

SUBSTANCE USE MANAGEMENT ON TRUST PREMISES POLICY (PATIENTS AND VISITORS)

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DOCUMENT CONTROL

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Contact for review	Consultant Clinical Psychologist – Dual Diagnosis Service Manager inpatient Services		
Lead Trust Director	Director of Mental Health and Social Care		

CONTRIBUTION LIST Key individuals involved in developing the document

Name	Designation or Group
Dr Helen Bellfield	Consultant Clinical Psychologist – Dual Diagnosis
Dr Nick Airey	Consultant Psychiatrist – Dual Diagnosis Lead
Paul Milverton	Deputy Head of Division (Mendip)
Neil Jackson	Inpatient Services Manager
Tracey Edwards	Security Manager
Team Managers	CMHTs and Inpatient Wards

Andrew Brown	Medicines Management Group
Members	Clinical Policy Review Group
Members	Clinical Governance Group
Jean Glanville	Claims and Litigation Manager
Andrew Sinclair	Equality and Diversity Lead
Members	Divisional Heads
Members	Service Leads
Members	Best Practice Group for Substance Use
Members	Community Hospital Best Practice Group

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1. INTRODUCTION

- 1.1 Substance use is a growing problem for all services. The Trust has developed a Dual Diagnosis Policy which should be read in conjunction with this document. This policy seeks to address the fact that substance use can pose particular difficult clinical and managerial problems when presented on Trust premises.
- 1.2 This Policy is not concerned with the moral or ethical judgement on the use of illegal drugs, but concerns usage by patients or visitors whilst on Trust property.
- 1.3 Patients have a right to receive care in a safe environment, free of substance use. There is evidence that indicates *‘the use of illicit and non-prescribed drugs and alcohol by psychiatric patients may exacerbate symptoms, trigger relapse into acute phases of illness and lead to self harm or violence to others, sometimes with tragic consequences. Services have a responsibility to help those already using substances, prevent others from becoming involved and protect the safety of patients, visitors and staff’* (Department of Health 2002).
- 1.4 As substances are not confined to patients, this policy includes visitors and carers.
- 1.5 For the purposes of this policy the term substance use (rather than misuse) is used as it implies no judgement on the behaviour or patients. ‘Misuse’ is retained where documents are quoted verbatim.
- 1.6 **‘Substance’ is taken to include controlled drugs unlawfully held, alcohol, prescription only medicines, over the counter medications, volatile substances (e.g. solvents in glues, propellants in aerosols and amyl nitrates [poppers]), herbal remedies and currently licit substances known to have psychotropic effect, often termed ‘legal highs’.** Some of these substances serve a legitimate purpose on the wards but must be managed appropriately. The potential for harmful use of nicotine and caffeine is recognised but not specifically addressed by this policy.
- 1.7 This policy covers patients in all services, but the interventions referred to are mainly aimed at those with a primary diagnosis of mental illness who also have problems with substance use. This includes patients with a dual diagnosis of mental illness and substance misuse disorder, and those without a diagnosis of substance misuse but whose substance use may worsen their mental illness and hamper treatment and recovery.
- 1.8 This policy sets out the procedures that must be implemented if staff suspect a patient in their care or a visitor is illegally in possession of, or supplying or using what is believed to be, or suspected of being, an illicit substance (Controlled Drug) as defined under the Misuse of Drugs Act 1971 and referred to as an illegal substance.

- 1.9 This policy acknowledges these situations can be difficult and is designed to assist staff if they suspect or discover a patient in their care is in possession of, supplying or using substances and to ensure the actions of staff remain within the law at all times.
- 1.10 Whilst some aspects of this policy will apply to community teams, its focus is mental health inpatient settings. This policy does not cover the pharmacological management of substance use.
- 1.11 This policy takes into consideration the requirement of the relevant statutory legislation such as the misuse of drugs, the health and safety and the equality and human rights legislation.

2. BACKGROUND

- 2.1 The Department of Health document *Dual Diagnosis in mental health inpatient and day hospital settings* (2006) states 'Commissioning agencies need to ensure that the assessment and treatment of substance use is addressed in all mental health service agreements and contracts'. It adds '*Individual assessments are likely to identify the need for "simple interventions" for substance use rather than a need for specialist addiction skills; for example for recreational or intermittent drug use, regular cannabis use, hazardous alcohol use or even mild dependence. A substantial number of cases may respond to simple motivational interventions provided by mental health staff as part of the overall care plan*'.
- 2.2 The law places an obligation on the Trust under the Misuse of Drugs Act 1971 to ensure no illicit drugs possession or supply takes place within its premises. This policy aims to ensure there are robust systems in place to prevent such activities from taking place within Trust premises.
- 2.3 The Trust adopts a serious approach to the personal possession of illegal substances, with a zero-tolerance strategy to the consumption and supply of illegal substances on its premises. Illegal substances are prohibited by law and are contrary to the principles of healthcare.
- 2.4 The Trust recognises the need to act responsibly to respect personal privacy and confidentiality; but due diligence should be on the amount and class of drugs in the patient's possession, protecting staff, patients and visitors from drug abuse-related risks such as aggression, needle-stick injury and maintaining a safe environment.
- 2.5 This policy acknowledges these situations can be difficult and is designed to assist staff if they suspect or discover a patient in their care is in possession of, supplying or using substances and to ensure the actions of staff remain within the law at all times.
- 2.6 The Misuse of Drugs Act (1971), is the main piece of legislation covering drugs and categorises drugs as class A, B and C. Offences under the Act

include: possession of an illicit substance unlawfully, possession of an illicit substance with intent to supply it, supplying or offering to supply an illicit drug (Controlled Drugs may be said to be supplied, even though neither money nor goods have changed hands.), allowing premises (occupied or managed) to be used unlawfully for the purpose of producing or supplying illicit drugs. For the current list check: (<http://drugs.homeoffice.gov.uk/drugs-laws/misuse-of-drugs-act/>).

