Delivering Quality Alcohol, Drugs and Tobacco Healthcare Services to People in Police Custody in Scotland

Guidance for Police Scotland and Healthcare Professionals

Substance Misuse Group
National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care
Delivering Quality Alcohol, Drugs and Tobacco Healthcare Services to People in Police Custody in Scotland - *Guidance for Police Scotland and Healthcare Professionals*

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1. Introduction

1.1 Background

This Delivering Quality Alcohol, Drugs and Tobacco Healthcare Services to People in Police Custody in Scotland - Guidance for Police Scotland and Healthcare Professionals has been developed by the Substance Misuse Group of the National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (Police Care Network). It sets out an evidence informed model of care for people with alcohol, drug and tobacco problems who come into police custody in Scotland.

The model of care, as outlined in section 4, has been developed using the best available evidence and expert clinical views. It outlines best practice for the identification and management of individuals, as well as advising on harm reduction and health improvement interventions and links to ongoing support in the community. The model of care is designed with particular attention to the unique police custody environment. It is intended for people in police custody and not for victims of crime who may also be seen by healthcare and forensic medical services.

Responsibility for the delivery of healthcare to people in police custody sits with NHS Boards. 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. This guidance can be used by all healthcare professionals working in police custody regardless of the model of service delivery. Whilst the service delivery models may vary, people in police custody should receive the same quality of service regardless of where they are in Scotland.

This guidance can be used by NHS Boards and Police Scotland to inform the way in which services are delivered and structured locally. It in no way constrains NHS, Police Scotland or associated partnerships should they wish to enhance the model with innovative elements of service delivery. The guidance is intended to supplement but does not replace existing national guidance such as that from the Scottish Intercollegiate Guideline Network (SIGN) or National Institute of Clinical Excellence (NICE).

The Police Care Network has been established to support networking across geographical, multi-agency and professional boundaries in support of local partnerships to ensure equity, mutual support and service co-ordination across the different agencies and professional groups involved. It has a role in developing guidance to support and improve service delivery, establishing data collection and quality improvement mechanisms and supporting the workforce through training and education. More information and resources can be found on the website - www.policecare.scot.nhs.uk. Where possible, for all resources referenced or referred to within this document, a hyperlink to the document is provided.
1.2 Measuring and Improving Quality

This Guidance can be used in conjunction with the Police Care Network’s Quality Improvement and Outcome Framework. The Framework contains a suite of evidence informed indicators that can assess outcomes of healthcare delivery within police custody healthcare services and support service planning and quality improvement. Eight of the indicators within the Framework cover alcohol service delivery and ten cover drug service delivery. The indicators can help NHS Boards, Police Scotland and wider partners understand what impact the services are having for individuals and how they are contributing to common outcomes (short, medium and longer term) as identified in the logic models in the Framework (Graham, Cornish, Fletcher 2015).

1.3 Education and Training

Education and training for healthcare professionals working in police custody in relation to substance misuse should be in line with NHS Board requirements. NHS Education Scotland (NES), in partnership with NHS, Police Scotland and COPFS, has undertaken work to support the educational needs of the workforce providing the service. NES’s Career and Development Framework for Forensic and Custody Healthcare Nursing describes the leadership of all aspects of care within a bio-psychosocial model which includes complex emotional and physical conditions. Further details on courses and resources can be found on the Supporting Health Care in Police Custody and Prison Portal and in Delivering Quality Alcohol, Drugs and Tobacco Healthcare Services to People in Police Custody in Scotland – Making it Happen (Police Care Network 2017).
2. Development of the Guidance

This Guidance has been developed by the Substance Misuse Group of the Police Care Network. It has been developed by experts working in the field for use by healthcare professionals and Police Scotland working within a police custody environment. The Guidance has been informed by seven key components:

- A Literature Review of peer reviewed journal articles relating to the evidence of substance misuse in police custody along with relevant guidelines, policy and strategy documents. These provided information on the epidemiology of alcohol and drug problems of those in police custody and an evidence base for the clinical management of individuals in police custody (Fletcher, Cornish, Graham, 2015a).

- A Service Mapping exercise was undertaken with NHS healthcare professionals working in police custody to determine the current service provision for people with substance misuse or mental health problems who come into police custody in Scotland. The mapping was used by the Group to inform recommendations for improvements to service provision (Fletcher, Cornish, Graham, 2015b).

- A service mapping exercise was undertaken with Police Scotland Custody Division staff to seek their views on the provision of mental health and substance healthcare within police custody. This was used by the Group to inform recommendations for improvements to the provision of healthcare delivered to people in custody.

- The Quality Improvement and Outcomes Framework was published by the Network in 2015. It provides logic models and evidence informed indicators for outcomes for healthcare delivery, including substance misuse services, in police custody. The evidence base and expert input into the development of the Framework was used by the Group to inform best practice for service delivery (Graham, Cornish, Fletcher, 2015).

- Expert views from members of the Substance Misuse Group. Membership of the Group can be found in Appendix A.

- Expert views from the wider Network and associated stakeholders. The Guidance was issued for consultation with a wide range of stakeholders. All comments were considered and changes made as appropriate.

- The National Guidance for the Delivery of Police Custody Healthcare and Forensic Medical Services was initially developed by the Network to inform service delivery prior to transfer of responsibility to the NHS (Police Care Network 2015a).

During the development of this Guidance a number of operational and strategic recommendations were considered and these are contained in a separate document Delivering Quality Alcohol, Drugs and Tobacco Services to People in Police Custody in Scotland – Making it Happen for consideration at local, regional and national level (Police Care Network 2017).
3. People in Police Custody - Health Needs Relating to Alcohol, Drugs and Tobacco

There is little literature available on the prevalence of health conditions among the police custody population in Scotland, therefore UK and international studies have been drawn from to provide a picture of the healthcare needs of this patient group. Population health varies between the countries for which data was available therefore this does not necessarily provide a truly accurate picture for Scotland.

The Scottish Health Survey reports that 2% of the Scottish population drink at harmful levels, with 1% having possible alcohol dependency\(^1\) (Scottish Government 2016a). Published journal articles have found that between 18% and 34% of people in police custody have hazardous alcohol intake or are alcohol dependent\(^2\) (Gahide et al. 2012; McKinnon and Grubin 2013).

According to the Scottish Health Survey, 21% of the Scottish population smoke, whereas up to 66% of people in police custody report being dependent on tobacco (Scottish Government 2016a). The Scottish Crime and Justice Survey 2014/15 found that 6% of adults (9% of men) reported taking one or more illicit drugs in the last year (Scottish Government 2016b). Up to two thirds of people in police custody are dependent on heroin, cocaine or cannabis, with people frequently using multiple substances (Payne-James et al. 2010; Ogloff et al. 2011; McKinnon and Grubin 2013; Chariot 2014).

In Scotland, approximately 1% of people are estimated to be infected with the Hepatitis C virus and most people acquired their infection through drug injecting practices (Taylor et al. 2012). People in police custody are known to present with increased prevalence of injecting drug use. In one UK study, of those people in police custody who reported drug dependency, 56% reported injecting drug use and 25% reported sharing needles. 6% knew they were Hepatitis B positive, 20% knew they were Hepatitis C positive and 4% were HIV positive (Payne-James et al. 2005). In a Scottish study, the Hepatitis C virus was identified in 19% of people in prison, ranging from 1% to 34% across prisons (Taylor et al. 2012).

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\(^1\) Using Alcohol Use Disorder Identification Test (AUDIT) scores.
\(^2\) Although there was significant variation between studies as to how this was identified.
4. Model of Care

This section sets out an evidence informed model of care for people with alcohol, drug and tobacco problems who come into police custody in Scotland. It outlines best practice for the identification and management of individuals, as well as advising on harm reduction and health improvement interventions and links with ongoing support in the community.

