Avon and Wiltshire Mental Health Partnership NHS Trust

Policy for the management of alcohol and drug use on AWP Trust premises

Board library reference	Document author	Assured by	Review cycle
P052	Consultant Nurse for Dual Diagnosis	Quality and Standards Committee	3 years

Contents

1. Introduction

The management of co-existing alcohol and drug problems is one of the biggest challenges facing mental health services. The detection, support and provision of appropriate interventions and the provision of a safe environment whilst inpatients are key component of an effective treatment.

2. Purpose

- producing or attempting to produce a controlled drug
- supplying or attempting to supply or offering to supply a controlled drug
- preparing a controlled drug
- using a controlled drug

Staff are legally required to take action highlighted in this policy if such activities are suspected.

3. Scope

This document is relevant to all groups of staff.

4. Definitions

4.1 Dual diagnosis

The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- A primary psychiatric illness precipitating or leading to substance misuse
- A substance use worsening or altering the course of a psychiatric illness
- Intoxication and/or substance dependence leading to psychological symptoms
- Substance use and/or withdrawal leading to psychiatric symptoms or illnesses.

5. Policy description

5.1 Key principles

The aim of this policy is to reduce the use of co-existing alcohol and drug use while an inpatient. This can be maximised by working collaboratively with service users, rather as being seen as having a purely custodial role. Staff need to appreciate what triggers use and how difficult it can be not to use while on the ward. The aim of this policy is to work with the service user to support the non-use while an inpatient.

Some service users will seek out and use alcohol and drugs while on the ward regardless of the support available. They may need agreed care arrangements and ultimately sanctions in order to reduce the risk to themselves or others.

The Trust's underlying philosophy is to view all alcohol and drug problems in terms of possible recovery. We do know not who or when people may enter recovery. Sometimes it is a gradual process; sometimes it may be precipitated by a life event, such as an admission to hospital, which should therefore be viewed as an opportunity to think about making positives changes to alcohol and drug use.

Many services users will want to recommence alcohol and drug use when they leave hospital. This needs to be acknowledged and discharge planning may need a pragmatic response which would include agreed levels of use or the monitoring of use. For those in forensic services with a high risk profile, abstinence may be the only feasible treatment goal.

Tolerance to alcohol and drugs can quickly reduce while the person is not using in hospital. Service users should be made aware there may be an increased risk of overdose if use were to recommence at previous levels which were tolerated.

Treatment facilities across the Trust need to display clearly the Trusts position towards substance use.

If you require any additional information, or support about specific substances please contact your local alcohol and drug service.

The policy should adhere the Mental Health Act Code of Practice (2015) and current Human Rights Act Legislation.

5.2 Information for patients and clients

When admitted the service user should be made aware of Trust policy regarding use while on the ward. Namely, that for the safety of all patients the Trust has a 'zero tolerance' for use on Trust premises. This information should be delivered as collaboratively as possible, for example, asking why we have such a policy, and how can we support the patient adhere to it.

To maximise collaboration in reducing the risk of use a series of questions could be asked.

- What do you think the policy might be for using alcohol and drugs while in hospital?
- Why do you think we have this policy? (Try to elicit risk to mental health, difficulty in assessing mental health when using, contra-indications to prescribed medication, the danger of giving alcohol and drugs to other services)
- How easy do you think it will be for you to adhere to it?
- What do you feel might be the consequences if you do not?
- What might be your main triggers/difficulties?
- How can we best support you while you are here?

Attempt to understand triggers and high situations associated with use, the management of urges and craving, practising distraction, mindfulness and relaxation techniques should all be considered as part of the psychosocial support.

Information about impact on mental and physical health should be available. Trust inpatient facilities should also display a directory of local services and mutual aid contacts that can help with drug and alcohol problems.

5.3 Assessing for alcohol and drug problems

Co-existing alcohol and drug use is common. Between 30-70% who are seen in health and social care settings will have a co-existing problem at some point (SCIE, 2009). Assessment of the service user in an informal accepting and professional manner. Explain the reasons for trying to determine their level of use and what will be done with the information.

