What is Equivalence in Police Custody Healthcare

End of Project Report

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Executive Summary

What constitutes quality healthcare delivery in police custody? While standards have been developed in other parts of the criminal justice estate, for instance the "Equivalence" standard in prisons, would that form of standard or similar be appropriate for police custody? This is the question we initially designed this research project around, but very quickly (both empirically and in discussion with our project Advisory Group) discovered that police custody healthcare at the present time is: a) far from an equivalency standard, and b) that the equivalency standard is a vague and unclear standard and so not one that is easy to implement.

Taking advice, we turned to the AAAQ Framework, developed from the Universal Declaration of Human Rights, especially the right to healthcare. The AAAQ Framework advises that healthcare should be AVAILABLE at the point of need; ACCESSIBLE in that the right forms of treatment are available, and that they are available to all, including the underprivileged; healthcare should be ACCEPTABLE to all and aware of the diverse needs and requirements of all persons in a population; and of GOOD QUALITY, including the material resources used for healthcare (the building, the instruments, the tools, appropriate medicines available).

Taking the AAAQ Framework as exemplifying the basic standard of healthcare we would like to see in police custody, we have been able to synthesise our findings and the framework to develop recommendations for healthcare practice in police custody.

Methods

The project included three methods-based work packages. Work Package One was an ethnography of four police custody suites, totalling approximately 500 hours of observation (130 hours spent directly in custody). Work Package Two involved semi-structured interviews with police custody staff and retrospective interviews with persons with Lived Experience of police custody. A total of 74 interviews were collected in total – 33 staff interviews and 41 Lived Experience interviews. Work Package Three consisted of quantitative analysis of 3,200 Custody Officer Risk Assessments and qualitative analysis of 40 case logs, a contemporaneous log of a person's period of detention as written by custody staff.

All data sets were analysed by the research team, and we also had Peer Analysis assistance from volunteers from Waythrough, a Third Sector organisation with experience of being in mental health crises in police custody. Given our rigorous analysis procedures and our Peer Analysis team, we are confident in the generalisability of our findings.

Findings

Our findings demonstrate that Healthcare Providers (HCPs) are not embedded in all police custody suites, which is delaying healthcare assessments and treatments as HCPs need to travel in from other locations. Not only does this delay treatments for detained persons but can also add to exhaustion and burnout for HCPs producing compassion fatigue and an inability to retain staff. The decision to not fully embed HCPs in all suites is a strategic choice, but one that limits the **availability** of HCPs.

We identified a postcode lottery of medicines provision across different healthcare providers resulting in divergent forms and standards of care dependent on where arrested. We would argue that different Patient Group Directives and medicines provision does not constitute **good quality** of material resources.

Stigmatising attitudes and disbelief were common across custody staff, resulting in delays or denials of treatment and care, either as a potential form of punishment or due to not trusting the medical histories of the detained persons. Such attitudes and the associated practices do not constitute **accessible** or **acceptable** healthcare.

Stigmatising attitudes particularly came to the fore with the provision (or lack thereof) of methadone for opioid dependent detained persons. There was no evidence of links with pharmacies or programmes to access methadone for detained persons on a treatment programme. This resulted in detained persons leaving custody and returning to criminal networks and in some circumstances being removed from treatment programmes. This again constitutes a breach of **good quality** care.

Data from our Lived Experience cohort expressed they felt confused during police interviews, having entered a state of withdrawal prior to the start of the interview but not received medication. As medications, especially those for treating opioid and alcohol dependency can result in drowsiness, sometimes HCPs discussed with the detained person whether to medicate given the close proximity of the interview. Medicating would mean a delay to the interview, while not medicating would mean that the person could be released sooner. Given the understandable desire to leave as soon as possible, detained persons choose the interview, but this can result in confusion and a lack of comprehension of what is being discussed. While we appreciate the attempt to empower detainees about their own care, given the enormous power imbalances within police custody, this responsibilisation results in detainees making decisions against their own interest and so appears to us as against **acceptable** healthcare.

Finally, support and referral to other services appeared to be inconsistent and we again see this as not conforming with **accessible** and **good quality** healthcare.

<u>Recommendations</u>

Taking these findings into consideration with the AAAQ Framework, we recommend the following changes to police custody healthcare to improve the standard of service:

Recommendation One: HCPs to be properly embedded within all custody suites.

Recommendation Two: All healthcare providers to sign up to a standardised medication list and PGD.

Recommendation Three: Healthcare providers to remind HCPs that there does not exist a guideline that recommends waiting for six hours of detention before medicating.

Recommendation Four: Staff within police custody to be trained to approach detained persons with professional curiosity rather than scepticism.

Recommendation Five: Methadone to be accessible in police custody to all on a rehabilitation treatment programme. To enable this, custody teams to develop robust relationships with local pharmacy and drug services to ensure swift provision of methadone when caring for a drug dependent detainee.

Recommendation Six: Alcohol and drug dependent detained persons to be acknowledged as vulnerable and provided with an Appropriate Adult.

Recommendation Seven: Consistent referral of support services to detained persons.

Introduction

Police custody suites are largely under-researched areas, especially when compared to other carceral environments, prisons for instance. While a small quantity of scholarship has developed in recent years, for instance the work of Prof Layla Skinns (2010, 2019) and Dr Roxanna Dehaghani (2019), police custody continues to be an underexplored area of scholarship. Against this background of a lack of scholarly interest in police custody in general, the absence of interest in healthcare in police custody is even more pronounced with only limited academic work in this area (Addison et al. 2018, De Viggiani 2013, Menkes and Bendelow 2014, McKinnon and Finch 2018, Rees 2020, Rees 2023). To rectify this omission, we originally designed this project, with the aim of understanding how healthcare is delivered in police custody and in what ways it could be improved.