- 2.7 The list of drugs prescribed under the Misuse of Drugs Act changes frequently as does the classification of drugs as class A, B and C (see Appendix 1). There are a large and growing number of drugs (often referred to as “legal highs”) which although not currently prescribed under the Misuse of Drugs Act have the potential for significant adverse effects, particularly in those with mental health problems and/or taking prescribed psychotropic drugs.
- 2.8 Liebling and Mckeown (1995) cited by Williams (2000) acknowledge any security related attempts to restrict the supply, possession and use of drugs and alcohol in inpatient wards are more likely to succeed if used together with productive strategies geared towards support e.g. giving health promotion information about the effects of drugs to health, and offering patients the help they require to address their drug and alcohol issues.
- 2.9 This policy should be read with reference to the following Trust policies, including:
- Controlled Drug Policy
 - Search of Patients, Persons and Property Policy.
 - Dual Diagnosis Policy
 - Clinical Assessment and Management of Risk of Harm to Self and Others Policy
 - Safeguarding Adults at Risk Policy
 - Safeguarding Children – Child Protection Policy and Process
 - Confidentiality and Data Protection Policy
 - Prevention and Management of Violence and Aggression (PMVA)
 - Equality and Diversity Policy
 - Leave for Voluntary/Informal Patients Policy
 - Physical Assessment and Examination of Patients Policy
 - Recovery Care Programme Approach Policy

3. AIMS AND SCOPE OF POLICY

3.1 It is also against Trust policy for patients to use legal substances like alcohol or non-prescribed medication on inpatient wards as using them will not only potentially render the patient less responsive to the care and treatment the Trust offers to them, but also have adverse effects if taken with prescribed psychotropic drugs.

3.2 The primary aims of this policy are to:

- Ensure Trust premises are not used for the supply, possession or use of illegal drugs or other substances.
- Enable the Trust to identify, and help any patients who have problems related to the use of drugs or alcohol.
- Protect patients, public and other staff from disadvantage or danger through use of substances.
- Prevent the use of illicit drugs, non-prescribed medication, substances with known psychotropic effects and alcohol on Trust premises
- Offer in-depth and appropriate interventions/guidance to all patients who report substance use or are believed to be using substances or are at risk of misusing substances.
- Prevent the use or supply of suspected illicit or illegal non-prescribed drugs.
- Provide guidance to staff on the correct course of action if they suspect a patient is in possession of a substance whilst on Trust premises.
- Ensure patients found to be in possession of a substance receive appropriate care.
- Protect patient confidentiality whilst protecting the needs of the community, working within the Misuse of Drugs Act 1971 and assisting the Police in accordance with the Crime and Disorder Act 1998.
- Confirm the responsibilities of staff regarding the confiscation of illegal drugs to protect both the Trust as an employer, and individual staff members as employees of the Trust, from potential legal liability under the Misuse of Drugs Act 1971.
- Clarify action staff should take when substances are, or may be, present to protect themselves personally (e.g. from assault by an aggressive patient or visitor) and legally (from litigation by a patient or visitor).
- Provide guidance on the appropriate action to take where substances are, or are suspected of being present on Trust premises.
- Protect staff e.g. from needlestick injury resulting from hidden syringes, or from potential assaults by aggressive patients/visitors under the influence of substances.

3.3 This policy also aims to:

- Provide an environment free from substances that could be used problematically. *Action should be aimed at making wards drug and alcohol free rather than accepting that their presence is inevitable* (Department of Health 2006);
- Provide a procedure to control substance use on hospital premises, combined with therapeutic approaches and support (Health Advisory Service, 2001);
- Ensure all patients are treated with dignity and respect, taking into account individual needs, the needs of society and the needs of the organisation, and encouraging the individual patient to participate in their treatment programme;

- Ensure staff have the knowledge, skills and attitudes to work with patients who use substances, or are at risk of such use and to offer appropriate care to address identified needs promptly;
 - Offer appropriate interventions to all patients who report substance use, are believed to be misusing substances or are at risk of misusing substances (e.g. recently detoxified from drugs or alcohol);
 - Ensure that staff respond to substance use issues in a safe, effective and sensitive way with due regard to the patient's wellbeing.
- 3.4 The Trust and those acting on its behalf acknowledge the illegality of the use of controlled drugs unlawfully held and do not condone this illegal act on Trust property. The Trust is aware of its responsibility to inform the Police, in certain circumstances, if illegal activity is suspected or occurs and will cooperate with the police in any subsequent investigation.
- 3.5 There are ambiguities about practical administration of the present law and in current social policy. The Trust must act responsibly to respect personal privacy whilst ensuring the actions of its staff remain within the law.
- 3.6 This policy aims to highlight the appropriate response to possession, administration or supply of substances on Trust property. The appropriate response depends upon the quantity and class of substances found. Whilst it is impossible to define the amount for personal use, common sense should be used. If there is any doubt, the issue must be discussed with the Service Manager or, out of hours, the On Call Manager.
- 3.7 This Policy should not be taken to infer any moral or ethical judgement on the use of substances, but is wholly concerned with their use by patients, or visitors whilst on Trust property.
- 3.8 This policy applies to all areas throughout the Trust. It is intended to apply only to patients and visitors to Trust premises.

4. DUTIES AND RESPONSIBILITIES

- 4.1 The **Chief Executive** has overall responsibility for the strategic and operational management of the Trust, including ensuring Trust policies comply with all legal, statutory and good practice requirements.
- 4.2 The **Heads of Division** are responsible for ensuring adequate dissemination and implementation of policies. Also to:
- Advise the Local Security Management Service when it is suspected or believed a patient or visitor is in possession of an illegal substance.
 - Ensure all staff within their area of responsibility are made aware of, understand and comply strictly with this Policy and understand the legal implications of failing to do so.
- 4.3 The **Service Heads/Managers** are responsible for:

- Ensuring that the confiscation of suspected substances from a patient is clearly recorded in the patient's RiO records and on a Datix Form.
 - Ensuring there is a copy of this policy on their ward/clinical area and for implementing it with their immediate staff.
 - Ensuring staff attend relevant training and monitor competency levels for staff in the management of substances in inpatient wards through supervision.
- 4.4 The **Local Security Management Specialist (LSMS)** will ensure appropriate arrangements operate within the Trust to facilitate the confiscation of illegal substances from patients and visitors and hand over to the Police (with or without patient information being given) to ensure the safety of staff, patients and visitors and remain within the confines of the law.
- 4.5 The **Head of Medicines Management** is the Accountable Officer (AO) for the Trust for the monitoring of all aspects of the use and management of controlled drugs (CDs) by all healthcare professionals. The AO is responsible for all aspects of the safe and secure management of CDs in the Trust. This includes ensuring safe systems are in place for the management and use of CDs, monitoring and auditing the management systems and investigation of concerns and incidents related to CDs.
- 4.6 **All Trust employees** must comply at all times with procedures set out in this policy.
- 4.7 **Line managers** must ensure all staff within their area of responsibility are made aware of, understand and comply strictly with this Policy and understand the legal implications of failing to do so.

