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Access to supervised doses of opioid substitution for people in police custody

Purpose of this advice

Recent reports have revealed inconsistencies in how people in police custody access their doses of methadone and buprenorphine. These doses are usually administered under supervision by the community pharmacist or community substance misuse team.

Even though it is not common that methadone and buprenorphine doses are needed for a patient in custody, procedures need to be in place to manage this.

Healthcare professionals, commissioners and regulators have written this briefing to help other healthcare professionals, including community pharmacists and police custody teams, give people safe access to these medicines.

Who should read this advice?

The briefing is useful for a range of stakeholders involved in caring for substance misusers in custody and in the community. The key audience includes:

- healthcare providers and healthcare professionals delivering healthcare in police custody
- community pharmacists
- community substance misuse service providers
- police custody teams
- substance misuse and police custody healthcare commissioners
- GPs

Key messages

1. No legal barriers prevent a pharmacist from supplying a suitably labelled dose to an authorised person on behalf of a detained person where the pharmacist would usually supervise the administration of the dose in the pharmacy.
2. The decision to give people access to doses of methadone or buprenorphine while in police custody is complex. However, where this is indicated and where proximity and opening hours of the usual community pharmacy allows, accessing the

pharmacy-held prescribed dose is safer and preferable to writing a separate prescription for the methadone or buprenorphine.

3. Achieving safe access to the doses from the pharmacy requires several steps, with contributions from the detained person, police custody, healthcare and pharmacy teams.

Scope and aims of the briefing

The scope of the briefing incorporates the issues raised in the case scenario in appendix A. It aims to:

1. Share a common understanding of the continuity of care and the safety issues that arise when a person on substance misuse treatment is detained in custody.
2. Explain what the community pharmacist should do when he or she is asked by a police officer or custody healthcare professional to supply a dose of methadone or buprenorphine for a person whose dose the pharmacist would normally supervise.
3. Recommend what advice or action the police and healthcare professionals need to take to assure the pharmacist that the request is appropriate.
4. Describe the operational and reimbursement implications of the above for the pharmacy contractor and substance misuse service commissioners.
5. Recommend action to take if the dose is not administered for clinical or operational reasons.

The scope excludes the substance misuse clinical assessment and clinical decisions made by healthcare professionals while a detainee is in custody. Other guidance exists for this.[*] This briefing assumes that the result of the assessment confirms a need for a dose of methadone or buprenorphine**.**

Background to healthcare for detained people

Each police force in England has one or more sites where people are held in police custody and may be legally detained for 24 hours or more depending on the circumstances of their arrest.

Police forces commission healthcare services to meet detained people's acute or ongoing health needs, including initiating or continuing prescribed medicines. Appendix B describes the care pathway for detained people and how access to medicines fits in.

A range of regulatory and operational policies and guidance underpin the access detained people have to healthcare. The key ones are:

- Police and Criminal Evidence Act 1984 (PACE) – code C within the Act describes the requirements for healthcare delivery

[*] RCPsych 2011 substance misuse detainees in police custody guidelines for clinical management

- Faculty of Forensic and Legal Medicine (FFLM) publications – FFLM is the leading professional body supporting healthcare delivery for detained people. Its guidance covers all aspects of healthcare delivery as well as the forensic functions that healthcare professionals perform to support police investigations
- FFLM's 'Safe and secure administration of medication in police custody 2014' describes specific recommendations of how medicines should be accessed and handled during custody
- National Police Chiefs' Council and College of Police guidance for authorised professional practice, detention and custody. This includes a section on healthcare and medicines access

The commissioning arrangements for community substance misuse services and police healthcare lie outside the NHS, which has implications for prescriptions and service remuneration (see box 1).

Box 1. Commissioning notes

Police forces commission healthcare services for detained people, so prescriptions written by the healthcare providers for people in police custody are usually **private prescriptions**. This could change when the NHS becomes responsible for commissioning these services in 2016. However, the principles of safe care included in this briefing will be the same for NHS prescriptions if these are eventually used. For clarity, this briefing will refer to the current use of private prescriptions for police custody healthcare. Local authorities commission substance misuse services, including supervised consumption services. Remuneration arrangements for these services vary between authorities and are separate to the remuneration for dispensing prescribed medicine.

What are the issues for access to medicines during custody?

As in any setting, the principles of medicines optimisation[†] (see box 2) apply for people in police custody, even though their time in custody may be short.

Box 2. Principles of medicines optimisation

1. Aim to understand the patient's experience.
2. Evidence-based choice of medicines.
3. Ensure medicines use is as safe as possible.
4. Make medicines optimisation part of routine practice.

