existing local systems

**Data source**

Measure referrals within Adastra

Uptake measure requires liaison with NHS / Third sector services

Drug and Alcohol Waiting Times Database

Scottish Drug Misuse Database

DAISy in the future

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\(^{115}\) National Institute on Drug Abuse (2012)

\(^{116}\) Information Services Division (2015c)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8</td>
<td>% of episodes where people detained for a drug related offence are identified as having previously attended police custody for a drug related offence in the past 12 months</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale / supporting literature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The rationale behind this indicator is that by being engaged in treatment, people are less likely to have problem drug use and engage in criminal activity.</strong></td>
</tr>
</tbody>
</table>

This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.

Treatment offers the best alternative for interrupting the drug use/criminal justice cycle for offenders with drug problems. Untreated substance using offenders are more likely to relapse into drug use and criminal behavior, jeopardizing public health and safety and taxing criminal justice system resources. Additionally, treatment consistently has been shown to reduce the costs associated with lost productivity, crime, and incarceration caused by drug use\(^\text{117}\).

In 59% of violent crime the victim said the offender was under the influence of drugs in 29% of violent crimes\(^\text{118}\).

<table>
<thead>
<tr>
<th>Operational definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> number of episodes where people detained for a drug related offence are identified as having previously attended police custody for a drug related offence in the past 12 months</td>
</tr>
</tbody>
</table>

**Denominator:** number of episodes where people are detained in police custody for a drug related offence

*Drug related offence* is defined as a drug specific offence e.g.: driving under the influence of drugs or where drugs are a contributory factor in the offence.

<table>
<thead>
<tr>
<th>Exclusions</th>
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</thead>
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<table>
<thead>
<tr>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Scotland</td>
</tr>
</tbody>
</table>

\(^\text{117}\) National Institute on Drug Abuse (2012)  
\(^\text{118}\) Scottish Government (2014a)
<table>
<thead>
<tr>
<th>Indicator D9</th>
<th>Outcome</th>
<th>% of new patients at specialist drug treatment services who report funding their drug use through crime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale &amp; Supporting literature</td>
<td>The rationale behind this indicator is that by individuals engaging in treatment they are less likely to have problem drug use and engage in criminal activity. This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details. Treatment offers the best alternative for interrupting the drug use/criminal justice cycle for offenders with drug problems. Untreated substance using offenders are more likely to relapse into drug use and criminal behavior, jeopardizing public health and safety and taxing criminal justice system resources. Additionally, treatment consistently has been shown to reduce the costs associated with lost productivity, crime, and incarceration caused by drug use. On average, in Scotland, a smaller percentage of new patients at specialist drug treatment services reported that they were funding their drug use through crime in 2011/12 (21%) than in the first year of recording (2006/07), when the percentage was 26%. A study by Bennett and Sibbitt showed that among a group of arrestees in the UK there was a subgroup of 9% of people with problematic drug use (most using heroin and crack) who were responsible for committing 52% of all offences reported by the full group of arrestees. Many admitted committing at least 20 offences a month over the year.</td>
<td></td>
</tr>
<tr>
<td>Operational definition</td>
<td>Numerator: number of new patients entering specialist drug treatment services who report funding their drug use through crime Denominator: number of new patients entering specialist drug treatment services</td>
<td></td>
</tr>
<tr>
<td>Exclusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source</td>
<td>Scottish Drug Misuse Database DAISY in the future This measure is currently reported on annually nationally by the Public Health Information for Scotland – Scottish Public Health Observatory, through the Scottish Drug Misuse Database.</td>
<td></td>
</tr>
</tbody>
</table>

119 National Institute on Drug Abuse. (2012)  
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>D10</td>
<td>% of people who die of a drug related death who have been detained in police custody in the preceding 14 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rationale &amp; Supporting literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rationale behind this indicator is that there is potentially a decreased tolerance from drugs following incarceration which may increase the risk of a fatal overdose. And also to help ensure that detention in police custody does not have a significantly detrimental impact on health and wellbeing.</td>
</tr>
</tbody>
</table>