5. EXPLANATION OF TERMS USED

- 5.1. **Alcohol use:** Any drinking of alcohol, either intermittent or continual, which interferes with a person's health, social functioning and/or work capability or conduct.
- 5.2 **Drug:** A drug is a substance which alters the way in which the body or mind works. The term drug applies to alcohol, drugs controlled under the Misuse of Drugs Act 1971, prescribed drugs, over-the-counter medication, solvents and other substances with known psychotropic effects. It is acknowledged that nicotine and caffeine are also drugs but these are not addressed by this policy.
- 5.3 **Drug use:** Use of illegal drugs and the use, whether deliberate or unintentional of prescribed drugs, over-the-counter medication, substances with known psychotropic effects and solvents.
- 5.4 **Unlawful Possession of a Controlled Drug:** It is unlawful for a person to have a controlled drug in their possession.

- 5.5 **Lawful Possession:** Providing they are acting in the lawful execution of their duty, the following people can have in their possession controlled drugs: Police Officers, Customs and Excise Officers, Carriers, Forensic Science laboratory personnel, Post Office employees and medical/nursing staff in the execution of their duty.
- 5.6 **Defence to Unlawful Possession:** Where staff take possession of a controlled/illegal drug for the purpose of preventing a crime taking place and delivering it into the custody of a person lawfully entitled to take custody of it.
- 5.7 **RCPA:** Recovery Care Plan Approach which provides a framework for effective mental health care with its principles of assessment, care plan, care coordination, review and putting the patient and where appropriate, the carer, at the centre of the process.

6. VALUES UNDERPINNING THE POLICY

- 6.1. All patients should have an assessment of substance use as part of the care pathway. The assessment:
- Should ascertain what substances the patients uses, the method of administration, pattern of use, the reasons behind and the consequences of use;
 - May take more than one session and should be continually reviewed.
- 6.2 The effect of substance use should be reflected in the risk assessment e.g. with respect to self-harm, aggression/ violence, mental health relapse. The assessment and risk assessment should be incorporated into any treatment programme.
- 6.3 As part of the multi-professional approach to individualised care, collaboration with specialist substance use services should be adopted.

7. ASSESSMENT FOR POSSIBLE ADMISSION TO INPATIENT WARDS.

- 7.1 If a patient is noted to be intoxicated at the time of assessment for possible admission to an inpatient ward, it may be necessary to determine if the patient is fit to be assessed. In some circumstances staff may decide to delay or postpone the admission until the patient is deemed fit to be assessed. **(Note that being under the influence of substances is not an automatic indication of unfitness to be assessed).**
- 7.2 Any decision to postpone the assessment based on intoxication should not be taken lightly and the staff involved in making this decision should only do so in the interest of the safety and rights of the patient. When faced with difficult decisions or where there is some disagreement, assessing staff are advised to consult with management and consultant

colleagues and where applicable to consult with key professionals involved in that patient's care.

- 7.3 If staff suspect the person they are assessing is intoxicated they should involve psychiatric doctors (Emergency Nurse Practitioners and Medical Doctors in general health settings) when considering the patient's fitness to be assessed. If a patient is experiencing acute alcohol withdrawal and this cannot be safely managed on a psychiatric ward, refer to the accident and emergency department.
- 7.4 Assessment of intoxication is an informed clinical judgment which may be further supported by additional assessment the person's consent (staff may consider using a drug screening kit or if under suspicion of alcohol intoxication using a breathalyser test).
- 7.5 All patients should be asked about their current and past drug and alcohol use as well as current contact with Substance misuse/ addiction services (for a brief drug and alcohol assessment see core assessments menu → Mental Health → Alcohol/Substance Misuse screen in RIO for mental health and Lifestyle Information section of the Multi-disciplinary Assessment Record for community health staff). This information should be handed over to ward staff if the patient is to be admitted. Ward staff should address these needs in the patient's care plan.
- 7.6 As part of the admission process patients will be informed that **'illegal drugs, non-prescribed drugs, and alcohol and any substances that can be misused for psychotropic effect, are not allowed on hospital premises, and the implications of acting in contravention are explained'** (Department of Health 2002).
- 7.7 It should be established if the patient has a substance use worker.

8. INFORMATION GIVING AND HEALTH PROMOTION

- 8.1 On admission to inpatient wards **all** patients should be advised of the Trust's position with regards to the possession and use of substances other than medication prescribed by ward doctors. Staff should also consider routinely informing carers/significant others.
- 8.2 Inpatient wards should ensure they have a poster at the entrance to the ward informing patients and visitors that the possession and use of illicit drugs on hospital premises is illegal, alcohol and other psychotropic substances are prohibited and all previously prescribed medication, over the counter medication, herbal substances and licit psychoactive substances should be handed over to ward staff. This message should be included in the ward's welcome pack and repeated in ward community meetings.
- 8.3 Patients who are known to have used substances in the past should be provided with health promotion information about the effects of substance use on health and informed about the help they can receive from their

ward team, and if appropriate specialist dual diagnosis or substance misuse services.

9. RISKS ASSOCIATED WITH SUBSTANCE MISUSE

- 9.1 It is common for patients who use substances to overdose either as a result of mixing different illicit drugs or by combining of substances and prescribed medication. If staff know or suspect a patient has been using substances they must consult a ward doctor immediately before going ahead with administering prescribed medication.
- 9.2 Patients self-administering substances intravenously are at risk of infection. Staff are urged to use universal precautions when handling such equipment. If the suspected substance is in a syringe (with or without a needle attached) it should be placed in the clinical waste bin immediately. There is no need to record this in the CD register however this should be clearly documented in the patient's clinical record.
- 9.3 There is also evidence that using substances may increase the patient's risk of self-harm, suicide or violence to others.
- 9.4 Inpatient staff should be vigilant when working with patients who use substances and should keep risk assessments up to date as well as considering reviewing the level of observation where necessary. Staff should make the physical health of patients a priority.