It is well established that people who have been arrested and detained in police custody have rates of health conditions more than those seen in the wider population (NHS England 2025) and therefore it is a critical point that the identification and management of health problems whilst detained are optimised. One area that has received most attention is people with mental health problems. There has been a large amount of research in prisons over the last half-century (See Emilian, Al-Juffali and Fazel 2025 for an up-to-date systematic review), and it was the publication of the Bradley Report in 2009 which put the plight of detained persons with a broad range of issues including mental health problems and intellectual disability detained in police custody squarely in the spotlight.

While the Bradley Report led to a range of developments in the delivery of care roles and responsibilities within police custody, not least the development of the Liaison and Diversion role, which supports and makes referrals for persons with mental health conditions, it was still not possible to identify a clear set of standards against which healthcare in police custody was to be held to account. The prison estate had long developed an "Equivalence" standard (House of Commons 2018, RCGP 2018), denoting that prisoners are entitled to equivalent care while they are detained to what they would receive in prison and so we began with the aim of assessing whether a similar "Equivalence" standard would be appropriate in police custody, and, if so, what would that standard include?

Some of our early experiences talking with staff and persons with Lived Experience of police detention, as well as observing police custody, made us aware that custody is presently far from an equivalence standard. At the same time, members of our Advisory Panel, especially Prof Andrew Forrester advised us of the weaknesses of the "Equivalence" standard for prisons and how a more detailed set of standards have come to be preferred. The AAAQ Framework (short for Availability, Accessibility, Acceptability, and Good Quality) adapted from the Universal Declaration of Human Rights (Exworthy et al. 2012; Exworthy, Wilson and Forrester 2018) provides more explicit standards for quality healthcare, especially in criminal justice settings, than the vague claim to equivalence.

Putting the AAAQ Framework into practice, quality healthcare should be AVAILABLE at the point of need; ACCESSIBLE in that the right forms of treatment are available, and that they are available to all, including the underprivileged; healthcare should be ACCEPTABLE to all and aware of the diverse needs and requirements of all persons in a population; and of GOOD QUALITY, including the material resources used for healthcare (the building, the instruments,

the tools, appropriate medicines available, etc.). We agree that the AAAQ Framework provides a more feasible model for identifying the kinds of medical practices and attitudes that constitute improved quality, and it is with this framework as a framing tool that we will present our findings and recommendations from our project.

Before turning to the findings and recommendations however, it is important to set out the questions that drove our research as well as where the research was completed.

In considering what would constitute key aspects of healthcare in police custody we wanted to emphasise: the interactions between custody staff and detained persons; the relationships between different kinds of staff in police custody; the spaces of police custody (the buildings); and the ways that potential healthcare risks are or can be identified and mitigated. This led us to ask the following the research questions:

1. How do custody staff (police and healthcare) interact with detainees and how do these interactions impact detainees' experiences of health and wellbeing in police custody? How do detainees' observable characteristics (age, body size, skin colour, gender) play into these interactions?

2. How do police and healthcare staff in custody interact with each other, and what is needed to achieve optimal multiagency working and deliver equivalence in healthcare?

3. What role does the age and space of police custody environments play in the delivery of healthcare?

4. What health information about detainees is accessed, recorded, managed, and shared within police custody, how is this done, and how is the information secured?

To answer our research questions, we accessed two English Police Forces, which we have provided the pseudonyms "Northton" and "Sutherland". We will discuss our methods in the following section, but it is important to note that both forces cover large geographical regions, including both urban and rural as well as affluent and deprived areas, and both forces have multiple custody suites across their constabulary area. Access was approved in both constabularies for custody suite observations, interviews with staff and for data sharing of Custody Officer Risk Assessments and Custody Logs. Retrospective interviews were also held with persons with Lived Experience of being detained in police custody and these were accessed through Third Sector organisations within the police force areas (we will discuss access processes in more detail in the methods section).

In the rest of the report, we will explore the key findings of our project as well as the recommendations for practice that derive from the findings as read through the AAAQ Framework. While we had three work packages, for this report we have presented our data and findings thematically and so data is often presented from multiple work packages to support the same claim. We will commence with a discussion of our work packages before explaining in detail our findings, and finally our recommendations. The report will conclude with a summary and some suggestions for putting the recommendations into action.

Methods

The project was separated into three methods-based work packages. Work Package One involved an ethnography of four police custody suites; Work Package Two, focused on semi-structured interviews of custody staff and persons with lived experience of detention in police custody; and Work Package Three included quantitative analysis of risk assessments collected when a person enters police custody, as well as qualitative analysis of the logs made by staff during a person's detention. We will explain further the details of each Work Package in turn.

Work Package One was based on an ethnography of four custody suites across the two police force case study areas (two custody suites per constabulary). Ethnography involves observation, conversations, photographing and detailed notetaking of the observations, experiences and insights developed within the custody suites. Dr Mwenza Blell (MB) visited each suite for one week, attending at different times of the day or night to take account of the impact of time of day on activities. Overall, MB was in custody for 130 hours but also spent time in the areas surrounding the custody suite, resulting in an overall period of observation of approximately 500 hours. Included in these additional hours are the many hours of careful note taking of MB's observations and experiences.

Work Package Two was in two parts a) semi-structured interviews with staff in police custody (Custody Officers (CO), Detention Officers (DO) and Healthcare Professionals (HCP)) led by Dr Gethin Rees (GR) and b) those with Lived Experience (LE) of being detained in police custody led by Dr Stephanie Mulrine (SM). The staff interviews were largely arranged with the assistance of senior police officers who contacted staff on our behalf and provided them with information about the project and GR's contact details. After contacting GR, a time and date for the interview was agreed and then carried out online via the Microsoft Teams platform. 33 interviews with staff were conducted in total. All staff interviews were audio recorded and were transcribed by a professional service. Staff transcripts were checked by GR for accuracy and all identifying features were made anonymous (e.g. names, places).