[†] Royal Pharmaceutical Society 2013: Medicines Optimisation: Helping patients to make the most of medicines

To achieve these, several key issues are taken into account when deciding whether a medicine is accessed and supplied or administered to a detained person. These include:

- when the doses of medicines are due and the length of time the person is likely to be detained, considering the clinical implications of delaying or omitting doses
- the likely release of the detained person and the timing of the next dose being during opening hours of their usual pharmacy
- the lack of verifiable information on the person's current medical history and prescribed medicines. Access to other health records, including the summary care record, is variable and symptomatic relief may be safer, especially for opioids
- the source of any medicines brought in by the detained person or accessed from his or her home. These are only used to continue treatment if the medicine is assessed as appropriate. Loose strips of medicines, individual tablets or capsules in unlabelled containers or liquid medicines, especially methadone, are not usually used. If doses are needed, a new supply is sourced via a prescription from the police custody healthcare provider
- the proximity of the detained person's usual community pharmacy that may hold a supply of the person's medicines that are awaiting collection

For substance misuse medicines, including methadone and buprenorphine, which are controlled drugs (CD), all of the above apply and handling these medicines requires compliance with the Misuse of Drugs Regulations 2001. Also, the clinical decision to access and administer doses of methadone and buprenorphine is complex because, as well as presenting symptoms, significant clinical risks and vulnerabilities must be taken into account.

However, when the dose of methadone or buprenorphine is indicated during custody, and where proximity and opening hours of the usual community pharmacy allows, accessing the pharmacy-held prescribed dose is safer and preferable to writing a separate prescription. This includes doses where a pharmacist supervises the administration (see box 3).

Box 3. Regulatory note

There are no legal barriers to prevent the community pharmacist from supplying the dose to an authorised person on behalf of a detained person where the pharmacist would usually supervise the administration of the dose in the pharmacy. The dose should be dispensed and supplied in a suitably labelled container as required by the Human Medicines Regulations 2012. The instructions to supervise the dose are not legally bound to the pharmacist but will be met by the healthcare professional who will supervise the detained person's self-administration of the dose (as per PACE).

Recommended steps for the safe access of pharmacy-held doses

During the healthcare assessment of the detained person, his or her usual community pharmacist may be contacted by the healthcare professional to establish the current prescribed doses and the time that the previous dose was collected or administered under supervision.

If the detained person is unwilling to divulge the name of his or her usual pharmacy or the pharmacy is closed or is too far away, the healthcare provider will normally reassess the risks versus benefits of providing methadone/buprenorphine via a separate prescription or symptomatic treatment.

If a supply of pharmacy-supervised doses needs to be collected, the following steps describe how to ensure this is delivered legally and safely:

1. **Contacting the pharmacy.** The healthcare professional involved in the decision should contact the community pharmacy that usually supervises the dose and speak to the pharmacist on duty to explain the need to access the medicine and to:
   - confirm the current prescribed dose
   - confirm the date and time that the previous dose was administered or collected
   - agree how many doses need to be supplied (in some instances, such as at weekends, doses are supplied to the patient rather than administered under supervision. If there is a risk that the detained person will remain in custody and needs more than one dose, or if there is a risk that the detained person will be released the next day when the pharmacy is closed, the healthcare provider may need to collect more than one dose of the medicine)
   - agree when the patient's authorised messenger (usually a police officer) can collect the next dose and provide supporting documentation

Safe practice tips:

- ✓ The pharmacist should note all details, including the name of the police station where the detained person is being held. To reassure themselves of the legitimacy of the caller, pharmacists should independently find the number of the police station and call back to establish that the detained person is there and that the dose is needed.

- ✓ If the healthcare provider cannot contact the pharmacy initially, or sources a prescription for the dose elsewhere, the healthcare professional should reattempt to contact the usual pharmacy before administering the dose. This is to verify when the previous dose was administered or supplied to the detained person and to inform the pharmacy that the dose has been accessed in custody. This minimises the risk that the pharmacist will supply a second dose if the detained person is released on the same day.