Alcohol and drug testing should be considered if there is uncertainty about the use of drugs. This should be framed as part of our assessment and not to 'catch people out'.

For full assessment procedure, see Trust alcohol and other drug guidelines.

There is an increasing misuse of Novel Psycho-active Substances (NPS's), which are also often known as, 'Legal Highs' or 'club drugs'. These are often powerful man made substances, which may or may not be legal, the government is looking at passing a law to try and categorise all "psychoactive" substances not current covered by other law illegal. Many NPS mimic common drug actions, such as stimulants, depressants and/or hallucinogens. These are not easily detected and their actions are variable. This can results in disinhibited, restless and aggressive behaviour, a dissociative state, or increase sedation. They can cause cardiac problems, increased pulse, chest pains or collapse. Seizures and variations in blood sugars have also been reported. If you believe someone may have taken NPS's, an assessment should be carried out, increase observation until the effects wear off. It may well result in a medical emergency requiring immediate transfer to A&E.

There are more details about NPS on the AWP Dual Diagnosis page.

5.4 Interventions for alcohol and drug problems

For further details on the Management of Co-existing Mental Health and Alcohol and Drug Problems, please refer to the AWP CPA Dual Diagnosis Procedural Guidelines.

5.5 Reducing the risk of use on Trust premises

If patients are suspected of using alcohol or illicit drugs, glues and aerosols, or any other substance for recreational use, a drug screen and/or property search may be requested of them. Finding such substances or refusal to cooperate with a search may result in discharge. See discharge protocol (section 5.3) for further details.

Staff will need to be aware of who might be dealing substances. If known ex-patients who deal are seen on hospital grounds, staff should assess their reasons for being present. If suspected of dealing, they should be asked to leave the hospital grounds immediately. Hospital security should be informed. If staff suspect individuals are dealing on Trust premises, the police also need to be informed.

Staff will need to be aware of particularly vulnerable patients, who may find it difficult to refuse substances if offered, and provide education, support, and protection, if appropriate.

The role of staff is to balance the needs and clinical risk of the individual against the needs and safety of other patients, visitors, and staff. Support and advice about individualised care planning in order to meet the patient's substance use needs can be accessed from the local Specialist Drug and Alcohol Service.

5.6 The use of Care Agreements

Service users should not be discharged simply because of substance use. These patients need an assessment of their problem, may need an increased dose of their opioid substitute and/or cognitive behavioural interventions to help them reduce and/or stop their illicit drug use.

The implementation of arbitrary, inconsistent sanctions (e.g. leave withheld) can be counterproductive, non-therapeutic, and unhelpful. Sanctions should be carefully considered, only as part of the care plan. Such sanctions may also be meaningless if they are clinically unenforceable due to co-existing problems with the client taking responsibility for their treatment and the consequences of their behaviour. Therefore, if sanctions are to be considered, proceed with caution following an agreed, whole team approach.

Successful use of care agreements depends on client co-operation and staff willingness to implement them. The primary responsibility of inpatient staff is to ensure a therapeutic response to substance misuse problems, the mental health status of the patient, or their level of clinical risk.

There is evidence that sanctions may occasionally be useful in providing clear, consistent, and care planned boundaries for the management of a patient's substance use.

It is important that the terms of the care agreement are agreed between the client and the care team.

It may contain the following:

- A statement agreeing not to use substances on the ward.
- An agreement that aggressive language or behaviour will not be tolerated.
- An agreement for staff to routinely screen or search if they have reasonable grounds for suspicion and when this would occur, e.g. after a period of leave.
- The patient also needs to consent to provide blood, urine (supervision if necessary), oral fluid and breath samples when requested by staff.
- A clear statement of the consequences if the care agreement is breached.

- The expected level of treatment participation and the benefits of this.

Factors to consider if a care agreement has been broken.

- Were the terms and consequences clear and agreed beforehand?
- Were the physical and psychological aspects of use addressed by staff, e.g. sufficient substitution dose, detoxification, nature of the illness, management of cravings, insomnia, and anxiety?
- Were the potential environmental pressures addressed beforehand, e.g. boredom, availability of leave, vulnerability of the patient?