In order to recruit those with lived experience of being detained in police custody, SM contacted charities, peer support groups and Third Sector organisations in the two constabulary areas. Relationships were established with a small number of organisations in each of the regions. Meetings were held to provide information regarding the impetus of research and negotiate an appropriate method to recruit potential participants. Fieldwork interviews were held face-to-face, online (Zoom) or via telephone depending on the preference and availability of the participant. All potential participants were advised that the interviewer (SM) was not linked to or working with the police to ensure they were aware that all contributions would be treated confidentially. Ensuring that potential participants were informed that SM was acting as an independent researcher in this manner was highly important. Participants were given, and talked through, the information sheet and consent form, and given the opportunity to ask questions before deciding to take part. Additionally, some snowball recruitment occurred where participants who had taken part endorsed the research and passed the contact details of the interviewer on to friends who had similar life experiences. SM interviewed 41 people about their experience(s) of detention within police custody, and specifically the care (including healthcare) that they received whilst

detained. These interviews were conducted with participants who frequently represented intersections of socially produced vulnerabilities, and therefore spoke of challenging and traumatic life circumstances and experiences. Interviews could be challenging and any concerns that arose for SM were discussed with support workers as appropriate. All interviews were audio recorded and were transcribed by a professional service. LE transcripts were checked by SM for accuracy and all identifying features were made anonymous (e.g. names, places).

All interviews were semi-structured to allow a selection of broadly framed questions that both GR and SM utilised and gave sufficient flexibility within interviews to explore the themes that respondents raised. To this end, there was structure within the interviews to enable both standardisation across the interviews and allow scope to explore experiences or processes not anticipated.

Work Package Three analysed the risk assessments collected by COs at the point a person is detained, as well as the logs created during a person's detention.

Risk Assessments

Both police forces were approached for data from their custody risk assessments (1600 from each force); a spread of records across the year 2022 was requested. To ensure representativeness, we asked for an equal number of records from each month (the first 134 arrests) with these 134 divided across the police force's custody suites. The number of risk assessments provided by each custody suite was decided based on the relative proportion of known arrests in each suite (so for instance Northton advised us that Town 1 made up 22% of its arrests, City 32%, Town 2 15%, and Town 5 31%). The risk assessments received aligned as far as possible with these proportions.

Both police forces supplied anonymised data on Microsoft Excel Spreadsheets. Both datasets contained rows of data containing arrest cases, organised in columns of demographic, arrest information, and risk assessment data. The custody records contained the CRN, the age, gender and ethnicity of the person, the first four digits of the postcode, reason(s) for arrest, and the answers to the questions on their custody arrival risk assessment.

Both datasets were checked for the presence of identifiable information; none was found in either spreadsheet. Data were transferred into IBM SPSS and cleaned to ensure fidelity across the dataset.

We then examined each case row by row for the recording of important physical and mental health conditions, along with the presence of neurodevelopmental conditions, declarations relating to self-injurious behaviours, issues relating to substances, and an analysis of items relating to mental vulnerability.

To decide on which items were clinically important we used clinical guidelines published by the Faculty of Forensic and Legal Medicine (FFLM) alongside previously published research in the field. The assessment of vulnerability has been the subject of some academic and legal debate ever since the introduction of the Police and Criminal Evidence Act (PACE) in 1984. For the purposes of this study, the research team developed a definition of vulnerability that strove to follow the PACE Codes of Practice as closely as possible.

Custody Logs

The research team requested a small sample of anonymised custody logs from each of the two police forces. Such logs are a record of what is recorded by custody staff during the period of a detained person's time in detention, including any interventions that have taken place. Entries

on the custody logs are made by COs, PACE Inspectors, DOs and HCPs.

We identified 30-40 "cases of interest" and requested the logs of these from the police forces. As some health issues in custody have the potential to have critical consequences, we were keen to see cases with Head Injuries, Alcohol Withdrawal, Epilepsy, Diabetes, and Asthma. In respect to mental health problems, we aimed to sample a broad range of mental health issues from low mood, anxiety to serious mental illness including psychosis. We also searched for key terms in the risk assessments (e.g. "suicide," "hospital," "straight to cell," etc.,) which enabled us to identify cases with complex health needs. To guarantee a balanced sample, we also included cases where the risk assessments contained little information. We also tried to ensure that there was variation in the age range of selected cases and made sure to include those who had multiple physical and/or mental health needs.

We were also interested in investigating the discourse of the police staff's documented notes to examine their use of language, terminology, and the way they used this to communicate with detained persons and each other.

Analysis The data from all Work Packages was analysed by the whole research team. Analysing each data set in accordance with data of the same kind (i.e. looking for similarities and differences between different respondents within the Staff or LE data sets), and across data sets and work packages. The themes that we have identified reflect the core points drawn out across all the work packages, regardless of the data set or kind of data the theme was derived from.

In addition, we also developed a "Peer Analyst" group, working with persons with Lived Experience of receiving healthcare in police custody recruited via a Third Sector organisation, based in a different region from our case study police force areas. The Peer Analyst group undertook a period of training to understand the impetus for the research and our methodological approach and learnt how to assess and analyse data. Subsequently, a series of sessions focused on analysing anonymised data from the project based on their experience and insight. This provided important discussion, which identified and underscored key themes. This work ensured real-world sense-checking of the data that we received, as well as providing crucial endorsement of the conclusions we were drawing based on that data.

Given these various analytical processes, our findings are representative of the experiences of those involved in police custody in the two case study constabularies. This work draws on and compares the findings with other studies (for instance the team members' previous research on police custody healthcare across England), in addition to the Peer Analyst group input. The findings presented here are also generalisable to healthcare delivery practices in police custody environments across England and Wales.

Findings

Accessibility of HCPs

The provision of healthcare in police custody has switched from Police Doctors/Forensic Medical Examiners who would attend when available to Healthcare Professionals (predominantly nurses and paramedics) who are expected to be located within police custody suites (often referred to as "embedded") for twelve-hour shifts. As a result, embedded HCPs were considered to be able to provide more effective support given their co-location within custody. While there are legitimate, work-related reasons why an HCP might not be within a custody suite at a particular time (for instance, needing to attend hospital following a road traffic accident to collect blood samples), the data made it clear that there were many times when HCPs were not embedded in all custody suites at all. Various reasons were provided for why HCPs were not embedded, largely this related to difficulties around sickness, holidays, and difficulties recruiting or retaining HCPs in post. Under these circumstances HCPs on shift were expected to cover multiple suites across the force area, either traveling between sites as need arises or providing telephone/virtual support.