4.1 Police Scotland Criminal Justice Services Division - Identifying People in Need of Healthcare and Forensic Medical Services

4.1.1 Police Pathway

The pathway below provides a high level overview of a person's journey, from coming into a police custody suite, to release or their continued journey through the justice system.

[Diagram of the police pathway]

*People in police custody may be transferred to another police custody suite during course of detention, although Police try to avoid this if the person in custody has considerable healthcare needs. If a person in police custody is moved he/she is moved as part of the same ongoing process and is not re-clerked.*
4.1.2 Identifying People in Need of Healthcare and Forensic Medical Services

The care and welfare of people in custody is the responsibility of Police Scotland. Diligence needs to be taken to identify people who may be in need of healthcare in order for Police Scotland to be able to carry out this duty. All people in police custody should be managed in accordance with the Police Scotland’s Care and Welfare of Persons in Police Custody Standard Operating Procedure (not publically available), which outlines processes for identifying people who require review by a healthcare professional or who should be transferred to Emergency Departments.

Police Scotland use a number of approaches to establish acute clinical and welfare risk:
- Answers to the Risk Assessment Question Set
- Previous Police awareness of substance misuse concerns
- Previous history of alcohol and drug related offences or violent crime

All people in police custody should be asked about substance misuse, including alcohol and prescription medication, in order to identify any need for early healthcare intervention. Based on the answers provided, police should refer to the Healthcare and Forensic Medical Service (Medical Working Group 2011).

People who are suspected of having concealed drugs internally should be managed according to the Management Guidelines for Persons Suspected of Having Drugs Concealed Internally, Version 2, June 2015 (Police Care Network 2015b).

People suspected of having taken new psychoactive substances should be managed according to The Standards for the pre-hospital clinical management of those suspected of being under the influence of new psychoactive substances developed by the National Prisoner Healthcare Network with input from wider partners (awaiting publication).
4.2 Healthcare Professional Healthcare Assessment

4.2.1 Healthcare and Forensic Medical Pathway

The Healthcare and Forensic Medical pathway outlines a person in police custody’s interaction with the Healthcare and Forensic Medical Service and wider NHS.

- Entry into Police Custody
- Risk Assessment Question Set undertaken
- Healthcare concerns identified?
  - yes
- Person wishes to self refer to Healthcare and Forensic Medical Service?
  - yes
- Forensic Medical input required immediately? E.g.: drink driving test
  - yes
- Previous Police awareness of substance misuse / mental health concerns / previous history of drug offences / violent crime?
  - yes
- Referral to Healthcare & Forensic Medical Service
- Healthcare assessment
- Immediate healthcare needs addressed
- Forensic medical capture (if required)
- Referral to specialist clinical service required? e.g. Forensic Psychiatry
  - Identify health improvement opportunity or other healthcare needs (if appropriate)
- NHS share Summary Care Plan with Police
  - Referral / Signpost to support organisations (if appropriate)
4.2.2 Healthcare Assessment

UK guidelines recommend that healthcare professionals should be involved in the management of people in police custody who misuse or who are dependent on substances. Substance misuse is known to be a contributory factor in a substantial proportion of deaths in police custody in UK and Europe. Early identification and management of people is key to reducing such events (Best et al. 2004; Heide et al. 2009; Medical Working Group 2011).

Accurate assessment of morbidities associated with substance misuse, including the degree and severity of dependence, is essential because both intoxication and withdrawal can put people in custody at risk of medical, psychiatric and legal complications and can affect interviewing and therefore, potentially, the judicial process.

Identifying individuals with alcohol problems is a necessary step in addressing the links between alcohol and offending behaviour. Addressing alcohol intake can potentially reduce re-offending and associated prison admissions (MacAskill et al. 2011).

Following referral from Police Scotland, a general healthcare assessment should be conducted by a healthcare professional. The healthcare assessment should take place within a designated healthcare area unless the patient is physically incapable of being brought to this location. Health Facilities Scotland have issued Guidance on police custody medical services facility design and cleaning (Health Facilities Scotland 2014).

Best practice indicates that the healthcare assessment should involve:

<table>
<thead>
<tr>
<th>A detailed alcohol and drug history, including:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of substance misused – it is important to know whether the patient misuses multiple substances, including legitimately prescribed medications, tobacco and alcohol. It is suggested that this is actively enquired about as alcohol dependency is often not recognised or reported by users of other substances.</td>
</tr>
<tr>
<td>Duration of substance misuse</td>
</tr>
<tr>
<td>Quantity taken per day, on an average / typical day and / or amount spent on substances</td>
</tr>
<tr>
<td>Frequency of use</td>
</tr>
<tr>
<td>Quantity used in the past 24-48 hours</td>
</tr>
<tr>
<td>Time of the last dose (Medical Working Group 2011; NICE 2007)</td>
</tr>
<tr>
<td>Route of administration. For those reporting an active history of intravenous drug misuse, clinical examination should include a &quot;site check&quot; to confirm the history and also look for abscesses, cellulitis, etc (Police Care Network 2015a)</td>
</tr>
<tr>
<td>Biological testing can help guide treatment (NICE 2007). A urine sample for drug screening can also be collected to support clinical findings, particularly for individuals who report non-intravenous illicit use or who are prescribed unsupervised methadone. An alcometer for non-evidential breath alcohol measurement can be a useful tool to aid diagnosis and management in those where alcohol excess is suspected as a possible cause of a decreased conscious state.</td>
</tr>
</tbody>
</table>

Checking the Emergency Care Summary for information on previous episodes of alcohol/drug intoxication, treatment or withdrawal

Checking other local patient management systems where possible
Checking temperature. If hot and sweaty it is suggestive of NPS use
Checking, where appropriate, whether the patient is on an opioid substitution therapy, usually with the Community Pharmacy or drug treatment services
Being cognisant of wider health, wellbeing and social needs
If, following a healthcare assessment, the patient is thought to have taken New Psychoactive Substances see section 4.4 or if the patient is deemed to be at risk of withdrawal, an assessment of withdrawal should be conducted - see section 4.3.1 and 4.4.2.

It is recommended that all consultations are recorded on Adastra, the national clinical IT system within police custody. The use of ‘fitness assessments’ as a reason for referral is inappropriate for addressing the healthcare needs of people in police custody. In order to accurately record activity and develop a better understanding of the clinical needs of this population group, the healthcare reasons that underpin the referral should be recorded on Adastra, with ‘fitness to be charged / detained / interviewed etc…’ noted as appropriate.
4.3 Alcohol

4.3.1 Patient Pathway - Alcohol

Entry into Police Custody

Risk assessment question set

Healthcare concerns identified

self refer

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

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

Referral to Healthcare & Forensic Medical Service

Healthcare assessment – biological testing

Drug misuse issues suspected – see section 4.4.1

Alcohol misuse issues suspected, healthcare (professional clinical judgement as to whether to do CIWA or screen or both)

No substance misuse issues identified

Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar)

Management of Withdrawal

Ongoing care as required in custody

Screening (FAST then AUDIT)

AUD with dependency 19+

AUD with hazardous and harmful patterns of alcohol consumption FAST +ve score 3+ AUDIT score between 8-19

Alcohol Brief Intervention

Check if currently engaged with specialist alcohol treatment services

Referral / Signpost / In-reach to support organisations

Key:

AUDIT Alcohol Use Disorders Identification Tool

CIWA-Ar Clinical Institute Withdrawal Assessment of Alcohol Scale

FAST Fast Alcohol Screening Test
4.3.1 Assessment of Alcohol Dependency and Acute Alcohol Withdrawal

Alcohol dependence is a cluster of behavioural, cognitive and physiological phenomena that typically include a strong desire to drink alcohol, a difficulty in controlling its use, persisting in its use despite harmful consequences, a higher priority given to taking alcohol than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state.