10. ON ADMISSION

- 10.1 Staff should use this opportunity to engage patients in an open dialogue and encourage them to disclose any substance use issues they may have. If not carried out pre-admission, a full substance use assessment should be carried out. If an assessment was carried out preadmission this should be reviewed and relevant additional information obtained. It is important to determine whether the patient is currently engaged with substance misuse services. Staff should inform patients of the treatment options available to them and agree an individual support plan in relation to their substance use problems. Staff should also encourage patients to self-refer to substance use services/dual diagnosis workers.
- 10.2 The consequences of non-compliance with the policy will be explained to patients. Patients ought to be aware of the presence of a consistent framework of consequences for substance use.
- 10.3 Patients need to be aware that their care treatment may include:
- Restriction to the ward (with appropriate consent and capacity assessments completed)
 - Restriction of visitors
 - Police involvement
 - Discharge
 - Assessment under Mental Health Act

- 10.4 All patients will be asked to sign a treatment contract giving an undertaking not to engage in substance use whilst an inpatient; consenting to staff searching possessions on suspicion that they are in possession of substances and agreeing to provide biological samples when asked to by staff (Appendix 2).
- 10.5 The patient will be asked if they have any drugs (controlled drugs, prescription drugs or over the counter medication), alcohol or volatile or psychotropic substances in their possession.
- 10.6 Where appropriate, substances should be destroyed in accordance with the Trust Medicine policy.
- 10.7 Alcohol - the patient should be asked for their permission to destroy it; if permission is given then the alcohol should be destroyed (poured away). If the patient does not give permission then the alcohol has to be stored and returned to the patient on discharge. Efforts should be made to encourage the next of kin/ carer to remove alcohol from the premises, once patient permission has been gained.
- 10.8 Staff should ask the patients if they have consumed any drugs (prescribed or non-prescribed) or alcohol on the day of admission. If they have taken prescribed drugs, ask for the name of drug. It is important to determine the amount and route for each substance (as part of the assessment).
- 10.9 If a patient is prescribed opioid substitute medication or benzodiazepines it is vital to inform the prescribing service/ doctor and dispensing chemist to validate the dosage and ensure community prescriptions are stopped (to prevent double prescribing).
- 10.10 There is a potential for patients to experience withdrawal on admission. Staff should observe for such signs (e.g. Delirium Tremens, Wernicke encephalopathy) and treat accordingly.
- 10.11 As part of the admission checklist, staff should ask for the patient's consent to go through their property. Staff will look for contraband items (e.g. weapons, lighters, substances and medication not prescribed on the ward including alcohol based products) and advise the patient to hand them over for safe keeping or disposal where applicable. The ward should have a contraband list for patients to see.
- 10.12 Staff should look out for contraband and non contraband items which might be associated with substance misuse e.g. syringes, needles, razors, deformed cutlery and foil paper (used by heroin and crack users) and solvent cans. If staff are concerned about the possible risks of a patient keeping an item which is not already identified as a contraband item then staff should politely ask the patient to submit the item for safe keeping as part of their property.

- 10.13 If it is suspected a patient has used substances then the patient is asked to give permission for their property to be searched. If they do not give their permission then consideration should be made for use of common law or police involvement.
- 10.14 If a patient detained under the Mental Health Act is suspected and does not give permission for their property to be searched, then there may be consideration for searching under the Mental Health Act Code of Practice Section 25.8 and the Trust policy on searching. All decisions regarding searches must be documented in the Electronic Patient Record.
- 10.15 **For any and all instances of substance use whilst a person is an inpatient the Trust re/lapse management protocol (Appendix C) should be worked through with the patient after intoxication effects have ceased. This should be reviewed prior to any subsequent period of leave and again upon return to the ward.**
- 10.16 If a person under the age of 18 is admitted to hospital and suspected to be under the influence of substances, an automatic Safeguarding Children referral should take place.

11. TREATMENT PROGRAMME

- 11.1 Discuss with the patient any concern they may have about their use of alcohol or drugs. This may include the administration of a self-assessment questionnaire. Past history of self-medication and substance use will help develop a profile of the patient's behaviour, a risk assessment, as well as an understanding of the effects of substance use on their behaviour and psychological state.
- 11.2 A drug and alcohol history should be established for each patient and this may involve recourse to past notes. In discussing historical substance use, its relationship with mental health problems can be explored. This should include consideration of interactions between substances taken by the patient in the past, or at the time of assessment and medication the patient is likely to need as part of treatment. Care needs to be taken to distinguish short-term issues, (such as intoxication and withdrawal states) from longer-term issues (such as chronic psychosis in the context of polydrug use).
- 11.3 A treatment programme will be devised and may include the following:
- Care plan detailing the patient's and professionals' responsibilities;
 - Mental health and substance use should be dealt with through a single care plan;
 - Involvement of specialist substance use team;
 - Contracts may be drawn up on specific issues of concern;
 - Contingency plans;
 - Checklist for police involvement;
 - Initial and subsequent assessments should always consider drug and alcohol use;

- RCPA Level Two should be used for ‘all those with severe mental illness and a destabilising substance misuse problem’ (Avoidable Deaths, 2006).
- 11.4 NICE Clinical Guideline 115 states ‘Brief interventions can be used opportunistically in a variety of settings for people not in contact with drug services (for example, in mental health, general health and social care settings) if concerns about drug misuse are identified by the person or staff member. These interventions should:
- Normally consist of two sessions each lasting 10–45 minutes
 - Explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgmental feedback’.
- 11.5 As well as brief interventions substance use work should be done alongside other therapeutic work as substance use work relates directly to assessment, medication management, recognising triggers, alternative ways of coping, relapse prevention, health promotion, goal setting and other areas of therapeutic work.
- 11.6 In circumstances where it is not possible or appropriate to discharge the patients, even though they have been using drugs or alcohol (for example patients who present a high risk of harm to themselves or others, or whose care plan may be seriously affected) treatment and care plans should address the necessary vigilance and supervision to ensure ward and patients’ security and safety.
- 11.7 The Adult Acute Inpatient Care Provision Implementation Guide (2002) states that ‘there should be regular pharmacy input to inpatient wards to educate staff and patients in medication management skills’ this should incorporate information on the effects on substance use.
- 11.8 If the patient is under 18 years of age, there should be a discussion among the multidisciplinary team (MDT) considering the benefits and risks of informing their legal carer or guardian.