A key impact of the absence of a HCP onsite is that it leads to delays in the provision of clinical assessments, medications and treatments. Delays for treatments were well documented across all data sets with case logs showing that there was regularly waiting times of over two hours before clinical assessments could be made. Similarly, the logs show that time delays appeared to be particularly present when an HCP was not embedded within the custody suite, which resulted in delays before the detained person received appropriate medical treatment as HCPs had to travel a distance to get to the police station.

I can live with not having food for a couple of hours, but you can't live with not having your medication when you're due it… And then again, I'm going on, and then if you're ill, I think if you're poorly, wrong, they had to take me to hospital to make sure I was all right. 'Cause I started shaking, 'cause yeah, I was remembering it, all through my cancer tablets, and that was from 2019. (Jim, LE, Northton)

Staff interviews also expressed problems with not having an embedded HCP onsite. COs in particularly felt that they were put at unnecessary risk if they were operating a custody suite without an HCP and did not consider a remote HCP an appropriate substitute.

Not like, "Oh, we're looking at your board from 50 miles away. We'll keep an eye on you." That doesn't help. I can do a better job than you bloody looking from 50 miles away. And it's noticeable. (Derek, CO, Sutherland)

Similarly, HCPs needing to travel across the force area was also problematic, especially in rural areas where roads were difficult to traverse. Long journey times and covering multiple suites resulted in exhaustion, which, over time could lead to burnout.

[I]t happened that somebody had rung in at short notice, sickness at [City]. So, the person from [Town 5] had gone through to [City] to cover, which, then, I'm based at [Town 1], I got a phone call to go through to [Town 2]. Wow, the board at [Town 2] was absolutely buzzing. My shift just went in like an instant. When I came out, it was the weirdest thing of being physically and emotionally exhausted. I ended up having to take a little nap, on my way back. But because it was my nightshift, by the time I'd driven home, I was then still tired and shattered and all these other things, with a bit of adrenalin still running through me, and

I still couldn't sleep properly after. (Marie, HCP, Northton)

Given the impacts not having an HCP embedded within each custody suite has to both detained persons and staff, it is troubling to learn that this decision is increasingly strategic in order to reduce costs, with virtual HCPs being considered the best way to provide healthcare support.

So [Healthcare Provider] statement was, "We're fully staffed," but at this present time, they don't have the funding for a HCP to be in every single station in the force… [T]he [Healthcare Provider] organisation goes, "There's no need for a HCP [in that suite]." But the people who are making those decisions have not worked in custody and have not dealt with- Whether you've dealt with one high-risk detainee or a hundred high-risk detainees, if you need a HCP in that situation, I need a HCP. And that's my frustration, the people who are making the decisions on the lack of funding to get a HCP on every site, and stuff like that, are just people who've never worked a day in custody. (Emily, CO, Northton)

We echo Emily's concerns here and our evidence leads us to recommend that the transition to HCPs necessitates embedding of HCPs in *all* custody suites. While we accept that there are reasons why HCPs might be called away for short periods of time (for instance to take blood samples following Road Traffic Accidents at hospitals), for the vast majority of time there should be an embedded HCP and sufficient resilience in the system to ensure that another HCP (not on shift but on-call) can provide cover, in case of sickness.

Recommendation One: In accordance with the "Accessibility" portion of the AAAQ Framework, we recommend that HCPs are truly accessible to persons detained in custody, by being properly embedded within custody suites. The practice of HCPs covering multiple suites leads to delays in treatment, compassion fatigue, and adds to greater burnout for HCPs (which further problematises retention and staffing issues). We believe the proper resourcing of HCPs would remove some of the significant barriers limiting quality care in police custody.

Postcode Lottery of Medication

While some HCPs can prescribe medications autonomously, assuming they are credentialed as nurse prescribers, at the present time many HCPs do not have this capacity and so are reliant on lists of medications provided by the companies they work for, which state what medications can be provided within custody for what needs. The Patient Group Directive (PGD) protects HCPs by setting out what they are safe to provide (and in what quantities), without requiring additional oversight and approval from another healthcare professional (for instance an FME or a doctor at hospital). Nurses were therefore reliant on the PGD to determine what medications they could provide for the people in their care.

Interestingly, Northton had recently changed healthcare provider and as such staff within that constabulary were acutely aware of the differences between the PGDs of the two companies, and in particular the negative effects that the change in medication provision had had on their daily practices.

Yeah, it was done before, before we moved [Previous Healthcare Provider], and I get it, like they're very risk averse [Healthcare Provider] and we can't give Ibuprofen, I think they're bringing that back now. We can't give Ibuprofen, they stopped Ibuprofen, Rennie's, what else did they stop when they came. Because Ibuprofen, and obviously the risk of ulcers and things like that. Yeah. I know when I can give it, and I love Ibuprofen and paracetamol together if someone's got... especially if they've had cuffs on and they've had a bit of a tussle. But, yeah, they stopped quite a few things when they came (Eleanor, HCP, Northton)

In particular, the provision of nicotine lozenges came up in both the staff interviews and the ethnography as something that was seen by staff as making their day tougher, but also as a way of unnecessarily providing additional suffering to people within custody.

It struck us as bizarre, given how key the PGD is for everyday practices that the medicines list is not standardised across providers. Our findings illustrate that a person being detained in a constabulary employing one provider will undoubtedly receive different forms of care if they were arrested in another force area (and we also have accounts in our data of people being transported to different police forces due to warrants being in place for their arrest), given the difference in medications available via PGD. The availability of products, for instance nicotine, being dependent on the provider of the service seems problematic to us and clearly produces a space for inconsistencies in care and perhaps maltreatment.