Acute Alcohol Withdrawal is the physical and psychological symptoms that people can experience when they suddenly reduce the amount of alcohol they drink if they have previously been drinking excessively for prolonged periods of time.

Alcohol withdrawal complicates other presenting symptoms and signs and carries a significant risk of morbidity and mortality if untreated. Alcohol-dependent people in custody may develop withdrawals as early as 6-8 hours after they have last consumed alcohol and before blood alcohol levels reach zero. Common clinical features include tachycardia, sweating, tremor and agitation. Severe alcohol withdrawal can lead to delirium tremens and seizures (NICE 2010a; Medical Working Group 2011).

As per NICE guidance, it is recommended that the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar) is used as a tool to assess withdrawal as an adjunct to clinical judgement. The CIWA-Ar, which is on Adastra, has well documented reliability, reproducibility and validity, based on comparison to ratings by expert clinicians. It is easy to use and has been shown to be feasible to use in a variety of clinical settings (Clinical Institute Withdrawal Assessment of Alcohol Scale).

4.3.2 Management of Alcohol Dependency and Acute Alcohol Withdrawal

Early intervention in acute alcohol withdrawal is crucial. If possible, intervention should be provided prior to patients exhibiting severe signs of withdrawal (based on clinical assessment and history) (Medical Working Group 2011). NHS Boards should have local protocols in place for the management of alcohol withdrawal which are suitable for use within a custody suite.

Before initiating withdrawal treatment, healthcare professionals should be satisfied that the patient is not under the influence of other substances that might significantly alter the action of the prescribed medication, thus making it unsafe. To treat symptoms of alcohol withdrawal, benzodiazepines such as chlordiazepoxide or diazepam are recommended. Local protocols should be followed for dosages (Medical Working Group 2011).

In accordance with NICE (2010a) Alcohol-use disorders: diagnosis and management of physical complications and SIGN Guideline 74 (2003) The management of harmful drinking and alcohol dependence in primary care, thiamine should be offered to people at high risk of developing or with suspected Wernicke’s encephalopathy. Prophylactic oral thiamine should be offered to harmful or dependent drinkers:

- if they are malnourished or at risk of malnourishment or
- if they have decompensated liver disease or
- if they are in acute withdrawal or
- before and during a planned medically assisted alcohol withdrawal

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3 Note that although SIGN Guideline 74 has been withdrawn, in the absence of an updated version, the broad key principles of SIGN apply.
4.3.3 Screening for Alcohol Use Disorders

Alcohol-use disorders (AUDs) cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence. For individuals who are not at immediate risk of withdrawal but who may have an AUD, screening is recommended.

Screening enables effective identification in order to signpost individuals to appropriate intervention, treatment and support options. In most cases, professional judgement and a clinical history as outlined in section 4.2 is sufficient information with which to determine the category of AUD, however best practice is to use validated screening tools to supplement this information (NICE 2010b; MacAskill et al 2011).

AUDs are defined as where an individual has hazardous, harmful or dependent drinking: NICE (2010a) provides the following definitions:

- *Hazardous drinking* is a pattern of alcohol consumption that increases someone’s risk of harm (physical health, mental health and social consequences).
- *Harmful drinking* is a pattern of alcohol consumption that is causing mental or physical damage.
- *Alcohol dependence* is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example liver disease or depression caused by drinking). Alcohol dependence is associated with increased criminal activity and an increased rate of significant mental and physical disorders.

The Fast Alcohol Screening Test (FAST) is a 4-item initial screening test taken from the Alcohol Use Disorders Identification Test (AUDIT) screening tool. It has been developed for busy clinical settings as a two-stage initial screening test.

If the individual scores 3 or more it is appropriate deliver an Alcohol Brief Intervention (ABI). If it is felt further questions are required to reach a more comprehensive result, it may be appropriate to continue with the use of the full AUDIT tool. AUDIT has been shown to be feasible to use in prisons and community justice settings. It can provide valuable information to detect and understand alcohol problems in people in police custody. AUDIT can be found in Appendix 3 (NHS Health Scotland 2015; Fletcher, Cornish, Graham 2015a).

Individuals drinking at hazardous or harmful levels can be offered an ABI (see section 4.3.4 below). Individuals identified as alcohol dependent can be signposted to / referred into specialist alcohol treatment services (see section 4.8).

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4 More than 50% of patients are identified by using just the first question (Public Health England 2016a).
5 New UK CMO Alcohol Guidelines were published in January 2016 (Public Health England 2016b).
6 AUDIT is regarded as the ‘gold standard’ screening questionnaire for detecting hazardous and harmful drinking with 92% sensitivity and 93% specificity (NICE 2010).
4.3.4 Alcohol Brief Interventions

Alcohol Brief Interventions (ABI) are practices that aim to identify a real or potential alcohol problem and provide enhanced motivation for an individual to make a change. NICE guidance advocates the use of ABIs in criminal justice settings (NICE 2010b). The ABI screening tools are internationally validated and are designed to give clinicians a consistent way to screen for alcohol problems. In the main these screening tools ask about drinking behaviours with the number of units as the first question in FAST which can quickly identify those who would benefit from an ABI.

Screening and ABIs in criminal justice settings have the potential to improve health and reduce reoffending, with associated societal and economic benefits. The frequent link between alcohol and crime, particularly violent crime highlights the value of such interventions (Coulton et al. 2012; Chariot et al. 2013; Newbury-Birch et al. 2014; Scottish Government 2015).

ABI delivery is an NHS Board Local Delivery Plan (LDP) standard, with NHS Boards able to deliver 20% of ABIs in ‘wider settings’ which includes police custody (Scottish Government 2015).

Through the use of FAST and / or AUDIT, those identified as having an AUD with hazardous and harmful patterns of alcohol consumption can receive an ABI. If this cannot be done immediately, NICE recommends an appointment should be offered as soon as possible thereafter.
NHS Health Scotland (2015) provides the following guidance in relation to the delivery of ABIs:

1. **Raise the issue** - you may raise the issue with the individual; the individual may raise the issue; or it could be in response to their presenting condition. You should seek permission from the individual to discuss their drinking further.

2. **Screen and give feedback** - give factual information on the potential effects their level of drinking may have on their health and wellbeing, this may include providing harm-reduction messages, and ask how the individual feels about this. Ask if they would like to discuss this further.

3. **Listen for readiness to change** - use open questions, reflect and summarise the discussion and, from the individual’s response to the information provided, choose a suitable approach.

4. **Choose a suitable approach** - if the patient has not thought about change at all, start with ‘Information and advice’, if you have permission to do so. If the patient is already trying to change, use one or more of the subsequent approaches:
   - **Information and advice** - on the effects of alcohol on health and wellbeing and the benefits of cutting down or abstinence.
   - **Enhance motivation** - build the patient’s motivation to change by helping them to weigh up the pros and cons of their drinking.
   - **Menu of options** - for changing drinking behaviour. Ask the patient if they can suggest ways to change their drinking pattern (e.g. lower-strength drinks, having drink-free days, taking up other activities). Try to let the individual to come up with the ideas. Perhaps lead with some or all of these questions: ‘What are some of your options?’, ‘What changes might work for you?’ and ‘Would you be interested in knowing about what some other people have found?’.
   - **Build confidence** – using a questioning style that enhances the individual’s belief in their ability to change (their self-efficacy). For example, identifying their previous successes, role models they can learn from and other people who can support them.
   - **Coping strategies** – help the individual to identify times when they might find it more difficult to stick to their plans to cut down and to come up with strategies for coping with these situations.
NHS Health Scotland provides guidance and training on ABI delivery, for further information visit their website.