If it is proven that an individual has been using substances recreationally while an inpatient, then the treatment team needs to assess the impact on the patient's treatment and clinical risk associated with their substance use. This should include:

- Impact on the individual's mental state, physical complications, and social circumstances.
- The frequency, amount, and nature of substance use.
- The impact of their behaviour on other patients and staff, including physical or verbal aggression.
- The patient's view of their substance use and likelihood of continued use.

Following a risk assessment, the following decisions can be made:

- Continuation of the current treatment
- Changing the treatment regime to improve clinical effectiveness, such as increasing dose of medication or psychological interventions.
- Implementing sanctions
- Discharging

An example of a service user contract is in Appendix 1.

5.7 Procedure for change to care arrangements

The following changes to care may include the following

- An increase in observation levels
- More frequent urine or other drug screening
- Restrictions on leave
- More frequent property searches
- Restrictions on visitors who may bring in drugs or alcohol
- Informing the police
- Transfer to another unit, including possibly to a more secure unit.

The following procedure should be followed:

- Discuss the appropriateness of changing care arrangements and decide which are most suitable with the consultant psychiatrist or senior team member. Possible restrictions to care should not be used as punishments, but must be primarily to improve the safety or effectiveness of treatment for the patient or others on the ward, or to reflect a recognition that treatment is not working.
- Inform the service user of the changes, explaining why they have been required, for how long they will continue, and what behaviour is necessary in order for the care arrangements to be reviewed.

- Record within the clinical record the decisions that have been taken, the changes that have been initiated, and the information given to the service user.
- If possible and appropriate, pass on the decisions and their rationale regarding the change to care to relevant relatives, friends, visitors, and appropriate staff.
- If the service user is suspected of a serious transgression of this policy, e.g. giving or selling illegal substances/alcohol to other patients, or has habitually abused and/or seriously breached this policy in some other way, this information should be passed onto the police and the clinical team needs to consider the appropriateness of discharge in light of possible risks.

5.8 Agreed use as part of leave arrangements

Patients who are at high risk of substance use when going on leave may need an agreed drug related individualised risk assessment and care plan. It may be pragmatic for them to record weekend use and its consequences in a diary. On their return to Trust premises, the zero tolerance policy should be reinforced. Patients will be informed that they may be subject to drug testing or searches on return from leave.

5.9 Discharge

If it is felt that the service user has no intention of complying with the treatment programme and/or the Trust's policy regarding the prevention of illicit substances/alcohol misuse, it would be appropriate at this point for the consultant psychiatrist or senior team member, in conjunction with the clinical team to complete a risk assessment and reappraise the risks and benefits of continuing treatment as an inpatient.

If there is no apparent serious threat to the service user or others, the consultant psychiatrist or senior team member, should consider whether discharge would be in the best overall interest of the Trust service and the patient, as the ultimate sanction.

Discharge should be carried out in accordance with a discharge plan (ideally, devised by the multi-disciplinary team after the service user's admission), risk assessment, community follow up, and informing the patient's GP and carers, if appropriate.

If the Mental Health Act status of the service user or their level of clinical risk is considered inappropriate for discharge, the consultant psychiatrist/senior team member should consider transfer to a more secure environment, if it is felt that continued safe management is not possible on an open ward.

An urgent CPA and discharge plan should be convened. Discharge planning should follow the AWP Care Programme Approach and Risk Policy.

When discharge from an inpatient setting occurs, the care co-coordinator and GP must be informed as soon as possible. CPA must also be completed and a follow-up appointment arranged.

5.10 Personal Searches and Disposal of Substances

When Trust staff become aware of illegal activity or activity contrary to Trust Policy involving substance/alcohol misuse, it is their responsibility to report this information to the most senior manager available immediately.

Where there is reasonable grounds to suspect that a patient is in possession of an illegal drug or other potentially harmful substance, then the most senior professional on duty on the ward, together with another member of staff should discuss the situation with the patient, explaining their suspicions, but being careful not to make a direct accusation of possession or misuse of an illegal substance or other psychoactive substance.