Recommendation Two: In keeping with the "Good Quality" provision in the AAAQ Framework, we recommend all healthcare providers to sign up to a standardised medication list and PGD so that all police custody suites have access to the most appropriate treatments, regardless of location, healthcare provider or constabulary.

Stigma and Disbelief

Examples of stigmatising behaviour were prevalent across all data sets, but we will begin with the case logs as they most directly highlight the contemporaneous and stigmatising language of custody staff and highlight the potential healthcare risks this attitude and approach to detained persons generates.

There were examples in custody logs where a member of custody staff would record that they believed that the medical issues being disclosed by the detained person on the risk assessment were untrue or exaggerated. For example:

DP stated she was pregnant, but it was 'not believed to be true'. (Northton, Female, Case Log 6)

There was evidence of custody staff using value judgements when documenting health conditions. Whilst it would be reasonable for an experienced custody officer to exercise judgement based on their experience, there were examples where there was a risk that these could undermine the significance of the health issue being disclosed by the detained person, thus trivialising a potentially serious health condition. In the case of one detained person who had injuries, and drug dependence, the following was recorded:

I have asked if he was okay, and he looked at me in a manner that made me think he was fine. (Sutherland, Male, Case Log 13)

The same detained person was described as a "sociopath" whose opiate dependency was described as a "*lifestyle choice."*

One log described a detained person who was having thoughts of self-harm and who had prior self-harm attempts, who is described as *"clearly emotional"* with a *"very weak attempt"* at harming himself when he attempted to hang himself (Northton, Male, Case Log 22).

There were numerous examples of generalisations being made when the person had co-occurring health issues, which may give the reader the impression that these detained persons were somehow viewed as an inconvenience by staff:

DP has a wealth of ailments and clinical issues. (Sutherland, Female, Case Log 1)

A similar attitude was taken when describing detained persons who were prescribed several medications to manage their health conditions:

[DP on a] raft of medication from hospital. (Northton, Male, Case Log 4)

There were also discrepancies in the medical terminology used by HCPs compared to custody staff. This was particularly prominent for language surrounding dependence on substances. For example, for both SM7 (Sutherland, Male, Case Log 7) and SM19 (Sutherland, Male, Case Log 19) the HCP referred to the detained person as "alcohol dependent", whereas the custody staff used the term "alcoholic." The latter term shows less sensitivity towards substance dependency, perhaps implying that custody staff place blame for the dependency on the detained person rather than acknowledging the dependency as a serious condition with the risk to become a medical emergency if the person progresses to alcohol withdrawal.

In general, the language used in the custody logs often conveyed a level of disrespect towards detained persons. For one detained person with multiple health issues, it was described that he:

*[S]uffers from a whole host of medical conditions (*Northton, Male, Case Log 19*)*

In another example, custody staff wrote that a detained person:

[T]ends to blame others for things not going his way. (Sutherland, Male, Case Log 9)

It is also assumed that the detained persons are purposefully making the job of the custody staff harder, for example:

*I have been through all the meals that are suitable for DP and she has managed to find an issue with all of them. (*Northton, Male, Case Log 16)

All these cases illustrate an underlying sense of dislike and a stigmatising attitude towards the detained persons by custody staff.

Across the data sets we commonly identified the stigmatising attitudes of staff impacting healthcare delivery to detained persons in two key ways: the first relates to denial of treatment as a form of punishment; and the second concerns scepticism and distrust of detained persons' medical histories. Taking denial of treatment as punishment first, there were instances of detained persons not being seen by the HCP in the custody suite or not being taken to hospital, despite healthcare issues being disclosed that should have been reviewed and (where applicable) treated. For example, bruising to the head of detained person NM21 (Northton, Male, Case Log 21) was noted in the risk assessment (alongside bruising to both wrists), yet they were not seen by an HCP. In one instance a detained person was purposefully denied medical treatment for their hand injuries in the Emergency Department because of their behaviour. SM13 (Sutherland, Male, Case Log 13) had infected hand injuries that required Accident and Emergency treatment, but the HCP stated: "*due to [the detained person's] abusive, aggressive behaviour, the medical treatment can wait*." (Sutherland, Male, Case Log 13) Triage processes enable these negative attitudes towards detained persons to materialise in the form of delayed or denied treatment.

The second impact of the stigmatising attitude for healthcare is the level of scepticism and distrust shown concerning medical histories.

And it's not that you want to call your patients liars, but some of them are, blatantly, because they will obviously look after their own end. And their way of thinking is they will say what they need to get the medication. (Kate, HCP, Sutherland)

A core facet of medical training and practice is taking a medical history and developing a care plan based around that history. Both during interviews and observations, we were struck by the level of scepticism and distrust that police and healthcare staff showed with respect to detained persons' accounts of their medical histories and the legitimacy of the medications that they brought with them into police custody. The scepticism was to such an extent that it led MB to write in her fieldnotes "The option to trust people just does not seem to be real for HCPs in custody." The scepticism partially derives from a risk-averse culture, driven by fears that detained persons are "drug-seeking" and looking to "top-up" for free.

Staff interviewed reported the concern with providing medication is that there is the possibility to overdose the detained person, potentially resulting in a death-in-custody. While this concern was reportedly most pressingly focused on opioid dependent detained persons, the policymaking around caring for those with an opioid dependence had extended to policies for the provision of all medication. For instance, a detained person would only be permitted to their medication if it was adequately boxed and labelled, clearly articulating what was in the box and the quantity and frequency of when it was to be taken. Very few of us carry medicines in their boxes around with us daily and so it is no surprise that people in police custody would also not have their medicines in this form.

In response to people not arriving with boxed and labelled medications, HCPs noted that another practice for limiting risk in the uncertainty (in their eyes) of what medications the detainee had previously taken or the legitimacy of the medication they have brought with them, was to limit medication provided within the first six hours of detention. In such a way any substances taken prior to arrest would have been metabolised before new medication is provided. While this practice is not recommended by organisations, for instance the FFLM, many of the HCPs confessed that they did follow this practice and some even implied that there was a guideline recommending it (although no such national guideline exists). The problems connected with this practice and other impacts from scepticism were exemplified by Clive.