Evidence suggests that ABI’s are more effective when delivered by healthcare professionals. This can be by healthcare professionals from the healthcare and forensic medical service or healthcare professionals from other services through referral to other services or through in-reach provision (Heather 2016).


If a person in custody is a dependent drinker (AUDIT score 19 or more) then he/she should be referred / signposted to specialist treatment (NICE 2010b).
4.4 Drugs

4.4.1 Drug Patient Pathway

Entry into Police Custody

Risk assessment question set

Healthcare concerns identified

sell refer

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

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

Referral to Healthcare & Forensic Medical Service

Healthcare assessment – biological testing

Forensic medical capture (if required)

Alcohol misuse issues suspected—see section 4.3.1

Drug misuse issues suspected

No substance misuse issues identified

*If currently taking Opioid Substitution Therapy liaise with Community Pharmacy

Management of withdrawal if required

Ongoing care as required in custody

Check if currently engaged with specialist drug treatment services

Referral / Signpost / In-reach to support organisations

See Appendix F 
Algorithm for collection of prescribed methadone or buprenorphine for persons in police custody
4.4.2 Assessment of Drug Withdrawal

The clinical history, as outlined in section 4.2.2 is sufficient information with which to assess whether a patient is at risk of drug withdrawal. Many patients in custody with drug problems have co-morbidities such as blood borne viruses, cardiac problems, respiratory disease and other early onset chronic illnesses. This will influence the risk of a person in custody withdrawing from opiates and should be avoided. Services may wish to using validated screening tools to supplement the clinical history. These tools are useful for indentifying potential drug withdrawal issues but are not tools for the management of withdrawal itself. It should be noted that these have not been validated for use in a police custody setting.

- The *Clinical Opiate Withdrawal Scale (COWS)* is an 11-item scale designed to be administered by a healthcare professional to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. The summed score can be used to help healthcare professionals determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids (National Institute on Drug Abuse 2003).

- The *Severity of Dependence Scale (SDS)* is a 5-item questionnaire that provides a score indicating the severity of dependence on opioids. Each of the five items is scored on a 4-point scale (0-3). The total score is obtained through the addition of the 5-item ratings. The higher the score the higher the level of dependence (World Health Organisation 2016).

- The *Drug Abuse Screening Test (DAST)* is a screening tool to quantify the extent of problem drug use. It has been used by researchers in police custody suites, although little comment has been made in the literature as to its reliability.

It is important to remember that signs of overdose may not be immediately obvious and may occur later. For example overdose from methadone or other substances swallowed immediately before arrest in order to escape detection may not be immediately obvious and may occur later (Medical Working Group 2011).

4.4.3 Management of Drug Withdrawal

As with all healthcare provision in police custody, early intervention is key. If possible, interventions should be provided prior to patient’s exhibiting signs of severe withdrawal (based on clinical assessment and history). Withdrawal can put a person in custody at risk of medical, psychiatric and even legal complications (Medical Working Group 2011). NHS Boards should have local protocols in place for the management of drug withdrawal which are suitable for use within a custody suite.

Multiple substance misuse is common in people in police custody (Payne-James et al. 2005). Before initiating withdrawal treatment, healthcare professionals should be satisfied that the patient is not under the influence of other substances such as alcohol that might significantly alter the action of the prescribed medication, thus making it unsafe. Local protocols should be followed for dosages (Medical Working Group 2011).
People will react differently to different drugs, and indications of withdrawal will vary as outlined below.

**The Drug Wheel**

The Drug Wheel is a new model for substance awareness, which covers traditional drug categories and reflects new drug trends such as emergence of New Psychoactive Substances (NPS). Classifying drugs in this way allows for advice and harm reduction information to be given by category, meaning that healthcare professionals do not need to know in-depth details of all the drugs currently on the market. A larger version is included in Appendix E and can also be found on the Drugs Wheel website (The Drugs Wheel 2016).

![The Drugs Wheel](image-url)
Benzodiazepines
The acute cessation of benzodiazepines can lead to a clinical picture of withdrawals similar to that seen with alcohol. The development of withdrawal symptoms is slower than that seen with alcohol, typically developing within two days. The risk of withdrawal seizures within police custody is low.

Psychostimulants
Withdrawal from psychostimulant drugs such as cocaine, ecstasy and amphetamine does not produce major physical withdrawals. Psychological dependency is common in habitual users, with insomnia and depression being precipitated on withdrawal.

Hallucinogens
Hallucinogenic drugs such as LSD have a relatively quick onset of symptoms (10-60 minutes) with recovery seen usually within twelve hours. No physical withdrawal syndrome is typical although anxiety may be precipitated.

Volatile substances
Solvent abuse leads to intoxication that can develop within one minute and persist for up to 45 minutes. Presentation can be similar to alcohol intoxication although perceptual disturbances and hallucinations are more common. There is no physical withdrawal syndrome and no specific management is required.

Cannabis
Withdrawal from cannabis may precipitate mild symptoms including insomnia, agitation and irritability. No specific treatment is required.

New Psychoactive Substances
New Psychoactive Substances are an emerging issue of concern to Police Scotland and to the NHS. There are challenges in responding to the emergence of NPS due to the limited available evidence. There are indications that NPS can cause a range of physical and psychological symptoms ranging from cardiovascular problems and seizures to psychological disorders such as anxiety, agitation, memory loss, depression and psychosis.

The health risks vary depending on the manner and method of NPS consumer. The National Prisioner Healthcare Network has developed Standards for the Pre-Hospital Clinical Management of those suspected of being under the influence of New Psychoactive substances in a secure mental health setting, Police custody and Prisons (National Prisoner Healthcare Network awaiting publication).

The Psychoactive Substances Act 2016 came in to effect on 26 May 2016. The Act makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises and import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect.

Opioids and Opioid Substitution Therapy
Many people in custody will use multiple opioids with differing half-lives resulting in a variation as to when withdrawal symptoms will develop. Opioid withdrawal can arise from both illicit and prescribed opioids. Typically withdrawals from heroin will commence approximately eight hours after last use. Clinical features include tachycardia, rhinorrhoea, pupillary dilation, sweating and gooseflesh.

Opioid withdrawals are influenced by psychological factors and subjectively people in custody may complain of numerous symptoms including tremors, nausea, feeling “hot and cold”, myalgia, anxiety and agitation. Greater weight should be given to objective clinical findings when assessing for opioid withdrawal.
4.4.4 Opioid Substitution Therapy (OST)

“Not continuing a legal prescription of methadone is interfering in an unacceptable way with an individual’s medical treatment” (Stark and Gregory 2005 pg.119). When people are detained in police custody there is a risk that continuity of medication and healthcare support can be disrupted. As long as it is safe and appropriate to do so, people in custody should have prescribed medication continued, this includes opiate substitution therapy such as methadone. This is of particular importance to pregnant women for whom there could be potential complications to their foetus in the event of sudden cessation of opioid use (Medical Working Group 2011).

Consideration should be given to treating opioid withdrawal symptoms with opioid agonist medication (NICE 2007). Opioid detoxification should not be routinely offered to people in police custody.

Patients in receipt of a prescription for methadone or buprenorphine can have the prescription confirmed by telephone contact with the dispensing pharmacists. A sample algorithm for prescribed methadone or buprenorphine and an authorisation form for collecting patient’s own methadone / buprenorphine from community pharmacy can be found in Appendix F.

Some NHS Boards stock methadone in police custody suites which can be dispensed and administered once an individual’s prescription is confirmed. Where this is not the case, Police officers should, if possible, collect this medication from the community pharmacy. Healthcare professional can administer the OST on a supervised basis following clinical assessment, if deemed appropriate.