2. **Prepare a document that will be taken to the pharmacy by an authorised person** (usually a police officer). This 'bearer's note', needed each time a supply is collected, gives the pharmacist additional assurance of the medicine required and provides a mechanism for patient consent to the supply. A template for this is in appendix C and contains:
   - name of the detained person, residential address and date of birth
   - address of the police station where the detained person is being held
   - details of the medication and the timing of doses
   - a statement that the dose will be given on the same day under the supervision of a healthcare professional unless clinical circumstances change
   - signature and contacts authorising the collection of the dose: the bearer's note as a minimum should include the signature of the police officer/custody sergeant authorising the collection and of the detained person – this confirms consent and covers the fact that the medicine is being collected on the patient's behalf (the patient's signature can be verified with the signature on the reverse of the current prescription form held in the pharmacy)
   - the name and contact details of the authorising healthcare professional
   - the name and address of the person collecting the dose from the pharmacy (the address of the custody suite is sufficient)

3. **Collecting the supply from the pharmacy**. These elements are the basis for a safe and legal supply:
   - the person collecting the supply hands over the bearer's note and shows proof of identity (eg, a warrant card or healthcare organisation ID) to the pharmacist
   - the pharmacist annotates the prescription with 'unsupervised' for the dose supplied. This will enable a pharmacist present on subsequent days to be aware of the supply
   - if more than one dose is needed, each dose should be dispensed into separate containers
   - the pharmacy controlled drug (CD) register entry includes the name and address of the person who collected the supply – the address of the custody suite is sufficient
   - suitable records are made in the pharmacy's patient medication record (PMR) and records made relating to the delivery of the supervised consumption service (see box 4)
   - the pharmacy retains the bearer's note for two years as it is a record of a CD transaction‡

‡ Recommendations for the Retention of Pharmacy Records – prepared by the East of England NHS Senior Pharmacy Managers 2015

- the pharmacist should not contact the usual prescriber of the supervised dose because disclosing that the patient is in police custody may breach patient confidentiality

Box 4. Pharmacy remuneration note

The remuneration for dispensing the dose will still be paid when the prescription is submitted to the NHSBSA Prescription Pricing Division. The remuneration for the supervision will not be paid as the pharmacist has not supervised the dose. The pharmacist should complete any documentation (as per the local enhanced service contract) omitting the claim for supervision for that day.

- if the dose is damaged or spilled once it has been supplied, the healthcare provider will need to write a prescription for that dose as the pharmacy will not be able to supply a replacement without one. An entry in the healthcare provider's CD register or a record in the custody record that the dose has been spilt is needed to account for the loss and ensure a complete audit trail exists.

4. **Receiving the supply at the police custody site and administrating the dose**. The police record the safe delivery of the supply, which is then stored securely using local arrangements until it is handed to the healthcare professional for further storage or immediate administration. In addition:
   - police forces have arrangements for securely storing and destroying detainees' property, including medicines. This storage includes using tamper-evidenced bags in areas often covered by security cameras. This means the risk of any unlawful access to the medicine is low
   - the police do not have to measure and record the quantity of the controlled drug being stored
   - as the medicine has been collected directly from the pharmacy it can be used by the healthcare professional for the supervised dose to be given. Note this is different to when the dose is accessed from the patient's home, when the usual practice is not to use this supply during custody because of the risk it has been tampered with
   - when the CD arrives at the police station, it is stored and documented using local service delivery and storage arrangements
   - the dose must be self-administered under the supervision of the healthcare professional (usually a doctor, nurse or paramedic). The healthcare professional usually assesses the detained person immediately before this to ensure that it is still clinically appropriate to give the dose
   - the healthcare professional makes the usual records to record the supervision of the administration of the CD

Safe practice tips:

- ✓ If the dose is not administered, the healthcare professional should notify the pharmacist accordingly and document this in the police custody care record.

- ✓ The pharmacist (who already has consent from the patient as part of the supervised consumption service provision) should contact the detainee's usual GP/substance misuse prescriber about the missed dose as required in local contractual arrangements and incident reporting. It is important that this communication does not include the fact that the patient had been in custody.

- when subsequent doses have been collected and the detained person is released, the healthcare professional (usually the forensic medical examiner (FME)) would authorise the stored supply to be i) handed to the detainee on release or transfer ii) retained if, for clinical reasons, the following dose is no longer needed. Any supplies not given to the detainee should be disposed of according to local procedures

Appendix A. Case scenario

John, aged 24, receives 50ml of methadone 1mg/ml daily via supervised consumption at his local community pharmacy in Cambridge. The substance misuse service in the city prescribes this via FP10MDA. As the pharmacy is closed on Sundays, John collects that day's dose on Saturdays. The local authority (Cambridgeshire County Council) commissions the community substance misuse service and the pharmacy's supervised consumption service.