So, in order for the police custody sergeant to give you any medication whatsoever, you have to be seen by a doctor at their facility. Even if you come in with medication on you, they won't give it to you because they don't know it's prescribed to you. The other way that they can do it is contact your doctor surgery and get confirmation from your doctor, but if you're arrested at six o'clock in the evening, and I've been arrested at that time in the evening, and I've not seen a doctor until about two, three o'clock in the morning. Yeah, it's quite a traumatic experience to go through when you're in that position and you're feeling really vulnerable and you're feeling really unwell… I was diagnosed by my doctor as epileptic. I had my Diazepam on me. The police Custody Sergeant wouldn't give me my Diazepam because it's a known controlled substance on the street… Yeah, because their argument was, "Well, we don't know what you've taken beforehand," and I'm like, "Regardless of what I've taken beforehand, I'm prescribed that medication for a condition which I have got, and it says on there one to be taken three times a day, morning, evening and night. Now, the morning's gone, the evening's gone. This is nighttime now and you've still not given me my medication." "Well, you have to wait until you see the doctor," and I'm like, "But it says on the box one three times a day. I've already missed two doses," and they go, "Well, we can't do anything until the doctor arrives." So, you're just at that point where you're powerless. You can't do anything. (Clive, LE, Sutherland)

Clive's example here identifies multiple problems raised by the scepticism and stigma inherent in dealing with detained persons presenting with their own medication. The questioning of the legitimacy of whether the person should have this medication, the expectation that they are exhibiting so-called "drug-seeking" behaviours, the fear that they could potentially overdose due to the lack of knowledge of what the person has consumed before detention (again, itself a product of the belief detained persons are "drug seekers"). All these combined come together to not only result in the detained person not receiving their prescribed medication, but also adds greater shame and stigma for that person, evidenced here by Clive noting that he experienced this process as traumatic due to being vulnerable and powerless in detention. While HCPs will justify this in terms of the medical half-lives of the various pharmaceuticals and argue that missing a dose or two will not take the person below the therapeutic benefit of the medication (especially when compared to the risks of overdose), the overall stigmatising effects of not believing the medical history of the person adds significant additional harms of being in police custody. As already discussed, a foundational aspect of healthcare delivery is taking on trust the medical accounts of

the patient, but in police custody this foundational aspect is sorely lacking.

Recommendation Three: Healthcare providers to remind HCPs that there does not exist a guideline that recommends waiting for six hours of detention before medicating. Clinical signs and symptoms should be recorded and clear communication should be made to the detained person about why they are or are not being medicated at a particular time, and when they are likely to be reviewed again.

Recommendation Four: In accordance with the "Acceptability" provision in the AAAQ Framework, which states that all are entitled to respectful and equal treatment in healthcare delivery, we strongly recommend that staff within police custody are trained to approach detained persons with professional curiosity rather than the scepticism that has clearly been demonstrated in this study. While we are aware there are cases where detained persons do not fully disclose (due to concerns over privacy, or in order to generate a quicker release) or are attempting to access medication when not physically withdrawing, we are also aware that custody staff have resources for discovering when these strategies are being invoked (for instance clinical scores) and rather than accepting manipulation and deceit as the norm, we would urge staff to have professional curiosity about what is leading to inconsistent claims/disclosures. Such professional curiosity will enable interactions between staff and detained persons to be empathetic, sensitive and non-stigmatising. The inability to trust the medical history of detained persons, not only undermines the basic standards of healthcare but also serves to reproduce stigma and inequality. On the other hand, listening and trusting detained persons' accounts with professional curiosity would promote interactions with detained persons more akin to trauma-informed practice.

Methadone

The provision of methadone was one of the most contentious points across all Work Packages and specifically highlighted some of the concerns we have already drawn attention to around timeliness of treatment, medications management and stigma. While there is a clinical assessment for opioid withdrawal, getting to be assessed is a difficult matter with COs and DOs making decisions about the need for an HCP assessment as evidenced from the custody logs:

[N]*ot withdrawn [sic] from drugs as [they] are trying to make out* (Northton, Male, Case Log 24)

[H]*e states he is already starting to have shakes although I couldn't see this* (Sutherland, Male, Case Log 8)

Furthermore, HCPs tend to triage drug withdrawal requests low down the order given the perceived lower potential risks of drug withdrawal. For instance, detained person SM13 (Sutherland, Male, Case Log 13) was not administered pain-relieving medication (not methadone) for over four hours after withdrawal symptoms were first reported. There was also one instance in which NF6 (Northton, Female, Case Log 6) waited six hours for treatment due to the HCP believing that the detainee has not been "*open and honest about what she has taken*." This latter example clearly echoing our earlier discussion about stigma and disbelief.

The result of all this scepticism was often either delayed or denied treatment and as a result, for the detained persons, periods of suffering. If not treated this suffering would then extend into the period of release and risks directly leading to reoffending.

You come out of there rattling, rattling your tits off, so what are you going to do? You're going, you don't want a score, you haven't scored, you are on a script, say your script's been stopped 'cause you've been in custody that long and whatnot, you're let off at six o'clock, eight o'clock at night nowhere open, no chemists, you can't get your script, what's next, 'do you know a score?' Isn't that what we're all trying to avoid? 'Cause that's just putting you right back in there. (Ron, LE, Northton)

As a result, not only does the lack of treatment in police custody result in ongoing suffering for the person, but also leads back into networks of criminality as the person attempts to medicate in the absence of legitimate avenues.