4.4.5 Administration of Naloxone in an Emergency Situation

Naloxone is an opioid antagonist; a drug which can temporarily reverse the effects of a potentially fatal overdose with opioid drugs such as heroin or morphine. Intramuscular injection of naloxone provides more time for emergency services to arrive and treatment to be given. Good practice is that it should be available for use by healthcare professionals and staff should be familiar with its administration.

4.4.6 Naloxone Take Home Kits

Following suitable training, ‘take home’ naloxone kits can be issued to people at risk of opiate overdose in order to prevent overdose deaths.

Whilst it is recognised that naloxone alone is not the solution to drug related deaths, it has been identified as an important intervention which can help reduce harm and support individuals towards recovery. Data from ISD’s National Drug-Related Deaths Database (Scotland) Report: Analysis of Deaths occurring in 2014 demonstrates that, where known, 26% (128) had been in police custody in the six months prior to death7. In 2014, 41 individuals were reported to have been in police custody in the four weeks prior to death and 71 in the twelve weeks prior to death (ISD 2016).

7 Police custody contact data was missing for 15% (86) of the cohort.
Should services wish to provide take home naloxone kits to people in police custody who are identified as at risk of opioid overdose, partnership working between NHS staff and Police Scotland is crucial. Healthcare professionals can provide training to the patient and the kit can be placed in the persons belongings for when they leave custody.

More information on the Take Home Naloxone Programme can be found on the Scottish Drugs Forum website (Scottish Drugs Forum 2016). Each NHS Board also has a Naloxone Lead.

4.4.7 Blood Borne Viruses

People in police custody are known to present with increased prevalence of injecting drug use and are therefore a high risk group for blood borne viruses. Based on clinical history and assessment, patients should be asked whether they know their status and if so whether they are actively in treatment, people should be referred or signposted accordingly to appropriate services for testing or treatment. It may also be appropriate to signpost to harm reduction services, such as needle exchanges.

People who are receiving medications for Hepatitis or HIV, should, where appropriate, have their medications continued whilst in custody. This could be through the patient’s own medication supply or accessed via community pharmacy. The Emergency Care Summary and other relevant IT systems should be accessed to provide information on compliance with their medication regime prior to accessing medications. With the patient’s permission, professionals could liaise with the relevant specialist services who care for them in the community to provide details of their care whilst in custody.

4.5 Tobacco

The vast majority of smokers can refrain from smoking for a period, but it should be remembered that the effects of withdrawal from any substance, including nicotine, are likely to be exacerbated by the circumstances of enforced detention. Many of the features of nicotine withdrawal are indistinguishable from anxiety (FFLM 2014).

Smoking is not permitted in police custody. Whilst addiction to tobacco may not be the most significant healthcare need for people in police custody, there is an opportunity to provide support for this hard to reach population. Police custody therefore presents an opportunity for smoking cessation promotion by way of brief interventions, where appropriate, and signposting to local agencies.

NHS Health Scotland provides a number of resources in this area which are available on their website (Health Scotland 2014).

4.6 Ongoing Care whilst in Custody

Remaining hydrated in police custody is important, especially for people who have consumed alcohol or drugs. A person withdrawing from drugs and experiencing vomiting can lose electrolytes quickly and not cope with the imbalance. Where appropriate, increasing fluid intake should form part of the Summary Care Plan (Scottish Courts and Tribunals 2009).
4.7 Communication with Police Scotland

Healthcare professionals should provide Police custody officers with clear and detailed instructions about any clinical supervision required including the frequency of visits needed. Consideration should be given to medications, hydration, carbohydrates and the levels of observations required.

After each consultation, a Summary Care Plan generated through Adastra should be provided to Police Scotland. A copy of the Summary Care Plan is provided in Appendix G.

The Information Sharing Protocol between Police Scotland and all geographical and special NHS Boards in Scotland for the purposes of the provision of healthcare and forensic medical services for people in the care of the Police provides the framework through which to share information between healthcare professionals and police (Police Care Network 2014).

4.8 Throughcare – to Other Services and through the Justice Process

There are well-established links between chaotic and or chronic substance/alcohol misuse and multiple re-offending. More direct integration between custody healthcare and local NHS Board services brings the potential to address this behaviour through joined-up access to critical service areas, such as mental health and substance misuse services. Patients identified as requiring further support or treatment should be referred or signposted to support services or that NHS Boards work with service providers to provide in reach Arrest Referral Services (Elvins et al. 2012).

It is recognised that making appointments for this patient group is problematic as the availability of people in custody to attend pre-arranged appointments can depend on court outcomes. Furthermore, research suggests that individuals are less likely to attend appointments made for them by others, as opposed to ones they have generated themselves. It is therefore recommended that patients are referred or signposted to support services or that NHS Boards work with service providers to provide in reach services such as Arrest Referral Services.

The British Medical Association (BMA) and Faculty of Forensic and Legal Medicine (FFLM) note that, where consent is provided, it is important for healthcare professionals in police custody to share information with other NHS services and Third Sector.

4.9 Links to Scottish Prison Service

Healthcare professionals in police custody and prison are encouraged to communicate with each other, with the patient’s consent, to obtain confirmation of the patient’s medical history (BMA and FFLM 2009). Arrangements should be made to ensure that details of the healthcare delivered in police custody suites can be accessed by prison based NHS healthcare staff, for example by suitable IT linkage to inform continuity of care. As a minimum the Summary Care Plan should be transported with the individual to Court and then onto Prison.
4.10 People with Multiple Needs

4.10.1 Mental health and substance misuse

Ensuring that people in custody have a mental health assessment is important for their care as there may be depression, psychosis or other psychiatric conditions that require treatment. When undertaking an assessment for psychiatric conditions, healthcare professionals should decide whether to obtain a psychiatric opinion, and if so, when. Examination of mental state is particularly important medico-legally because if a drug, for example NPS, amphetamines, cocaine, cannabis or alcohol, gives rise to a psychotic state, this may have implications for the offence or affect fitness for interview (Medical Working Group 2011).

Co-morbidity of severe mental illness and substance misuse is common. For example a diagnosis of schizophrenia may coexist with a diagnosis of drug or alcohol dependence. Drug use can cause rapid worsening of mental state in a stable psychotic illness. Intoxication can mimic psychosis which may be triggered by stimulants. A psychotic state may arise that persists beyond the elimination of the drug. Withdrawal states such as those seen with alcohol or benzodiazepines may result in vivid hallucinations and clouding of consciousness (Scottish Executive 2003; Medical Working Group 2011).

Substance misuse may also be associated with other psychiatric conditions including affective disorders such as depression that can result in acts of self harm, suicide and aggressive behaviour. This is a particular problem following stimulant withdrawal. Drug and alcohol misuse can mask other underlying psychiatric disorders (Medical Working Group 2011).

All people in custody who have a dependency on substances will feel psychologically dependent on their drug of choice when coming into custody. Patients in police custody are not expecting a therapeutic detoxification regime, and as such prevention of withdrawal from any substance is of paramount importance.

4.10.2 Diabetes

For people with Type 1 Diabetes, Hypoglycaemia may also occur as a complication of heavy alcohol use and stimulant ingestion. Ensuring that people have adequate quantities of carbohydrates should be incorporated in the Summary Care Plan. For more information on the management of diabetes in Police custody, see section 4.6 of the National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services version 2 - June 2015 (FFLM 2012; Police Care Network 2015a).

4.10.3 Pregnant women

The potential for harm from the use or abuse of substances such as drugs, tobacco and alcohol is particularly acute during pregnancy and can have a severe and damaging impact on pregnancy and the health of the baby. Pregnant women who develop withdrawal symptoms following the cessation of alcohol consumption should be managed with the short-term use of a long-acting benzodiazepine (WHO 2014).