The National Drug Related Death Database Report for Scotland for deaths occurring in 2013 reported that 7/10 individuals who died of a drug related death had recent experience of drug treatment, hospital, prison or police custody. Evidence on increased overdose risk after release from custody or following treatment suggests that it is vitally important that services work together to promote retention in treatment, continuity of care and awareness of overdose risk.\(^{121}\)

In 2013, around one third of the cohort of deaths from the National Drug Related Death Database (96, 31%) had been in police custody at some point in the six months prior to death. Forty two individuals were reported to have been in police custody in the four weeks prior to death, while 69 were reported to have been in police custody in the twelve weeks prior to death. Given the amount of missing data, 2013 figures are likely to underestimate the actual level of police custody contact among the cohort. Around half of the cohort (213, 51%) had been in prison at some point in their lives prior to death. Over one in ten (55, 13%) had spent time in prison in the six months prior to death, as in 2012 (59, 13%)\(^{122}\).

The 14 day timeframe is based on unpublished data collected as part of the National Drug Related Death Database.

<table>
<thead>
<tr>
<th>Operational definition</th>
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<tbody>
<tr>
<td>Numerator: number of people who die of a drug related death who have been detained in police custody in the preceding 14 days</td>
</tr>
<tr>
<td>Denominator: number of people who die of a drug related death</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
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</thead>
<tbody>
<tr>
<td>Individuals who died of other causes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Drug Related Death Database</td>
</tr>
</tbody>
</table>

\(^{122}\) Data is incomplete
6.4 Mental Health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH1</td>
<td>% of episodes where people are detained in police custody premises as a ‘Place of Safety’ as defined by section 297 of the Mental Health Care and Treatment (Scotland) Act</td>
</tr>
</tbody>
</table>

Rationale & supporting literature

The rationale behind this indicator is to help ensure that people are treated in the most appropriate location.

This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.

Her Majesty’s Inspectorate of Constabulary for Scotland *Thematic Inspection of Police Custody Arrangements in Scotland (2014)* states that ‘we are pleased to note that generally custody staff understand the inappropriateness of using police custody as a ‘place of safety’ under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This practice is almost universally discouraged, with police being encouraged to take people whom they believe to be in need of a mental health ‘place of safety’ to more appropriate local health care facilities. The use of police custody under section 297 is not appropriate and partners should support Police Scotland in this regard'.

With one or two exceptions, there was little evidence of police stations being used as the ‘first point of call’ place of safety under section 297. The exceptions cited were as a result of a lack of co-operation from local mental health services and reluctance by local hospitals to accept people brought in under section 297.

Support in Mind’s qualitative report on people’s experience of police custody suites as places of safety, highlights that the majority of people with mental health disorders do not think that police cells are an appropriate place for people who have not committed a crime and who are in distress. They felt that it criminalised people with mental health disorders for being unwell and that they were stigmatised as a result. Support in Mind advocated that community, NHS or voluntary sector premises with greater support services would be more appropriate.

The Mental Welfare Commission (MWC) has a role in monitoring the Mental Health (Care & Treatment) (Scotland) Act 2003 and the welfare parts of the Adults with Incapacity (Scotland) Act 2000. If the monitoring work carried out by MWC shows up a serious problem they might follow this up through a visit or an investigation. The MWC also analyses the information to create a picture of how these laws work regionally and nationally.

Although covering England and Wales, The House of Commons Home Affairs Committee took evidence from a range of professionals who advocated that police cells were not appropriate places for people in mental distress and recommended that in England and Wales, the option of using police cells as ‘places of safety’ be removed from the Mental Health Act.

Operational Definition

Numerator: number of episodes where people are detained in police custody premises as a ‘Place of Safety’ as defined by section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003

Denominator: number of episodes where people are detained in a ‘Place of Safety’ as defined by section 297 Mental Health (Care and Treatment) (Scotland) Act 2003

---

123 Her Majesty’s (HM) Inspectorate of Probation, HM Constabulary, HM Crown Prosecution Inspectorate and the Care Quality Commission (2014)
126 House of Commons Home Affairs Committee (2015)
The Mental Health (Care and Treatment) (Scotland) Act 2014 defines “place of safety” as:

(a) a hospital;
(b) premises which are used for the purpose of providing a care home service (as defined in section 2(3) of the Regulation of Care (Scotland) Act 2001) or
(c) any other suitable place (other than a police station) the occupier of which is willing temporarily to receive mentally disordered persons.