One HCP explained how the process was supposed to work:

Yes. So, we would look at when they last had it [methadone], and say they had it yesterday, and they came in this morning, and they were like, "Oh, I need my methadone. The chemist shuts at five o'clock." We would then say to the police, "Listen, what's the chances of them getting out? Can we try and not push it forward, but be mindful of the fact that this might be an issue." And if they can't get it, they can't get it. The alternative is that we medicate them under PGD for opiate withdrawal [alternative pain medication, not methadone]. And then, we would inform the chemist, or the place where they would have... "Do you want me to let them know that you haven't come and collected it because you're in here?" "Yes. Because then they'll think I just haven't shown up." Because if they miss three days on the bounce, then they cancel the script. So, we don't want that to happen because it's not in their interests, and it's not in ours. So, we try and avoid that. But if it's unavoidable, well then, we'll ring them and say, "They're here. They just can't come for it." (Belinda, HCP, Northton)

Belinda's explanation however, was a rare example of a professional interview that

offered the option of contacting the pharmacy or clinic to access a person's methadone. The majority of professionals we spoke to stated that methadone was not an option (again assuming a person was clinically assessed as being in withdrawal, which, as we have already indicated is a complex and difficult process in its own right). There was no incidence of Belinda's approach happening for those interviewed within the LE sample, and experiences of accessing symptom alleviating medication were rare.

The FFLM make it clear that methadone should be available in police custody, and we would strongly support and endorse their recommendation.

Wherever possible (and where clinically appropriate), methadone or buprenorphine treatment should be continued for anyone detained in police custody and already stable on such medication in the community. ***It is unacceptable to have a rule to automatically withhold opiate replacement therapy in police custody.*** *Withholding such treatment from detainees who are compliant with their regime may increase the risk of relapsing or re-offending, and with pregnant detainees there are significant risks to the unborn child.* (Faculty of Forensic and Legal Medicine 2020: 44/45 emphasis in original)

Alongside the risks of relapsing and reoffending that the FFLM raised (and we have also evidenced), it should also be noted that a failure to liaise with the pharmacy/clinic that provides a person's methadone can result in that person being removed from their treatment scheme. This process could be mitigated if the custody staff communicate to the pharmacy that a patient is in custody and arranges for their methadone to be collected and provided within custody.

But, yeah, I just don't agree with it, and it winds me up because if someone gets lifted, I don't know, like on a Thursday night and no-one lets the pharmacy know. And they don't get released until Monday, they're off the script and they miss three doses, yeah, it's- I've fought it and fought it (Eleanor, HCP, Northton)

Lived Experience data from WP2 also highlighted that given the waiting lists for treatment programmes in non-custodial contexts, people trying to get on to a programme have resorted to criminal activity, as that will put them on a treatment programme far quicker than in non-carceral contexts.

They refer you, you go in with an addiction, they refer you to agencies. Which, it still takes two months. I used to get myself sent to prison, just get myself a shoplifting charge, get 30 days, get put on a script within the day. (Zack, LE, Northton)

Given the length of time it takes to get back on a treatment programme it is imperative that custody teams liaise with services as soon as possible if a person on a treatment programme is detained.

Recommendation Five: In accordance with the FFLM recommendations, methadone to be accessible in police custody to all on a rehabilitation treatment programme. To enable this, custody teams to develop robust relationships with local pharmacy and drug services to ensure swift provision of methadone when caring for a drug dependent detainee.

Medicating Before Interviews

During ethnographic site observations we saw cases of HCPs advising COs to delay a police interview for a number of hours to allow any medications that the detained person had consumed to metabolise. Medications, especially those provided to deal with the effects of opioid and alcohol withdrawal are likely to make the person drowsy and therefore could have a significant impact on their responses during the interview. Providing time for the person to sleep off the medication would improve the quality of the evidence provided. Interestingly, some HCPs also advised us that they discussed with the detained person who was in opioid withdrawal whether they wanted to be medicated or not, with the option being that if they were not medicated they could be interviewed sooner.

Common amongst the LE interviews was the explanation that rather than strategising to obtain drugs, detained persons would respond to questions in ways most likely to reduce their time in custody. Given that detained persons are forced into behaving strategically to leave sooner, we understand the provision of the option to be medicated or not as an act of responsibilisation. By this we mean creating a situation where the detained person is expected to make a choice between the side-effects of their withdrawal and their strong desire to leave custody. This responsibilisation of those in withdrawal had many negative effects, not least participants feeling so unwell during the interview that they were unsure about what they had said and confessing to acts that they had not done.

I've admitted to things that I haven't done, just to get them out, just to get out of the way just to get out of there, to get my meth, to get to jail. It's madness yes, but do you know looking back I've got these things on my record now and I'm thinking, "Fucking hell, I haven't even done that," and it just looks worse every time I go to court so. I know it's mad. I don't know if they do that on purpose, but I don't think they should be able to do shit like that anymore. Some police stations are still stuck in the stone age with things like that. (Zack, LE, Northton)

Our findings indicate that there needs to be more consideration about the interaction between drug consumption (or lack of consumption) and the effects that this has on a person during a police interview. Due to the power dynamics in police custody and the understandable desire to leave custody as swiftly as possible, detained persons might not act in their own interests if offered a choice between a faster interview or being medicated. To assist with the decision, we recommend that alcohol and drug dependent detainees are recognised as being vulnerable and so are provided with an Appropriate Adult, who would be able to assist them in making the decision of whether to be medicated prior to the police interview or not.

Recommendation Six: Alcohol and drug dependent detained persons to be recognised as vulnerable and provided with an Appropriate Adult in order to provide the detained person with an independent support to help them understand the benefits and limitations of being medicated prior to a police interview.