Advise the service user that it is illegal to be in possession of illicit substances, that the Trust does not allow illegal drugs or recreational psychoactive substances on its treatment facilities, and may authorize pharmacological tests to detect substances.

Inform the service user that their confidentiality cannot be guaranteed in circumstances where an illegal act has occurred.

If staff have reasonable grounds to suspect that a service user is in possession of illicit or harmful substances, request the patient to hand over these items to them for disposal.

Staff should wear disposable gloves while having contact with the substance. It is treated as an "unknown" substance, as its identity can only be established following forensic analysis. If staff are uncertain of how to dispose of a particular substance contact the ward pharmacist for advice.

Two members of staff should place the item in a bag or envelope with the following details:

- Found by
- Location
- Found in possession of
- Ward
- Date and time

If the service user surrenders the suspected substance, it must be placed in the controlled drugs (CD) cupboard (or a designated secure area if there is no access to a CD cupboard)

This means the staff member has 'legal possession' of the confiscated "unknown" substance and is legally authorised to destroy/dispose of the substance providing it takes place within 24 hours (where practicable), and is done in the presence of another member of staff noting the date, quantity (when possible), description, type of substance (when possible), and destruction method. If possible, a pharmacist should be called to the ward to do this.

Record details in Controlled Drug Register.

Syringes, needles, and other drugs paraphernalia (spoons, filters, etc.), which are found must to be disposed of in a sharps bin immediately.

Record in the clinical records the action taken and advice given to the patient, including help and support offered with regard to drug problems or substance/alcohol misuse and dependency.

Complete an adverse incident form.

Liaise with the consultant psychiatrist/senior manager to determine whether further action is required. This may require the need to liaise with other agencies, relatives, or carers. Action may include personal and room searches, urine testing, breathalysing, or informing the police if necessary (e.g. if quantities appear to be greater than for personal use).

In instances where the police are informed, the attending officer and nurse in charge will sign the controlled drug record and the police will take possession of the substance.

The balance between treatment and the pursuit of criminal prosecution should be documented in the care plan. It may be necessary to convene a CPA meeting to determine the most appropriate course of action.

Where a service user refuses to hand over suspected substances, staff should request a non-invasive body search (e.g. asking a patient to turn out pockets) and a room search.

If the service user refuses, staff should contact the patient's consultant or on call consultant and senior manager to inform them of the situation. Authorisation for a room/individual search will be needed from the consultant psychiatrist or senior staff member or service manager, balancing the individual rights of the patient against the perceived clinical risk.

Explain to the service user that the staff have reasons and rights to proceed with a search of the patient's person and property, room, etc., if the suspected substances are not handed over.

Please read this policy in conjunction with the Trust Search Policy, currently awaiting revision.

5.11 Police searches

Police can be invited onto the ward for a specific suspicion, and specific areas where suspected drugs might be found need to highlighted to the dog handlers.

Where it is suspected that illicit drugs are being used, the police will be asked to attend with dogs to search the premises.

Service users will be informed on admission that it is part of the hospital routine to provide a safe environment for patients while in hospital and the consequences if drugs are found.

Therefore, a local search policy should be agreed between each in-patient unit and their local police station. Areas that should be covered in the policy include:

- Actions if substances found, depending on what substance, quantity, whether for own use, evidence of dealing, e.g. for cannabis it is agreed that the police will remove and issue a warning.
- Agreed disclosure of patient information.

Personal data may be disclosed where there is an over-riding legal duty to do so, for example, a serious crime and/or to prevent abuse or serious harm to others, including children. Decisions to disclose in these circumstances should be made on a case-by-case basis.

Possession of illicit substances for personal use does not represent a serious crime. When the police are called upon to visit the unit to collect confiscated substances, they may ask for details.

However**,** practitioners are under no legal obligation to report a service user for taking illicit substances.

Service users supplying drugs to others: When there is evidence of a service user supplying drugs to others, this does represent a serious crime to the police, and from a service point of view poses a potential threat of serious harm to others. Police involvement should always be sought. Please note; "sharing" is viewed as supplying.