Abrupt withdrawal of methadone is best avoided at any point due to the possible risks to the pregnancy, such as miscarriage, fetal distress and premature labour. Buprenorphine is not licensed for use during pregnancy, but there is no evidence of adverse effects on pregnancy or neonatal outcomes.
A pregnant woman can continue with buprenorphine treatment on specialist advice, and it is recommended that the woman gives her informed and documented consent (Medical Working Group 2011; NICE 2015).

In line with NICE Guideline CG110 *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* services should check that pregnant women are engaged in antenatal services, and where appropriate, make a referral (NICE 2010c).

### 4.10.4 People under 18

Whilst young people may not present in police custody with alcohol withdrawal symptoms, NICE advises that using a validated screening questionnaire, as well as a providing an ABI for young people who are thought to be at risk from their use of alcohol is beneficial, particularly for those involved in crime or antisocial behaviour. However NICE recommends that when broaching the subject of alcohol and screening, healthcare professionals should ensure discussions are sensitive to the young people’s age and their ability to understand what is involved, their emotional maturity culture, faith and beliefs (NICE 2010a).
5. Appendixes

Appendix A - Substance Misuse Membership

Dr Duncan Stewart, Consultant Addictions Psychiatrist, NHS Lothian (Chair)
Ms Amanda Adams, Alcohol Team, Scottish Government
Ms Hannah Cornish, Programme Manager, National Services Division (NSD), NHS National Services Scotland (NSS)
Mr Phil Eaglesham, Organisational Lead for Health Equity (Community Justice), NHS Health Scotland
Superintendent Andy Edmonston, Custody Division, Police Scotland (until September 2015)
Dr Emma Fletcher, Specialty Registrar in Public Health, Information Services Division (ISD), NSS (until November 2015)
Dr Lesley Graham, Public Health Lead for Drugs, Alcohol and Health and Justice, ISD, NSS
Ms Sharin Garden, Clinical Psychologist, Grampian Forensic Mental Health Service, NHS Grampian
Ms Elaine Holbury, Healthcare Manager, HMP Grampian
Ms Elizabeth Hutchings, Specialist Pharmacist in Substance Misuse, NHS Fife
Mr Sandy Kelman, Team Leader, Aberdeen City Alcohol & Drugs Partnership, NHS Grampian
Mr Colin MacDonald, Service Manager Police Custody Health Care, NHS Greater Glasgow & Clyde
Mr Barry Muirhead, Senior Clinical Forensic Charge Nurse, Forensic Medical Examiner Service, NHS Lothian
Ms Laura McDonnell, Programme Support Officer, NSD, NSS (from February 2016)
Mrs Pauline Mullen, Programme Support Officer, NSD, NSS (until February 2016)
Mr Tim Parkinson, Professional Officer, Scottish Association of Social Workers (SASW)
Mr Grant Scott, Professional Nurse Advisor for Prison & Police Custody Healthcare, NHS Greater Glasgow & Clyde
Mrs Hilary Scott, Team Leader, ADP National Support & Drug & Alcohol Treatment Waiting Times, Drugs Policy Unit, Scottish Government
Ms Karan Simson, Team Leader, NHS Greater Glasgow & Clyde
Inspector Sandra Steward, Police Custody Healthcare, Police Scotland
Ms Susan Wynne, Service Improvement Facilitator, Scottish Ambulance Service
# Appendix B – Clinical Institute Withdrawal Assessment of Alcohol Scale

## Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

<table>
<thead>
<tr>
<th>Nausea/Vomiting</th>
<th>Tremors</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: None</td>
<td>0: No tremor</td>
</tr>
<tr>
<td>1: Mild nausea with no vomiting</td>
<td>1: Not visible, but can be felt fingertip to fingertip</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4: Intermittent nausea</td>
<td>4: Moderate, with patient’s arms extended</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>7: Constant nausea and frequent dry heaves and vomiting</td>
<td>7: Severe, even w/ arms not extended</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Activation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: No anxiety, patient at ease</td>
<td>0: Normal activity</td>
</tr>
<tr>
<td>1: Mildly anxious</td>
<td>1: Somewhat normal activity</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4: Moderately anxious or guarded, no anxiety inferred</td>
<td>4: Moderately fidgety and restless</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>7:Equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions</td>
<td>7: Paces back and forth, or constantly thrashes about</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paroxysmal Sweats</th>
<th>Orientation and cloring of sensornium - Ask: “What day is this? Where are you? Who am I?” Rate scale 0-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: No sweats</td>
<td>0: Oriented</td>
</tr>
<tr>
<td>1: Barely perceptible sweating, palms moist</td>
<td>1: Cannot do serial additions or is uncertain about date</td>
</tr>
<tr>
<td>2</td>
<td>2: Disoriented to date by no more than 2 calendar days</td>
</tr>
<tr>
<td>3</td>
<td>3: Disoriented to date by more than 2 calendar days</td>
</tr>
<tr>
<td>4: Heads of sweat obviously on forehead</td>
<td>4: Disoriented to place and/or person</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7: Drenching sweats</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tactile disturbances - Ask: “Have you experienced any itching, pins &amp; needles, sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?”</th>
<th>Auditory Disturbances - Ask: “Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn’t there?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: None</td>
<td>0: Not present</td>
</tr>
<tr>
<td>1: Very mild itching, pins &amp; needles, burning, or numbness</td>
<td>1: Very mild hardness or ability to startle</td>
</tr>
<tr>
<td>2: Mild itching, pins &amp; needles, burning, or numbness</td>
<td>2: Mild hardness or ability to startle</td>
</tr>
<tr>
<td>3: Moderate itching, pins &amp; needles, burning, or numbness</td>
<td>3: Moderate hardness or ability to startle</td>
</tr>
<tr>
<td>4: Moderate hallucinations</td>
<td>4: Moderate hallucinations</td>
</tr>
<tr>
<td>5: Severe hallucinations</td>
<td>5: Severe hallucinations</td>
</tr>
<tr>
<td>6: Extremely severe hallucinations</td>
<td>6: Extremely severe hallucinations</td>
</tr>
<tr>
<td>7: Continuous hallucinations</td>
<td>7: Continuous hallucinations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visual disturbances - Ask: “Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn’t there?”</th>
<th>Headache - Ask: “Does your head feel different than usual?” (Does it feel like there is a band around your head?” Do not rate dizziness or lightheadedness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: Not present</td>
<td>0: Not present</td>
</tr>
<tr>
<td>1: Very mild sensitivity</td>
<td>1: Very mild</td>
</tr>
<tr>
<td>2: Mild sensitivity</td>
<td>2: Mild</td>
</tr>
<tr>
<td>3: Moderate sensitivity</td>
<td>3: Moderate</td>
</tr>
<tr>
<td>4: Moderate hallucinations</td>
<td>4: Moderately severe</td>
</tr>
<tr>
<td>5: Severe hallucinations</td>
<td>5: Severe</td>
</tr>
<tr>
<td>6: Extremely severe hallucinations</td>
<td>6: Extremely severe</td>
</tr>
<tr>
<td>7: Continuous hallucinations</td>
<td>7: Continuous</td>
</tr>
</tbody>
</table>

**Procedure**

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for “Orientation and cloring of sensornium” which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time.

2. Propylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie, start on withdrawal medications). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.


4. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.
### Assessment Protocol

<table>
<thead>
<tr>
<th>Assessment Protocol</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If urine score 2-8 repeat q1h x 8 hrs, then if stable q6h x 8 hrs, then if stable q6h.</td>
<td></td>
</tr>
<tr>
<td>c. If urine score &gt; 8, repeat q6h x 72 hrs.</td>
<td></td>
</tr>
<tr>
<td>d. If indicated, (see indications below) administer PRN medications as ordered and second on MAR and below.</td>
<td></td>
</tr>
</tbody>
</table>

### Narcosis/Vomiting (0-7)

- 0: None
- 1: Mild nausea
- 2: Vomiting
- 3: Intermittent nausea
- 4: Persistent nausea
- 5: Frequent dry heaves
- 6: Vomiting

### Tachycardia (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

### Anxiety (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

### Agitation (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

### Paroxysmal Sweats (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

### Tactile Disturbances (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

### Auditory Disturbances (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

### Visual Disturbances (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

### Headache (0-7)

- 0: None
- 1: Mild
- 2: Moderate
- 3: Severe
- 4: Very severe

---

### Total CIWA-Ar score:

- **PRN Med:**
  - **Dose given (mg):**
  - **Route:**
  - **Time of PRN medication administration:**

---

### Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)

**EN Initiatives:**

<table>
<thead>
<tr>
<th>Scale for Scoring</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 9: absent or minimal withdrawal</td>
<td>a. Total CIWA-Ar score 8 or higher if ordered PRN only (symptom-triggered method).</td>
</tr>
<tr>
<td>10 - 19: mild to moderate withdrawal</td>
<td>b. Total CIWA-Ar score 15 or higher if no scheduled medication (scheduled + prn method).</td>
</tr>
<tr>
<td>more than 20: severe withdrawal</td>
<td>Consider transfer to ICU for any of the following: Total score above 20, q6h scoring &gt; 10 or on opioid.</td>
</tr>
</tbody>
</table>

---

**Signature:**

<table>
<thead>
<tr>
<th>Signature / Title</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature / Title</td>
<td>Initials</td>
</tr>
</tbody>
</table>
Appendix C – Alcohol Screening Tools

This is one unit of alcohol…

...and each of these is more than one unit

<table>
<thead>
<tr>
<th>Alcohol</th>
<th>Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half pint of regular beer/lager or cider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 small glass of wine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 single measure of spirits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 small glass of sherry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 single measure of aperitifs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FAST Scoring System

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often during the last year have you failed to do what was normally expected from you because of your drinking?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often during the last year have you been unable to remember what happened the night before because you had been drinking?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?</td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring:
If score is 0, 1 or 2 on the first question continue with the next three questions
If score is 3 or 4 on the first question – stop here. An overall total score of 3 or more is FAST positive.

What to do next?
If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.
Score from FAST (other side)

Remaining AUDIT questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1 - 2</td>
<td>1</td>
</tr>
<tr>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Have you or somebody else been injured as a result of your drinking?</td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

TOTAL AUDIT Score (all 10 questions completed):
0 – 7 Lower risk,
8 – 15 Increasing risk,
16 – 19 Higher risk,
20+ Possible dependence
### Appendix D – Drug Screening Tools

#### D1 Clinical Opiate Withdrawal Scale

**Clinical Opiate Withdrawal Scale**

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Patient’s Name: ____________________________</th>
<th>Date and Time __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for this assessment: __________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Resting Pulse Rate:</strong></th>
<th><strong>GL Upset:</strong> over last 1/2 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td>5 multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sweating:</strong> over past 1/2 hour not accounted for by room temperature or patient activity.</th>
<th><strong>Tremor:</strong> observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no report of chills or flushing</td>
<td>0 no tremor</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
<td>4 gross tremor or muscle twitching</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Restlessness:</strong> Observation during assessment</th>
<th><strong>Yawning:</strong> Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
<td>4 yawning several times/minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pupils:</strong></th>
<th><strong>Anxiety or Irritability:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 pupils pinned or normal size for room light</td>
<td>0 none</td>
</tr>
<tr>
<td>1 pupils possibly larger than normal for room light</td>
<td>1 patient reports increasing irritability or annoyance</td>
</tr>
<tr>
<td>2 pupils moderately dilated</td>
<td>2 patient obviously irritable or anxious</td>
</tr>
<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Bone or Joint Aches:</strong> if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</th>
<th><strong>Gooseflesh skin:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
<td>5 prominent piloerection</td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Runny nose or tearing:</strong> Not accounted for by cold symptoms or allergies</th>
<th><strong>Total Score</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
<td>The total score is the sum of all 11 items</td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
<td>Initials of person</td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td>completing assessment: ____________________________</td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td></td>
</tr>
</tbody>
</table>

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

This version may be copied and used clinically.

The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 20 item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has “exhibited valid psychometric properties” and has been found to be “a sensitive screening instrument for the abuse of drugs other than alcohol.”

**The Drug Abuse Screening Test (DAST)**

**Directions:** The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or “over-the-counter” drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

<table>
<thead>
<tr>
<th>Statement</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you used drugs other than those required for medical reasons?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you abused prescription drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you abuse more than one drug at a time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Can you get through the week without using drugs (other than those required for medical reasons)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Are you always able to stop using drugs when you want to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Do you abuse drugs on a continuous basis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you try to limit your drug use to certain situations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you had “blackouts” or “flashbacks” as a result of drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you ever feel bad about your drug abuse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Does your spouse (or parent) ever complain about your involvement with drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do your friends or relatives know or suspect you abuse drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Has drug abuse ever created problems between you and your spouse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Has any family member ever sought help for problems related to your drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you ever lost friends because of your use of drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Have you ever neglected your family or missed work because of your use of drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Have you ever been in trouble at work because of drug abuse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Have you ever lost a job because of drug abuse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Have you gotten into fight when under the influence of drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Have you ever been arrested because of unusual behavior while under the influence of drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you ever been arrested for driving while under the influence of drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Have you engaged in illegal activities in order to obtain drug?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Have you ever been arrested for possession of illegal drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Have you ever experienced withdrawal symptoms as a result of heroin drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Have you had medical problems as a result of your drug use (e.g., memory loss, hallucinations, convulsions, bleeding, etc.)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Have you ever gone to anyone for help for a drug problem?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Have you ever been in a hospital for medical problems related to your drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Have you ever been involved in a treatment program specifically related to drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Have you ever been treated as an outpatient for problems related to drug abuse?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scoring and interpretation:** A score of “1” is given for each YES response, except for items 4, 5, and 7, for which a NO response is given a score of “0.” Based on data from a heterogeneous psychiatric patient population, cutoff scores of 5 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorder. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4, 7, 14, 20, and 22.
**SEVERITY OF DEPENDENCE SCALE (SDS)**

The following questions are about your drug use prior to commencing treatment. For each of the five questions, please indicate the most appropriate response, as if applied to your drug use in the month prior to starting treatment.

*Note: Give Response Card to participant. When reading out the questions below, replace “(drug)” with the name of the principal opiate for which treatment is currently being received, e.g. heroin, opium, etc.*

<table>
<thead>
<tr>
<th>Question</th>
<th>Never/always never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always/nearly always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you think your use of (drug) was out of control?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Did the prospect of missing a fix (or dose) make you anxious or worried?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Did you worry about your use of (drug)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Did you wish you could stop?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. How difficult did you find it to stop or go without (drug)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

SDS **TOTAL:** ________
Appendix E – The Drugs Wheel

The Drugs Wheel
A new model for substance awareness

Outer ring: Controlled under the Misuse of Drugs Act 1971 or The Human Medicines Regulations 2012
Inner ring: Controlled under the Psychoactive Substances Act 2016 • Temporary Class Drug Order

Not to be used for commercial purposes, visit www.thedrugswheel.com for licencing details
Appendix F – Sample resources for the collection of methadone / buprenorphine from community pharmacists

F1 Sample Algorithm for the Collection of Opioid Substitution Medication from Community Pharmacies for People in Police Custody

To be adapted for local use as required

1. Patient's assessment by healthcare professional / Police Custody Risk Assessment by Police Custody Officer indicates that providing daily dose of prescribed opiate substitute treatment is appropriate
2. Community pharmacy is open, local and police staff available to collect dose

Yes

Contact Community Pharmacist
1. Confirm prescribed dose and instalment instructions
2. Confirm date and time* that previous dose was supervised or collected
3. Ascertain how many doses may be collected (according to instalment instructions, length of time person is likely to be detained and time of release)
4. Confirm that doses will be dispensed in separate bottles.
5. Agree when the patient’s authorised messenger (usually a police officer) can collect the next dose.