12. DRUG TESTING AND SEARCHES

- 12.1 A drug test may usefully inform the assessment/treatment of any patient who has a sudden and unexpected change in presentation regardless of whether they are a known drug user or not. Staff are reminded drug tests should not be carried out routinely on all patients but only on patients suspected of taking drugs, as part of their agreed care plan and with their consent. When taking a sample it is vital for staff to ensure patients are treated with dignity and respect.
- 12.2 For searches refer to the Search of Patients, Persons and Property Policy. Make sure there is a second member of staff to witness and be aware of gender and cultural issues. Like drug testing, personal searches

should only be carried out when staff suspect possession of substances and not as a routine unless it is part of an agreed care plan or contract.

- 12.3 The consent of the patient must be sought at all times. If a patient refuses to be searched and you suspect they possess substances seek assistance from the police who may be able to assist with searching the patient.
- 12.4 Staff carrying out searches should not discontinue searches as soon as they find substances but should complete the search as more substances might be hidden elsewhere.
- 12.5 Patients will be informed that to determine drug and alcohol levels, tests will be requested as part of continuous assessment. Refusal to provide a sample for testing will be interpreted as non – compliance with treatment.
- 12.6 Prior to obtaining a sample patients should be asked if there is any reason it should test positive. Testing biological samples may be helpful in initial assessment and in monitoring substance use as part of an individual care plan. It should be used when it is thought that it will provide significantly better evidence than other less intrusive means.
- 12.7 If biological samples are taken, the following should be considered:
- The least intrusive method possible should be employed (e.g. mouth swab);
 - Oral mouth swab testing should be witnessed by a second member of staff;
 - Proportionate provisions should be in place to avoid fake/contaminated samples (e.g. pat down search prior to and check temperature/ creatinine levels of urine sample);
 - Sampling can be unreliable and hence caution if needed with regard to how any single result is used clinically. Tests used should be fit for purpose and thought should be given to avoid false positives (e.g. heroin specific testing (monoacetyl morphine) rather than general opiates). Where the result is disputed a second test could be performed. There should be arrangements for the occasional use of laboratory analysis;
 - Heavy users of cannabis might test positive for up to six weeks due to the way it is eliminated from the body (the only conclusive result in the short term would be a positive following a negative).
 - On testing positive, all leave should be reviewed with reference to the risks posed (to the individual and others) by their substance use. The results of testing should be brought to the attention of the MDT.
 - Ordinarily if a patient refuses to submit to testing it could be regarded as a positive test;
 - Screening should be done in collaboration with the patient, with a clear explanation about why it is being conducted and any implication the results will have for their care.

13. MAINTAINING A SAFE WARD ENVIRONMENT

- 13.1 All inpatient wards should carry out daily environmental checks. The objective of such checks is to identify areas where drugs may be hidden (including communal areas of the ward and toilets or where some patients may be able to remain hidden from view) or there are opportunities to carry out dealing. It is important to have designated visiting areas that allow for proper observation of patients and visitors.
- 13.2 When carrying out environmental checks staff should consider movement in and out of the building. Staff should know the whereabouts of all patients and should know who is coming in and out of the ward.
- 13.3 In situations where illicit substances (or substances suspected of being illicit) are discovered in the everyday course of events or in communal areas of the ward, the MDT should discuss the implications of this. A Datix should be completed. (Refer to the Serious Incidents Requiring Investigation (SIRI) Policy).
- 13.4 If there is serious concern or evidence that illicit substances are being supplied on the premises, then police should be informed and advice taken from them without exception. A Datix Form should be completed.

14. MONITORING VISITOR ACCESS

- 14.1 It is possible for patients who use drugs or alcohol to have contacts with other substance users in the community. Visiting access needs careful monitoring, particularly if a patient is completing an intense treatment programme.
- 14.2 Staff should find a balance between providing safe care and facilitating appropriate visitor contact. With some flexibility, it may be helpful to agree a nominated list of visitors with individual patients. However it is acknowledged that in order to do so, staff are relying on co-operation from patients.
- 14.3 If a visitor is in possession of drugs or supplying drugs to patients, they will be asked to leave immediately and reported to the police. If they do not leave, ask the police for assistance in order for the visitor to be safely removed from Trust premises.
- 14.4 If a visitor was asked to leave the premises for possession or supply of illicit substances, the ward manager, in consultation with the MDT, should prohibit the visitor from visiting, and write to them informing them of such a decision.

15. RESPONSES TO SUSPECTED POSSESSION AND SUPPLY OF SUBSTANCES (Illustrated as flowchart, Appendix H)

- 15.1 The MDT responsible for assessing and reviewing the patient treatment plan may decide due to the level of risk posed (either to the patient or

others) transfer to a care area providing high levels of supervision is necessary.

- 15.2 Cause for suspicion might include the presence of paraphernalia or sudden changes in mood, loss of appetite, drowsiness, hallucinations, incoherent speech, furtive behaviour, unusual spending, unusual stains, marks or smells, dilated/ pin point pupils (naturally these do not supply conclusive proof as a patient's illness or medication might be the reasons). If it is suspected a patient has used substances then the patient will be asked to provide a screen (e.g. urine tested, breathalysed).
- 15.3 If there is suspicion, or evidence, of a patient bringing supplies of controlled drugs onto the premises, police involvement should be considered.
- 15.4 Evidence supporting any suspicion needs to be gathered and clearly recorded, professional observations are required to inform objective decision making and may be required as evidence.
- 15.5 Members of staff who have suspicions / concerns should report them to the senior member of staff on duty, who should then gather evidence to support this. Support and second opinions are important in addressing a potentially difficult situation and to assess whether medical treatment is necessary. Assessment may identify toxicity requiring urgent medical treatment.
- 15.6 The patient suspected of being involved in substance use is to be given the opportunity of explaining their actions. Not all patients knowingly become involved in activities, and may be under particular duress. Patients may benefit from the opportunity of learning and developing new coping strategies with the help and guidance of professionals. **Somerset Partnership has developed a protocol to guide staff in working with these issues included as Appendix C.**
- 15.7 The nurse in charge of the ward will inform the Ward Manager and discuss the situation with the relevant Consultant Psychiatrist, and an action plan implemented. The action plan may need to incorporate taking blood or urine samples, modifying leave plans, and/ or imminent discharge. The Mental Health Act status of the patient needs to be considered.
- 15.8 **Response by member of staff to suspicion of possession of small quantities of illegal substances for personal use** (This might include a small block of cannabis resin, leaves or a few pills, tablets or capsules. If white or brown powder and/or drug injecting paraphernalia is seen e.g. syringes, needles, torn coke cans, foil, burnt metal spoons, bottled lemon juice indicating IV drug use, proceed as for more serious situations see following).
- Inform nurse in charge of the ward or senior nurse/practitioner in community teams;