If no place of safety is immediately available, a constable may, under subsection (1) or (3) above, remove a relevant person to a police station; and in any such case, any reference in this section and in section 298 of this Act to a place of safety shall be construed as being a reference to a police station.\(^{127}\)

<table>
<thead>
<tr>
<th>Exclusion</th>
<th>Individuals who are detained under different sections of the Mental Health Care and Treatment (Scotland) Act 2003</th>
</tr>
</thead>
</table>
| Data source | Police Scotland                                         
               Mental Welfare Commission – PSO1 data                                                               |

\(^{127}\) Scottish Government (2003)
<table>
<thead>
<tr>
<th><strong>Indicator</strong></th>
<th><strong>MH2</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Identification</strong></td>
<td>% of episodes where people, after coming into police custody, are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Rationale &amp; supporting literature</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This indicator will provide an indication of prevalence in order to assist in the quantification of service demand and to ensure people receive the most appropriate treatment and support.</td>
</tr>
</tbody>
</table>

A study undertaken by Payne-James et al in a custody suite in London found that 24% detainees had previous significant mental health or psychiatric conditions and 7.1% had previously been sectioned under the Mental Health Act 1983\(^\text{128}\). |

A study from England and Wales found that approximately 20% of detainees seen by healthcare teams suffered from psychiatric conditions and approximately 20% of Forensic Physician assessed patients had mental health concerns or suffered from depression\(^\text{129}\). |

Her Majesties Inspectorate of Constabulary for Scotland *Thematic Inspection of Police Custody Arrangements in Scotland* (2014) found that of the 310 custody records sampled, 68% of detainees declared either medical, mental health or substance misuse issues\(^\text{130}\). |

People with mental ill-health are disproportionately found within the criminal justice system and imprisonment can lead to an acute worsening of mental health problems\(^\text{130}\). |

This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details. |

<table>
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</thead>
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<td><strong>Numerator:</strong> number of episodes where people, after coming into police custody, are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003</td>
</tr>
<tr>
<td><strong>Denominator:</strong> number of episodes where people are detained in police custody</td>
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<table>
<thead>
<tr>
<th><strong>Exclusions</strong></th>
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</thead>
<tbody>
<tr>
<td>Individuals detained under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Data source</strong></th>
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</thead>
<tbody>
<tr>
<td>Police Scotland</td>
</tr>
</tbody>
</table>

\(^\text{130}\) Gormley, C., (2013)
<table>
<thead>
<tr>
<th>Indicator MH3</th>
<th>Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of episodes where people identified as having a mental health disorder are currently engaged with specialist mental health services</td>
<td></td>
</tr>
</tbody>
</table>

**Rationale & Supporting Literature**

The rationale behind this indicator is to identify people who are not currently engaged with specialist mental health services in order to ensure they are signposted or referred to appropriate treatment or support services.

This indicator is not an indication of the quality of care within the healthcare and forensic medical service. See section 4.5 for further details.

Although within a prison context, MacAskill et al’s 2011 study identified the need for rapid response and pathways providing links with community-based services.\(^{131}\)

Her Majesties Inspectorate of Constabulary for Scotland *Thematic Inspection of Police Custody Arrangements in Scotland (2014)* noted that "with the increasing vulnerability of detainees in police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. A detainee will often present with complex and multiple needs and already be known to a number of agencies. Local community planning partners will have community safety and health and social care partnerships set up to address many of these needs, but may not necessarily focus on police custody as a referral or delivery point for these services. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely.\(^{132}\)"

**Operational Definition**

**Numerator:** number of episodes where people identified as having a mental health disorder are currently engaged with specialist mental health services

**Denominator:** number of episodes where people are identified as having a mental health disorder

- *Currently engaged with specialist mental health services* is defined as either:
  - self reported
  - identified (with consent) as being in contact with specialist mental health services through existing local systems