Referrals

Respondents with lived experience reported a lack of consistency when asked if they had received support information or some form of intervention whilst detained in police custody. Few of our LE cohort, for instance Greg, could recall being offered a form of referral:

Yeah, I don't know what they're called, I think, like, mental health team, they give you, like, telephone numbers for them, but at the minute, the whole thing, when you leave, they, like, give you a number for, I don't know what they're called, liaison and diversion team, yeah... No, I've not had contact with them, they give me their number and I had to ring them up, but I don't get round, they never spoke to me, they just get out there when you fucking want a fag, don't you, you get out of there. (Greg, LE, Northton)

While on the other hand Ahmed could not recall any kind of referral across multiple periods in police custody:

No, nothing like that. They've got a little thing up on the wall like, 'Drug misuse, call this support line.' but they don't get anyone to come in and have a talk to you about it, you know try to talk to you, they just leave you alone and just give you what you need and that, food and stuff like that. (Ahmed, LE, Sutherland)

Ahmed went on to reflect on the value such a referral might have had:

It could be useful, yes, why not? It wouldn't harm them, would it, to have a chat? Maybe they've had enough and they want to get the right support and they don't know where to get it from. So just like leaflets, brochures, whatever, NA, Narcotics Anonymous, meetings and stuff like that, why can't they start promoting that in the cells and having a support worker in the cells? (Ahmed, LE, Sutherland)

Ahmed's thoughts echo Addison et al. (2018) in their AcCePT study where a brief intervention in police custody was shown to be effective for persons arrested when intoxicated. As a result, we have been left with the impression that while there is the potential for support and referrals to be provided in custody, at present this is either not being done, or is being done in an inconsistent, or tick-box fashion.

Recommendation Seven: Consistent referral of support services to detained persons. When Liaison and Diversion teams are available, custody teams can defer this activity to them, but when they are not available we recommend that COs actively do more to refer detained persons to support services either during the detention or as they are leaving. Providing information and having brief interventions during the period of detention would be most effective as evidenced by Addison et al. (2018).

Recommendations

Recommendation One: HCPs to be properly embedded within custody suites. The practice of HCPs covering multiple suites leads to delays in treatment, compassion fatigue, and adds to greater burnout for HCPs (which further problematises retention and staffing issues). We consider the proper resourcing of HCPs would remove some of the significant barriers limiting quality care in police custody.

Recommendation Two: All healthcare providers to sign up to a standardised medication list and PGD so that the same medications are available in all custody suites, regardless of location, police force or provider.

Recommendation Three: Healthcare providers to remind HCPs that there does not exist a guideline that recommends waiting for six hours of detention before medicating. Clinical signs and symptoms should be recorded and clear communication should be made to the detained person about why they are or are not being medicated at a particular time, and when they are likely to be reviewed again.

Recommendation Four: Staff within police custody to be trained to approach detained persons with professional curiosity rather than the scepticism that has clearly been demonstrated in this study. While we are aware there are cases where detained persons do not fully disclose (often in order to generate a quicker release) or are attempting to access medication when not physically withdrawing, we are also aware that custody staff have resources for discovering when these strategies are being invoked and rather than accepting manipulation and deceit as the norm, we would urge staff to have professional curiosity about what is leading to inconsistent claims/disclosures. The inability to trust the medical history of detained persons, not only undermines the basic standards of healthcare but also serves to reproduce stigma. On the other hand, listening and trusting detained persons' accounts with professional curiosity would promote interactions more akin to trauma-informed practice.

Recommendation Five: Methadone to be accessible in police custody to all on a rehabilitation treatment programme. To enable this, custody teams to develop robust relationships with local pharmacy and drug services to ensure swift provision of methadone when caring for a drug dependent detainee.

Recommendation Six: Alcohol and drug dependent detained persons to be recognised as vulnerable and provided with an Appropriate Adult in order to provide the detained person with an independent support to help them understand the benefits and limitations of being medicated prior to a police interview.

Recommendation Seven: Consistent referral of support services to detained persons. In the absence of Liaison and Diversion services we recommend that COs actively do more to refer detained persons to support services either during the detention or as they are leaving. Providing information and having brief interventions during the period of detention would be most effective as evidenced by Addison et al. (2018).

Summary and Next Steps

As set out in the introduction, the AAAQ Framework is a useful standard for reflecting on the delivery of healthcare (especially in criminal justice environments) and identifying its weaknesses and to make recommendations. Taking each of the four standards of the AAAQ:

Availability – Recommendation 1 – relating to the timeliness and embeddedness of HCPs.

Accessibility – Recommendations 3, 4 and 7 – especially the emphasis on ensuring that healthcare is available to all and in a non-stigmatising manner.

Acceptability – Recommendation 6 – especially acknowledging the desire of people to want to leave custody, which can result in decisions being made that are not in their best interest.

Good Quality – Recommendations 2, 5 and 7 – especially the standardisation of medication and the PGD.

Combined with our data the AAAQ has been a useful heuristic for converting the changes we want to see in police custody into a set of recommendable standards.

These recommendations on their own are insufficient however, and need to be established in governance procedures, for instance Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service/Care Quality Commission inspections or the Authorised Professional Practice (APP) guidance. We also think that the Police and Crime Commissioners can play a role here as commissioners of providers. While the contracts between forces and provider companies do state that HCPs working in custody will perform in a trauma-informed/non-stigmatising manner and will provide care in a timely fashion, our evidence pays testament to the fact that these agreed terms are not being met in practice. What role can the PCCs play in ensuring that providers continue to hold up the standards that are agreed in the contract? We would be willing to provide a series of questions, again developed from our AAAQ recommendations, to enable PCCs to check-up on whether provider companies are continuing to meet their commitments, but is a more overarching governance approach needed?

On top of these questions, we should also reflect on the continuing need for detentions in police custody and whether alternative strategies would be preferable. As Skinns, Wooff and Rice (forthcoming) highlight, detention in police custody should be the last resort after all other tools (street bail and voluntary interviews for instance) have been explored and rejected and only when detention is *justifiable* and *equitable*. We should also explore other options for the location of police interviews, for instance Third Sector organisations for some (if only a limited) redressing of the power imbalance between detained persons and the police. While these issues are wider than healthcare, they are, of course, linked – if a person was not detained, their healthcare would not be the police's responsibility.

Finally, given our experiences in police custody, we do not ever foresee a time where we could confidently say that healthcare in police custody is equivalent to that of persons at liberty, and as we have said throughout, it would be difficult to know what equivalence would actually look like, but we can foresee forms of healthcare that attempt to minimise harm and suffering within police custody. Our recommendations, developed from our findings and the AAAQ Framework are the first step to reducing that suffering, for as long as people continue to be detained in police custody.

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