Pharmacist available

Complete authorisation form
include name and signature of patient & police officer collecting dose and medication information. Sign and date. Expect pharmacist to confirm arrangement by phoning custody suite independently

Pharmacist unavailable / Pharmacist refuse to supply

Contact Community Pharmacist before detainee is released if there is a clinical need to do so
Police custody healthcare professionals and Pharmacists to discuss patient treatment and consult instructions in the British National Formulary if required

Manage withdrawal
Manage withdrawal symptoms according to local prescribing policy (usually prescribed dihydrocodeine (unlicensed indication))

Contact Pharmacist at earliest opportunity

No

Pharmacist unavailable

Manage withdrawal symptoms according to local prescribing policy

Contact Pharmacist at earliest opportunity

Collect medication from pharmacy:
- Pharmacist will require the authorisation note and ID of collecting officer.
- If more than one dose is supplied (in accordance with instalment instructions) they should be dispensed in separate containers.
- Pharmacist annotates supply “unsupervised” if relevant and records in patients medication record
- Pharmacist records collecting officer’s name and custody suite address in CD register
- Pharmacy retains authorisation note for 2 years.
- If Pharmacist refuses supply add reason for refusal in the appropriate place on form together with pharmacist name and GPhC number.

Contact Community Pharmacist
1. Confirm prescribed dose and instalment instructions
2. Confirm date and time* that previous dose was supervised or collected
3. Ascertain how many doses may be collected (according to instalment instructions, length of time person is likely to be detained and time of release)
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Police custody healthcare professionals and Pharmacists to discuss patient treatment and consult instructions in the British National Formulary if required

Manage withdrawal
Manage withdrawal symptoms according to local prescribing policy

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include name and signature of patient & police officer collecting dose and medication information. Sign and date. Expect pharmacist to confirm arrangement by phoning custody suite independently

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Contact Community Pharmacist before detainee is released if there is a clinical need to do so
Police custody healthcare professionals and Pharmacists to discuss patient treatment and consult instructions in the British National Formulary if required

Manage withdrawal
Manage withdrawal symptoms according to local prescribing policy

Contact Pharmacist at earliest opportunity

Collect medication from pharmacy:
- Pharmacist will require the authorisation note and ID of collecting officer.
- If more than one dose is supplied (in accordance with instalment instructions) they should be dispensed in separate containers.
- Pharmacist annotates supply “unsupervised” if relevant and records in patients medication record
- Pharmacist records collecting officer’s name and custody suite address in CD register
- Pharmacy retains authorisation note for 2 years.
- If Pharmacist refuses supply add reason for refusal in the appropriate place on form together with pharmacist name and GPhC number.
F2 Sample authorisation form for collecting patient’s own methadone/buprenorphine from Community Pharmacy

Healthcare and Forensic Medical Services  
[Address of Division]  
Tel:...........................................  
[name]

For the attention of the duty pharmacist at………………………………………………pharmacy

Re: [title, forename, surname] [address of patient ]  
DOB  
Custody number:  
C/O [address and telephone number of police station]

Dear Pharmacist

Please supply the bearer of this note, [insert name of bearer and custody suite address], with my daily dose / doses\(^8\) of methadone / buprenorphine (delete as applicable), which is due on: [insert date(s)]

<table>
<thead>
<tr>
<th>Name of medicine</th>
<th>Dose</th>
<th>Number of doses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I will take this under the supervision of the healthcare professional while I am temporarily detained. I consent to relevant clinical information being shared between police custody healthcare professionals and the community pharmacy.

Signed (patient)…………………………………………………………………………

Print name:…………………………………………………………………………

Dated:………………………………………………………………………………

Authorised for collection by custody officer:

Name:………………………………………………………………………………

Signed:………………………………………………………………………………

Dated:………………………………………………………………………………

Medication supplied by pharmacy?   Y / N  
Reason if not supplied………………………………………………………………

Pharmacist Name………………………………………………………………………

GPhC number……………………………………………………………………………

\(^8\) Supervised dose may be legally supplied. Instalment directions must be followed.
### Summary Care Plan

<table>
<thead>
<tr>
<th>Date</th>
<th>+</th>
<th>+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess and indicate reasons and need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of dependence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendix table</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If to reduce</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If to stop</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History: alcohol, nicotine or psychoactive substances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history: alcohol, nicotine or psychoactive substances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diabetic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diabetic control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>kidney failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>liver failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current social/medical service participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication review</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Official - Sensitive Personal**

SUMMARY CARE PLAN CUSTODY AND FORENSIC MEDICAL EXAMINATION

NHS Scotland
<table>
<thead>
<tr>
<th>Other committals, health recommendations or advice for custody staff for care in custody:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**MEDICATION**

<table>
<thead>
<tr>
<th>Assessment of suicide risk</th>
<th>Estimated level of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
</tr>
</tbody>
</table>

**Reason for medication:**

<table>
<thead>
<tr>
<th>Reason for medication</th>
<th><strong>NO</strong></th>
</tr>
</thead>
</table>

**Date:**

<table>
<thead>
<tr>
<th><strong>Examined by:</strong></th>
<th><strong>Examined date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td><strong>Examined date:</strong></td>
</tr>
</tbody>
</table>

**Number:**

<table>
<thead>
<tr>
<th><strong>Examined by:</strong></th>
<th><strong>Examined date:</strong></th>
</tr>
</thead>
</table>
## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABI</td>
<td>Alcohol Brief Intervention</td>
</tr>
<tr>
<td>AUD</td>
<td>Alcohol Use Disorder</td>
</tr>
<tr>
<td>AUDIT</td>
<td>Alcohol Use Disorder Identification Test</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>CiWA-Ar</td>
<td>Clinical Institute Withdrawal Assessment of Alcohol Scale</td>
</tr>
<tr>
<td>COWS</td>
<td>Clinical Opiate Withdrawal Scale</td>
</tr>
<tr>
<td>COPFS</td>
<td>Crown Office and Procurator Fiscal</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>DAST</td>
<td>Drug Abuse Screening Test</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>Codes are the classification found in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition</td>
</tr>
<tr>
<td>ECS</td>
<td>Emergency Care Summary</td>
</tr>
<tr>
<td>FAST</td>
<td>Fast Alcohol Screening Test</td>
</tr>
<tr>
<td>FFLM</td>
<td>Faculty of Forensic and Legal Medicine</td>
</tr>
<tr>
<td>FP</td>
<td>Forensic Physician</td>
</tr>
<tr>
<td>FME</td>
<td>Forensic Medical Examiner</td>
</tr>
<tr>
<td>ISD</td>
<td>Information Services Division</td>
</tr>
<tr>
<td>ICD-10</td>
<td>10th revision of the International Statistical Classification of Diseases and Related Health Problems</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
</tr>
<tr>
<td>LSD</td>
<td>Lysergic Acid Diethylamide – hallucinogenic drug</td>
</tr>
<tr>
<td>NES</td>
<td>NHS Education Scotland</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
</tr>
<tr>
<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
</tr>
<tr>
<td>NPS</td>
<td>New Psychoactive Substances</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guideline Network</td>
</tr>
<tr>
<td>SDS</td>
<td>Severity of Dependence Scale</td>
</tr>
<tr>
<td>ROC</td>
<td>Recovery Orientated Systems of Care</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</table>
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