- *Mental health disorder* is defined as per the Mental Health (Care and Treatment) (Scotland) Act 2003 and includes mental illness, personality disorder and learning disability.\(^{133}\)

**Exclusions**

**Data source**

\(^{131}\) MacAskill, S., Parkes, T., Brooks, O., Graham, L., McAuley, A. and Brown, A., (2011)

\(^{132}\) Her Majesties Inspectorate of Constabulary for Scotland (2014)

\(^{133}\) Scottish Government (2003)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH 4</td>
<td>% of episodes where people identified as having a mental health disorder are referred to specialist mental health services</td>
</tr>
</tbody>
</table>

### Rationale & supporting literature

The rationale behind this indicator is to ensure that people are provided with an opportunity to engage with appropriate support services if desired.

A more direct form of integration between custody healthcare and the local NHS board also brings the potential for joined-up access to critical service areas, such as mental health. The ultimate, overarching aim of bringing healthcare closer to those in need who might otherwise overlook or avoid contact with NHS services is to improve health and assist in reducing crime and re-offending rates.\(^{134}\).

A study from England and Wales found 25% of people in police custody were already in contact with other healthcare teams.\(^{135}\)

With the increasing vulnerability of detainees in police custody, there is a statutory duty as well as an obvious opportunity for Police Scotland and their partners in the public and voluntary sectors to work together to tackle what can be a hard to reach group. Across the country, arrangements for liaison between health care practitioners, mental health services and substance misuse services vary widely.\(^{136}\) HMICS (2014) noted that guidance published by the Association of Chief Police Officers (ACPO) stated that police forces should agree with partner agencies exit and aftercare strategies for mentally vulnerable detainees on release from custody.

A focus group undertaken by the Revolving Doors Agency in England with people who had been in police custody found that participants would like the community services to be described to them and made aware of what these can provide so that they can give informed consent to the healthcare professionals in the police station to contact the services on their behalf.\(^{137}\)

Contact with the police presents an early opportunity, through intervention and liaison, to engage appropriate services and potentially avoid future offending by those with learning disability.\(^{138}\)

### Operational Definition

Numerator: number of episodes where people identified as having a mental health disorder are referred to specialist mental health services

Denominator: number of episodes where people are identified as having a mental health disorder

*Mental health disorder* is defined as per the Mental Health (Care and Treatment) (Scotland) Act 2003 and includes mental illness, personality disorder and learning disability.\(^{139}\)

### Exclusions

Individuals already in contact with mental health services.

### Data source


\(^{135}\) Payne and James 2010

\(^{136}\) Her Majesties Inspectorate of Constabulary for Scotland (2014)

\(^{137}\) Revolving Doors Agency (2013)

\(^{138}\) Her Majesty’s Inspectorate of Probation, HM Constabulary, HM Crown Prosecution Inspectorate and the Care Quality Commission (2014)

\(^{139}\) Scottish Government (2003)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH5</td>
<td>% of episodes where people referred to specialist mental health services take up the referral</td>
</tr>
</tbody>
</table>

**Rationale & supporting literature**

The rationale behind this indicator is to ascertain to what extent people are taking up referral opportunities / entering into treatment. This will assist services in determining potential enablers / barriers to attendance. As MH4.

**Operational definition**

- Numerator: number of episodes where people referred to specialist mental health services take up the referral
- Denominator: number of episodes where people are referred to specialist mental health services

Take up referral is defined as an individual having completed a wait for services\(^\text{140}\)

**Exclusions**

Data source

Uptake measure requires liaison with NHS / Third sector services

Local measurement

\(^{140}\) Information Services Division (2015c)
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH6</td>
<td>% of episodes where people identified as having a mental health disorder are detained in police custody and are identified as having previously attended police custody in the past 12 months</td>
</tr>
</tbody>
</table>

**Rationale & supporting literature**

_The rationale behind this indicator is that by being engaged in treatment people are less likely to engage behaviour that may lead to them being in custody._

As per MH3 and MH4.