Cambridgeshire Police arrest John at 2pm on Thursday 16 April. They book him into the custody suite where he explains he is on methadone and was going to collect his dose from the pharmacy as usual that morning but had not yet done so. He claims his last dose was at 9.30am on Wednesday 15 April. An officer contacts the police's healthcare provider. A nurse arrives at the police station at 3pm and:

- contacts John's community pharmacy (with his consent) to confirm the details of his current prescription and to establish that the previous dose had been supervised at 9.30am on Wednesday
- assesses John and decides he needs his methadone dose for Thursday as soon as possible
- discusses this with a doctor/forensic physician (off-site, employed as part of the police custody healthcare team), who agrees with the nurse – the nurse documents this agreement on the healthcare's IT system
- contacts the pharmacy and requests that it dispenses the methadone so that this can be collected by a police officer and then the dose administered under the supervision of the nurse (as per PACE code C)

Taking account of legal and professional requirements, the pharmacy should be able to supply the dose as requested to enable the safe continuity of John's methadone. The scenario raises some questions:

a) Are there any legal reasons the pharmacist couldn't supply the methadone to the police officer?

b) What supporting documentation should the police/healthcare provider give to assure the pharmacist that the supply is appropriate?

c) What record should the pharmacist make on the PMR and the FP10MDA?

d) Who else needs to know that the supply has been given via the police/healthcare team?

e) What are the implications for service remuneration for the pharmacy contractor?

f) If the request is made on a Saturday can the pharmacy also provide Sunday's dose for supervised administration (if John is still detained) or for the police to safely store this so they can give it to John when he is released?

g) Another option is for the healthcare prescriber to write a private prescription, which may be the only option if the pharmacy is a long distance away. What are the clinical/operational risks of this versus the pharmacy's dispensed supply?

Appendix B. Care and medicines pathway summary for detainees in police custody

The detainee is processed and a risk assessment completed that includes medical risks/history and current medication information.

Any patient-held medication is relinquished into police custody for storage or continuity of use. Healthcare are contacted about whether to continue current medicines, access medicines from the detainee's home and to assess the detainee's fitness for custody or interview. Decision of whether an HCP attends varies depending on agreed processes between providers and police forces. The detainee also has the right to request a healthcare examination in accordance with PACE.

The healthcare professional completes a clinical assessment. Emergency urgent care is accessed via ambulance/paramedic and transfer to A&E. A special form is completed for this by healthcare.

Health needs are documented and a care plan developed (e.g. withdrawal from substance misuse; physical injuries; acute mental health needs), especially around substance misuse.
Some forces may allow salbutamol inhalers to be held by detainees if authorised by the clinician or custody sergeant.
Outcomes of the clinical assessment determine the need for:

- continuity of medicines prescribed prior to custody if not already determined by the police (custody) officer's initial healthcare contact
- additional medicines for newly identified clinical needs including substance misuse needs
- referral to the mental health crisis team for assessment; referral to hospital for treatment of illness or injury
- referral to a doctor by a nurse if clinical needs are beyond scope of practice or if a prescription is required (dispensed on-site visit or via a pharmacy)

In some forces medicines may be dispensed from stock packs or over labels completed for detainee supply via police (custody) officers with appropriate documentation. The medicines are stored securely by the police. Only certain medicines are supplied on release as advised by the clinical team.

- medicines are held as stock in a locked medicines cupboard in the medical consultation room for use and management by healthcare only. Some items are over-labelled as these would be supplied under PGD and/or on release for the detainee to complete treatment (e.g. antibiotics).
- short-term supplies (e.g. 24-48 hours maximum) prescribed for the detainee are provided in appropriately labelled containers using a ratified SOP and appropriate information.
- detainee's own medicines for supply continuity may also be used underpinned by SOPs
- police (custody) officers in some forces can supply homely remedies (e.g. nicotine replacement, paracetamol) via access to a separate storage cupboard and using police procedures and documentation
- proforma are completed by healthcare if in attendance when a detainee requires transfer to hospital. Any medicines on return are re-authorised by healthcare and treated as detainee's own medicines

Once dispensed and supplied to the police officers, the medicines administration is supervised by the officers (in most sites only one of them) as per labelled instructions and where permitted under PAC. This is recorded.

Appendix C. Template for bearer's note (for local adaptation)

FAO the duty pharmacist at…… pharmacy

Re: [title, forename, surname],
[Address of detainee]
Age:
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 of methadone/buprenorphine (delete as applicable), which is due on: [insert date(s)]:

Name of medicine	Dose	Number of doses

I will take this under the supervision of the healthcare professional while I am temporarily detained.

Signed (detainee):.....

Print name:.....

Dated:…….....

Witnessed by the duty doctor/nurse: [insert organisation and contact number]

Name:.....

Signed:.....

Dated:.....

Authorised for collection by custody sergeant:

Name:.....

Signed:.....

Dated:.....

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