6. Roles and responsibilities

6.1 Executive Director of Nursing and Quality

The Executive Director of Nursing and Quality is nominated by the Board as the Executive Lead with responsibility for the development and implementation of this procedure.

6.2 Managers

All managers will be responsible for ensuring that: this procedure is followed and understood as appropriate to each staff member's role and function. Also that staff have the required skills and competencies to carry out this procedure. Staff attends appropriate training. Documentation standards are maintained and reinforced through supervision and appraisal.

7. Training

A range of dual diagnosis training is available to support staff, as outlined in the Trust learning and development training matrix.

8. References

8.1 NICE Guidance

- psychosocial interventions (2007)
- opioid detoxification (2007)
- methadone and buprenorphine (2007)
- alcohol (2010)
- interventions to reduce substance misuse among vulnerable young people (2007)
- generalised anxiety disorder and panic disorder (2011)
- self-harm (2004)
- bipolar disorder (2006)
- depression (2007)
- schizophrenia (2009)
- co-existing psychosis and substance misuse (2011).

9. Appendices

9.1 Appendix 1 – Sample Client Contract

The use of contracts has been shown to be helpful in the management of substance misuse and these should be adhered to at all times. If you break the terms of this contract then agreed measures to help reduce your substance misuse will be instigated and there will be an immediate review of your care plan.

Avon and Wiltshire as an organisation exists to promote mental health and the care and treatment of clients with a mental health disorder. However, it has been identified that there is a problem with substance misuse on many psychiatric Inpatient Units. The use of psychoactive substances can profoundly and adversely affect mental health. Additionally, the Trust has corporate responsibility for the safety and security of its clients and staff. Therefore, the Trust cannot allow the presence or misuse of any psychoactive substances on its properties.

[It should be noted that prescribed drugs or those bought over the counter can also be harmful if used against medical advice. The staff of the Trust may consider any substance, even unidentified, as presenting a possible cause of harm and treat it as a harmful substance].

We will undertake to provide you with a safe and therapeutic environment, the opportunity to discuss your substance misuse issues with your named worker and a package of care tailored to your needs within your care plan.

We therefore ask you to agree to:

- Abstain from drinking alcohol whilst an inpatient.
- Abstain from taking any drugs other than those prescribed by your hospital doctor.
- Random urine samples being taken to screen for substance misuse or breathalyser testing for the consumption of alcohol.
- Personal searches of yourself and your property by nursing staff in accordance with the Trust Policy on Conducting Personal Searches.

If you break the terms of this contract then any of the following measures may be instigated and there will be an urgent review of your care plan.

- Increased observation levels

- Regular drug screening
- Restrictions on leave
- Searching property
- Limiting or supervising visits
- Transfer to a higher security unit

In exceptional circumstances you may be discharged for substance misuse. This will only be carried out within a discharge plan jointly devised by the multidisciplinary team and other professionals involved in your care, yourself and your carer(s) and when all other options are exhausted.

I agree to abide by this contract:

Signed by Client: **Date:**

Witnessed By Senior Nurse: **Date:**

Signed by RMO: **Date:**

Version History

Version	Date	Revision description	Editor	Status
1.0	01 June 2006	First version, approved by Clinical & Practice Governance	RE/FL	Approved
2.0	17 Dec 2010	Quality & Healthcare Governance Committee	RE/TW	Approved
2.1	2 July 2015	Policy reviewed	RE/TW	Draft
3.0	1 September 2015	Approved by Quality and Standards Committee	RE	Approved
4.0	13 June 2017	Removal *of "For further information see the Controlled Drug Procedure" at section 5.10 as this statement is incorrect as our AWP Controlled Drugs document does not make reference to the destruction of unknown substances / drugs.*	Consultant Nurse for Dual Diagnosis Specialist Clinical Pharmacist	Approved
4.1	6 September 2018	Extended to 30 September and marked as under review	JK Nursing Director	Approved
4.2	3 September 2019	Extended to 30 March 2020	Nursing director	Approved