**Operational definition**

- **Numerator**: number of episodes where people identified as having a mental disorder are detained in police custody and are identified as having previously attended police custody in the past 12 months
- **Denominator**: number of episodes where people detained in police custody are identified as having a mental disorder

*Mental health disorder* is defined as per the Mental Health (Care and Treatment) (Scotland) Act 2003 and includes mental illness, personality disorder and learning disability

**Exclusions**

**Data source** Police Scotland

---

Appendices

Appendix A - Quality Improvement and Outcome Sub Group

**Chair:** Dr Lesley Graham, Public Health Lead for Drugs, Alcohol Health & Justice Information Services Division (ISD), National Services Scotland (NSS)

Mr Jonathan Cameron, Head of Projects and Programmes, Information Technology, NSS
Miss Hannah Cornish, Programme Manager, National Services Division (NSD), NSS
Dr Emma Fletcher, Specialty Registrar in Public Health, ISD, NSS
Mr David Harley, Planning & Performance Manager – Mental Health Services, NHS Greater Glasgow and Clyde
Inspector Graham Milne, North Region Healthcare, Police Scotland
Mr Barry Muirhead, Senior Charge Nurse, Forensic Medical Service, NHS Lothian
Mrs Pauline Mullen, Programme Support Officer, NSD, NSS
Mrs Sally Patrick, Head of Nursing, Urgent Care/Forensic Medical Service, NHS Tayside
Dr Alex Stirling, Consultant in Public Health Medicine, ISD, NSS
Mrs Jessica Davidson, Senior Clinical Forensic Charge Nurse, NHS Lothian
Mr Neil Mellon, Primary Care Manager, NHS Ayrshire & Arran
Ms Elaine Parry, Principle Analyst, ISD, NSS
Ms Fiona Webster, Principal Information Development Manager, ISD, NSS
Appendix B – Consultation List

- Alcohol & Drug Partnerships
- Crown Office & Procurator Fiscal Service
- Faculty of Forensic Legal Medicine
- Forensic Executive for the Royal College of Psychiatrist in Scotland
- Forensic Mental Health Network
- Healthcare Improvement Scotland
  - Standards & Indicators Team
  - Scottish Patient Safety Programme
- Health Scotland
- Her Majesty’s Inspectorate of Constabulary for Scotland
- Mental Welfare Commission
- National Co-ordinating Network for Healthcare & Forensic Medical Services for People in Police Care
  - Mental Health Short Life Working Group
  - Quality & Outcome Information Short Life Working Group
  - Substance Misuse Short Life Working Group
  - Medicines Management Group
- NHS Boards (Territorial):
  - Alcohol and Drug Services / Addictions Leads
  - Arrest Referral Services
  - Directors of Finance
  - Directors of Planning
  - Directors of Public Health
  - Mental Health Services
  - NHS Board Leads for Healthcare & Forensic Medical Services
- NHS National Services Scotland
  - Public Health & Intelligence
  - National Services Division
- Police Scotland
- Scottish Ambulance Service
- Scottish Government
  - Alcohol Policy Unit, including the Alcohol Waiting Times Team and the Alcohol, Tobacco & Diet Team
  - Drugs Policy Unit
  - Mental Health Division
  - Primary Care Division
  - Criminal Justice Outcome Indicator Performance Team
- Scottish Prisoner Healthcare Network
- Scottish Prison Service
Appendix C – Patient Pathways

Detainee in Police Custody Healthcare Interface Pathway

Entry into Police Custody

Risk assessment question set

Need for healthcare professional

yes → Refer to Healthcare & Forensic Medical Service

no → Review of previous convictions in particular drug offences / previous violent crime

Concerns regarding substance misuse / previous history of drug offences / violent crime

yes → Strip search – looking for concealed drugs / weapons

no → Placed into cell, Belts, shoe laces removed from person

Forensic Medical input required immediately? E.g.: drink driving test

yes → Contact Healthcare & Forensic Medical Service

no → Process subsequently

Detained. Further information gathered. Detainee consults with solicitor. Interviewed with solicitor present

Sufficient evidence

yes → charged

Kept in custody until next lawful day

Sherriff

Released pending outcome of PF Review

kept in custody

Prison pending outcome of PF Review

Police cell in care of G4S pending prison availability

Detainee may be transferred to another police custody suite during course of detention, although Police try and avoid this if the offender has considerable healthcare needs.