- If staff are unsure whether a substance handed in by/found on a patient may be an illegal controlled drug (CD) then they should contact the police for advice;
- Request the patient surrender the illegal substances whilst they are in hospital;
- Inform patient there is a suspicion they are illegal substances and that they will be handed to the Police for destruction (the Police are the only people authorised to remove illegal substances, pharmacy can remove medicinal drugs see Trust Medicines Policy Appendix C p52).
- Obtain consent to this process by completion of the form (Trust Medicines Policy Appendix C page 52 for a copy). If the patient refuses to sign the form, the member of staff must record this fact on the form. The form should then be filed in the patient's clinical notes
- If police are informed and asked to take possession of the suspected illegal CD, it should be dealt with by two members of staff, one of whom should be a registered nurse, as follows:
 - Wear disposable gloves and retain the substance – exceptions are syringes which must be disposed of in the sharps bin immediately.
 - Place the item in a bag or envelope labelled with the date and time, ward, by whom it was found/received and where it was found.
 - Seal the package and store in the CD cupboard.
 - An entry should be made in the CD record book on a page, designated for suspected illegal CD/ substances, at the back of the book. The entry should include the date, time and signature of registered nurse and witness.
 - Inform the registered nurse in charge and the Accountable Officer for Controlled Drugs.
 - An untoward event form should be completed.
 - An entry should be made in the patient's record if appropriate.
- The removal by the police must be recorded in the CD record book including the signature of the registered nurse and police officer.
- All illegal drugs should be handed to police even if patient details are not given due to confidentiality.
- If the patient refuses to hand over any substances within their possession, inform them of the suspicion of their possession of illegal substances and that the Police will be called. Do not attempt to remove an item by force or by searching property
- Do not under any circumstances return suspected illegal substances to a patient on discharge. A person doing so would be committing an offence of unlawful supply of a Controlled Drug under current law.
- If the Police are called in and decide to take action, the officer should be asked to accept responsibility for the illegal substance and any subsequent action. A record should be made in the Ward

CD Record Book of what is handed to the Police and the receipt obtained from the police attached to the record.

- Staff may be asked to make witness statements to the Police in order to maintain the continuity of evidence
- A Datix Form should be completed including details of police officers attending and the incident number.

15.9 **Response by member of staff to patients found with large quantities of illegal substances - suspicion of intent to supply, OR known or suspected IV drug user (see flowchart Appendix H)**

- Inform nurse in charge of the ward or senior nurse, and either the On Call Manager or the Service Manager, depending on the time of day.
- The Manager should decide if the Police should be informed, as this is a criminal offence that warrants overriding the patient's confidentiality in the public interest. The Manager should inform the Police via the control room at Police HQ, and obtain an incident number. **The patient should not be informed about the action taken**
- Request the patient surrender the illegal substances whilst they are in hospital
- Inform patient there is a suspicion that they are illegal substances and that they will be destroyed
- Obtain consent to this process by completion of the appropriate form (Trust Medicines Policy Appendix C page 52 for a copy). If the patient refuses to sign the form, the member of staff must record this fact on the form. The form should then be filed in the patient's clinical notes
- If the patient refuses to hand over any substances within their possession, inform them of the suspicion of their possession of illegal substances and that the police will be called.
- Do not attempt to remove an item by force.
- Do not attempt to search such a person or their property.
- If police are informed and asked to take possession of the suspected illegal CD, it should be dealt with by two members of staff, one of whom should be a registered nurse, as follows:
 - Wear disposable gloves and retain the substance – exceptions are syringes which must be disposed of in the sharps bin immediately.
 - Place the item in a bag or envelope labelled with the date and time, ward, by whom it was found/received and where it was found.
 - Seal the package and store in the CD cupboard.
 - An entry should be made in the CD record book on a page, designated for suspected illegal CD/ substances, at the back of the book. The entry should include the date, time and signature of registered nurse and witness.

- Inform the registered nurse in charge and the Accountable Officer for Controlled Drugs.
 - An untoward event form should be completed.
 - An entry should be made in the patient's record if appropriate.
- The removal by the police must be recorded in the CD record book including the signature of the registered nurse and police officer.
 - All illegal drugs should be handed to police even if patient details are not given due to confidentiality.
 - If the patient refuses to hand over any substances within their possession, inform them of the suspicion of their possession of illegal substances and that the Police will be called. Do not attempt to remove an item by force or by searching property
 - Do not under any circumstances return suspected illegal substances to a patient on discharge. A person doing so would be committing an offence of unlawful supply of a Controlled Drug under current law.
 - Staff may be asked to make witness statements to the Police in order to maintain the continuity of evidence
 - Make an entry in the Ward CD Record Book on a separate page (either within the designated patient's own CD Record Book or at the back of the standard Ward/Department CD Record Book). Record the patient's name, the date and time of the confiscation, a description of the substance and amount and two witnessing staff signatures.
 - A Datix Form should be completed including details of police officers attending and the incident number.
- 15.10 **Preservation of evidence** - Care should be taken in preserving evidence for use by the police. Scenes of crimes should be preserved, as should all physical evidence of the activity witnessed. The police will take as evidence any drugs or other items as seen to be required by them as evidence.
- 15.11 The disposal of drug taking paraphernalia found on site (if not required as evidence by police) should be carried out on site. This paraphernalia should be treated as clinical waste, and sharps should be disposed of via the clinical waste route.
- 15.12 A Datix form should be completed by members of staff witnessing such activities as soon as possible after the event has been occurred, so that events are clear in their mind. Only facts should be documented, staff should bear in mind that incident forms could be used as evidence.
- 15.13 If the incident involves a child or young person under the age of 18 years, or a pregnant woman, then the advice of the Safeguarding Lead should be sought.