If a detainee is moved he / she is moved as part of the same ongoing process and is not reclerked.
Detainee may be transferred to another police custody suite during course of detention, although Police try and avoid this if the offender has considerable healthcare needs.

If a detainee is moved he / she is moved as part of the same ongoing process and is not reclerked.

Healthcare in Police Custody Pathway

Entry into Police Custody

Risk assessment question set

Previous Police awareness of substance misuse / mental health concerns / previous history of drug offences / violent crime

Healthcare concerns

self refer

Forensic Medical input required immediately? E.g.: drink driving test

Referral to Healthcare & Forensic Medical Service

Healthcare assessment

Immediate healthcare needs addressed

Forensic medical capture (if required)

Referral to specialist clinical service e.g Forensic Psychiatry (if required)

Health improvement activity (if appropriate)

Referral / Signpost to support organisations (if appropriate)

NHS share Summary Care Plan with Police
### Appendix D – Topic Specific Logic Models

#### Alcohol

<table>
<thead>
<tr>
<th>Situation</th>
<th>Priorities</th>
<th>Inputs</th>
<th>Activities</th>
<th>Participants</th>
<th>Short time / Most attributable</th>
<th>Medium</th>
<th>Long time / least attributable</th>
</tr>
</thead>
<tbody>
<tr>
<td>High levels of health morbidity within population alcohol use disorders</td>
<td>Identification, clinical management and appropriate referral for people requiring healthcare in police custody</td>
<td>Workforce • Police Scotland • NHS Scotland • Scottish Government Information Technology Models of Care &amp; Integrated Care Pathways Time to develop partnership working Education, Training and Development Money Accommodation Equipment</td>
<td>Police Scotland Risk Assessment Question Set for use by Custody Staff Healthcare professional healthcare assessment Alcohol Screening: FAST / AUDIT Delivery of Alcohol Brief Interventions (ABIs) Management of alcohol withdrawal Deliver appropriate treatment Appropriate referral to specialist alcohol services Develop and deliver training packages for staff Data recording &amp; sharing</td>
<td>People in police care - people with alcohol use disorders Healthcare staff who work with people in police care Police Custody staff Staff working in specialist services – NHS and Third sector Staff working in community setting – Local Authority, NHS and Third Sector Staff working in Criminal Justice, Crown Office &amp; Procurator Fiscal Court service Offender transport service Scottish Prison Service</td>
<td>Decrease in individual alcohol consumption Decrease in alcohol related morbidity and mortality People treated in appropriate setting Increase in integrated care Person centred support Decrease numbers of drunk and incapable returns to custody Decrease in number of people in Police custody at A&amp;E Increase number of referrals to specialist alcohol services Increase in uptake of alcohol specialist care Skilled, competent workforce Increase information to develop needs assessment and inform service planning</td>
<td>Increase in number of people in a sustained recovery Decrease in alcohol related (re)offending Decrease in people with alcohol use disorders in police custody Decrease in resources spent on alcohol related crime Increase in equity of service provision for people with alcohol use disorders in police custody Increase in employment for people who have been in police custody</td>
<td>Fewer alcohol related health inequalities Increased health and wellbeing Increased social capital Increase in social inclusion Safer communities Decrease cost of crime to society</td>
</tr>
</tbody>
</table>
## Drugs