16. REMOVING SUSPECTED ILLEGAL SUBSTANCES FROM CLINICAL AREAS

- 16.1 Controlled drugs may **only** be removed from clinical areas by persons authorised to do so by legislation, such as police officers and pharmacists. Police officers would only be expected to remove substances in cases where they have had involvement.

17. SUSPICION OF DRUGS BEING USED ON TRUST PREMISES (see flowchart Appendix G)

- 17.1 There must be good cause for suspicion e.g. the smell of the drug being smoked or information provided by other patients, visitors or staff, or any packages a patient has swallowed and later excretes that are suspected of being an illegal Substance.
- 17.2 Any suspicion must be reported first to the Senior Nurse in charge of the Ward who will then inform the Ward Manager and the patient's Consultant. It may also be appropriate to involve the senior manager on call for that particular service.
- 17.3 Unless the patient is present and has given permission, and the procedure is witnessed by another member of staff, it is illegal to search a patient or his/her property. This may be construed as an infringement of the patient's rights (and their confidentiality, including their right to privacy). A search of a person without their permission could lead to the searcher being charged with assault. This does not preclude nursing and medical staff from searching a patient in order to establish the possible causes of their medical condition so that appropriate treatment may be administered, in accordance with standard clinical practice.
- 17.4 The patient must be advised that the Trust has a policy in accordance with the Misuse of Drugs Act 1971 of not allowing drugs to be used or held unlawfully on its premises. Care must be taken when discussing the situation to ensure they are not accused of possessing/using an illegal substance. The patient must be advised it could be dangerous to take drugs brought in without the knowledge of staff as it may affect his/her treatment by interacting dangerously with prescribed drugs.
- 17.5 The reasons for the suspicion and any advice given to the patient should be recorded in the clinical record.
- 17.6 The patient, if appropriate, may be offered the opportunity to discuss the issue with clinical staff and/or be offered a referral to specialist drug treatment services.
- 17.7 The patient must be advised that if drugs are subsequently found the procedure detailed in this policy may be instigated.
- 17.8 Staff must complete a Datix Form and sign the form for receipt of the confiscated drug.

18. SUSPICION OF DRUGS BEING USED IN TRUST GROUNDS (flowchart Appendix G)

- 18.1 Where it is reported a person is suspected of being in possession of or using a controlled drug outside buildings but on Trust premises, the individual should be challenged, but must not be searched and if the individual refuses to hand over the suspected illegal substance or refuses to stop using the suspected illegal substance they are to be escorted off the premises and warned the police may be called if the individual refuses to co-operate.
- 18.2 Staff involved in such instances must complete a Datix Form.
- 18.3 On discovering a suspected illegal substance the member of staff should alert the nurse in charge/ward/team manager.
- 18.4 The nurse in charge of the ward or area should place the substance in a suitable secure container with a label identifying the source (patient's initials and hospital number) and a brief description of the contents. The label should be over the seal and signed by the nurse and by the nurse in charge of the hospital as a witness. The container should be put into a locked controlled drug cupboard. Gloves should be worn at all times. All events should be documented on a Datix form and witnessed by both nurses.
- 18.5 With the agreement of the Senior Manager on duty the local police should be contacted.
- 18.6 Upon arrival of the police they will remove the suspected illegal substance.
- 18.7 A Datix Form should be completed including details of police officers attending and the incident number.

19. RESPONSE TO PATIENTS SUBSTANCE USE

- 19.1 Factors which will need to be taken into account include the seriousness and extent of the problem, including any legal issues if:
- Controlled drugs are involved;
 - The patient's mental state;
 - The risk of harm to self and others;
 - The patient's social circumstances;
 - Input from relatives and carers;
 - The patient's fitness for discharge;
 - The appropriate action if the patient repeats the use of illegal drugs
 - The intensity of observation and supervision arrangements;
 - Reviewing leave arrangements;
 - The possibility and usefulness of transfer to another ward or setting;
 - The possibility of contacting the police;

- The potential for prosecution or other sanctions, such as warning letters, injunctions or anti-social behaviour orders;
 - If they have a substance use worker.
- 19.2 Developing a framework of agreed responses to substance use incidents would be of benefit. This should consider the patient's needs; the gravity of the substance use situation, impact on others (including patients) and whether it is a recurring issue. Sanctions including discharge, suspension of leave and increased observation levels ought to be considered. It is expected Consultant Psychiatrists will contribute and abide by this or offer explanations when they choose not to. Consistency in the response of the service is helpful for ward staff and patients alike.
- 19.3 Discharge - The Dual Diagnosis Good Practice Guide (Department of Health, 2002) notes that 'the use of contracts with patients where discharge is presented as a sanction can be counter productive. If discharge is used as a sanction, this can result in the withdrawal of services from needy and vulnerable individuals. Often discharge is found to be an empty threat, as the statutory frameworks prevent the discharge of patients with complex needs'.
- 19.4 If a decision is taken to discharge the patient then follow up arrangements, as part of the RCPA need to be agreed and in place prior to discharge. When a patient with drug or alcohol problems is discharged, rapid follow-up arrangements need to be agreed and put in place as part of the RCPA. Follow up arrangements need to be in place as this patient group tends to be at high risk of deterioration of mental state or may be vulnerable to increased risk of suicide or violence to others.
- 19.5 The G.P. should be informed the patient is to be discharged to enable care to continue within community setting and provide relevant and recent information regarding care.
- 19.6 Consideration of referral to specialist substance use services and other community resources should be given.
- 19.7 This policy does not override the clinical decision making of risk assessment and care planning for patients who are being treated for their substance misuse problem. Each case will be dealt with on an individual basis in relation to the patient's care plan, risk assessment and relapse management plan. See Appendix E for guidance.
- 19.8 If a patient presents as intoxicated and leaves Trust premises with the intention of driving a vehicle intoxicated staff should inform the police of patient details (name, address and vehicle registration, make and model where known), in consultation with their manager.