<table>
<thead>
<tr>
<th>Situation</th>
<th>Priorities</th>
<th>Inputs</th>
<th>Activities</th>
<th>Participants</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
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<td>High levels of health morbidity within population - drug problems</td>
<td>Identification, clinical management and appropriate referral for people requiring healthcare in police custody</td>
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<td>Police Scotland Risk Assessment Question Set for use by Custody Staff Healthcare professional healthcare assessment Drugs screening (self report / urine test) Management of drug withdrawal Deliver appropriate treatment Appropriate referral to specialist services – drugs services Develop and deliver training package for staff Data recording &amp; sharing</td>
<td>People in police care dependent on legal and illegal substances People in police care who have drugs concealed internally Healthcare staff who work with people in police care Police Custody staff Staff working in specialist services, Local Authority, NHS and Third sector Staff working in Criminal Justice, Crown Office &amp; Procurator Fiscal Court service Offender transport service Scottish Prison Service</td>
<td>Decrease in drug related morbidity and mortality Decrease in individual drug consumption People are treated in appropriate setting Increase in integrated care Person centred support Increase number of referrals to specialist substance misuse services Increase in uptake of substance misuse services Increase staff knowledge, competence and awareness Increase information to develop needs assessment and inform service planning</td>
<td>Increase in number of people in a sustained recovery Decrease in drug related crime Decrease in resources spent on drug related crime Increased equity of service provision for people with drug problems in police custody Increase in employment for people who have been in police custody Fewer drug related health inequalities Increase in health &amp; wellbeing Increased social capital Increase in social inclusion Safer communities Decrease cost of crime to society</td>
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<tr>
<td>High levels of co-morbidities</td>
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<td>Below average engagement with NHS services</td>
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<tr>
<td>Inequalities in service delivery across Scotland</td>
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<tr>
<td>High levels of drug related crime</td>
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### Mental Health

<table>
<thead>
<tr>
<th>Situation</th>
<th>Priorities</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Participants</th>
<th>Short time / Most attributable</th>
<th>Outcomes</th>
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<td>High levels of health morbidity within population - mental health disorders&lt;br&gt;High levels of co-morbidities&lt;br&gt;Below average engagement with NHS services&lt;br&gt;There are inequalities in service delivery across Scotland</td>
<td>Identification, clinical management and appropriate referral for people requiring healthcare in police custody</td>
<td>Workforce&lt;br&gt;• Police Scotland&lt;br&gt;• NHS Scotland&lt;br&gt;• Scottish Government&lt;br&gt;• Local Authority staff&lt;br&gt;Information Technology&lt;br&gt;Models of Care &amp; Integrated Care Pathways&lt;br&gt;Time to develop partnership working&lt;br&gt;Education, Training and Development&lt;br&gt;Money&lt;br&gt;Accommodation&lt;br&gt;Equipment</td>
<td>Police Scotland Risk Assessment Question Set for use by Custody Staff&lt;br&gt;Mental Health Screening&lt;br&gt;Appropriate referral to specialist mental health services&lt;br&gt;Deliver appropriate treatment&lt;br&gt;Develop and deliver training package&lt;br&gt;Data recording &amp; sharing&lt;br&gt;Advocacy</td>
<td>People in police care with mental health disorders&lt;br&gt;Healthcare staff who work with people in police care&lt;br&gt;Police Custody staff&lt;br&gt;Staff working in specialist services – NHS and Third sector&lt;br&gt;Staff working in community setting – Local Authority, NHS and Third sector</td>
<td>Decrease in suicides post release&lt;br&gt;People are treated in appropriate setting – e.g.: appropriate locations for places of safety&lt;br&gt;Increase in integrated care&lt;br&gt;Person centred support&lt;br&gt;Increase number of referrals to specialist mental health services&lt;br&gt;Increase in uptake of specialist mental health services&lt;br&gt;Increase staff knowledge, competence and awareness&lt;br&gt;Increase information to develop needs assessment and inform service planning&lt;br&gt;Increase use of diversion schemes&lt;br&gt;Increase use of community triage schemes</td>
<td>Decrease in mental health disorders&lt;br&gt;Increase in number of people in a sustained recovery&lt;br&gt;Decrease in the people with mental health disorders in police custody&lt;br&gt;Increase in employment for people who have been in police custody&lt;br&gt;Increase equity of service provision for people with mental health disorders in police custody</td>
<td>Fewer health related health inequalities&lt;br&gt;Increase in health and wellbeing&lt;br&gt;Increase in social capital&lt;br&gt;Increase in social inclusion&lt;br&gt;Safer communities</td>
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