20. KNOWLEDGE OF ILLEGAL DRUG USE/FOUND ON A VISITOR (AND STILL HELD BY THE VISITOR) (Flowchart Appendix I)

- 20.1 Any member of staff who finds an illegal substance in the possession of a visitor must contact their manager immediately. The member of staff will advise the visitor that possession of the item is unlawful, and ask the visitor to hand over the item voluntarily. This *must* be supported by a second member of staff to act as a witness.
- 20.2 If the visitor hands over the item a Disclaimer Form (see Medicines Policy, Appendix C, p52) should be completed and signed by the patient/visitor. If the visitor refuses to sign the form the appropriate member of staff should record the fact on the disclaimer form.
- 20.3 If the visitor refuses to hand over the item, he/she must be advised it is suspected an offence is being committed and that the Police will be called, and his/her identity may be disclosed.
- 20.4 If the visitor refuses, the member of staff will contact the police and (if staffing levels permit) will remain in attendance with the patient/visitor until the police arrive. Staff will request the police remove the visitor from the premises.
- 20.5 Trust Staff are NOT to exercise force in removing the item from the person. Although this might be acceptable in law (and would therefore be unlikely to lead to a successful claim against the member of staff or the Trust), there is a risk of incurring injury. The Police should be called in all cases where the patient/visitor is unwilling to hand over the item voluntarily.
- 20.6 In cases where the police have been called, the police must be requested to accept responsibility for the item and any subsequent action. Staff must be aware that they may be asked to make a witness statement to the police in order to maintain continuity of evidence.
- 20.7 Except where there is considered to be a risk of injury to staff, actions to ensure removal of a suspected illegal substance from a visitor should not be allowed to delay or otherwise adversely affect essential treatment.
- 20.8 **Under no circumstances** should the item be returned to the visitor or any agreement made whereby the patient will receive controlled drug substitutes for surrendering suspected illegal drugs.
- 20.9 Staff must complete a Datix Form, sign the form for receipt of the confiscated drug including details of police officers attending and the incident number.

21. VISITORS SUSPECTED OF BEING UNDER THE INFLUENCE OF SUBSTANCES

- 21.1 Police involvement should be considered for visitors who refuse to leave and/or are causing a disturbance for the safety of staff, patients and visitors.
- 21.2 If a visitor presents as intoxicated and leaves Trust premises with the intention of driving a vehicle intoxicated staff should inform the police of visitor details (name, address and vehicle registration, make and model where known), in consultation with their manager.

22. DISCOVERY OF SUSPECTED ILLEGAL DRUGS FOUND ON A CONFUSED OR UNCONSCIOUS PATIENT

- 22.1 The drugs are to be removed from the patient, the Disclaimer (Medicines Policy, Appendix C, p52) and the drugs stored for collection by the Pharmacy Department. This action should be fully recorded in the patient's notes and a Datix form should be completed.
- 22.2 When the patient is no longer unconscious/confused, the patient should be informed the substance was found and removed. The patient should be asked what medication they were taking so that details of the medication can be entered in the patient's notes. The patient must be informed that appropriate medication is provided by medical staff and that the suspected illegal drugs discovered had been disposed of for safety reasons.

23. SUPPLY OF A CONTROLLED DRUG

- 23.1 Any person(s) suspected of supplying a controlled drug to any person on Trust property is to be reported to the police immediately.
- 23.2 If there is suspicion or evidence of visitors bringing supplies of controlled drugs onto the premises, police involvement should be considered. Visitors who are known or suspected of supplying substances may be banned from Trust premises. A decision to exclude visitors, and/ or to report them to the police, should be taken after careful consideration, in the context of the multidisciplinary care team meeting. The decision should be taken at an appropriately senior level and reasons should be documented. If possible, a letter should be sent to the individual informing them of their ban and how long it will last before a review. Inpatients with substance use issues may be asked to provide a nominated list of visitors.

24. RETURNING THE ILLEGAL DRUG TO THE PATIENT

- 24.1 Under no circumstances may the suspected illegal substance be returned to the patient or anyone else, except for police who are entitled to take lawful custody of it. Any member of staff doing so would be committing a criminal offence and may face both legal and disciplinary action.

24.2 Any drugs handed to the Pharmacy Department will be destroyed in conjunction with the Controlled Drugs Policy.

25. SUSPICION OF DRUGS BEING USED BY A MEMBER OF STAFF

25.1 Any suspicion that a member of staff is in possession of, using or supplying an illegal substance must be reported to the ward/team/service manager.

26. CONFISCATION AND DISPOSAL OF SUBSTANCES (see flowchart Appendix H)

26.1 The Misuse of Drugs Act, 1971 provides that it shall be defence if the person can prove that they “took possession of an illegal drug to prevent another committing a crime or for the purpose of delivering it into lawful custody”.

26.2 The person must prove that as soon as possible after taking possession they took all such steps as is reasonably open to them to destroy it appropriately (see paragraphs below) or to deliver it into lawful custody.

26.3 For procedure of storage and disposal of illicit substances refer to the Trust Controlled Drugs Policy.

26.4 Where a patient is found in possession of suspected illicit drugs in an inpatient area, they will be asked to surrender the substances to staff.

26.5 Staff should observe universal precautions when handling illicit substances i.e. use of gloves and washing hands after handling drugs. Staff are urged not to sniff any substances.

26.6 Until confirmed by appropriately trained personnel, staff are advised to refer to items found as “suspected illicit substances” without using the chemical, “street” name until it is confirmed by the police (where applicable).

26.7 The possession or supply of illicit drugs is against the law. Therefore any suspected illicit substances must not be returned to the patient once he or she has surrendered them and the police should be notified.

27. CONFISCATION AND DISPOSAL OF ALCOHOL AND NON-PRESCRIBED LEGAL DRUGS

27.1 Other substances, which the patient held lawfully, such as alcohol, medicines previously prescribed and medication bought over the counter cannot be destroyed without the patient’s consent. The patient has a right for such items to be returned to them at the time of their discharge.

- 27.2 Once consent has been obtained from the patient, the patient should be given the option to have the alcohol or non prescribed medication removed by a relative or carer of an appropriate age.
- 27.3 If there is no agreement reached with the patient and staff believe there is a risk to the patient or others in returning the property, they should consult with the patient's Responsible Clinician or the manager to gain agreement to retain the property.
- 27.4 Advice from the Trust pharmacist should be sought if there is uncertainty about confiscation or disposal of substances.

28. EXAMINATION OF PATIENTS' PROPERTY

- 28.1 A patient's property and personal effects may normally only be examined for three reasons:
- In order to register and safeguard that property on behalf of the patient;
 - Where examination may aid diagnosis and subsequent management of the patient's medical condition;
 - To ensure the safety and well-being of the patient and others.

In both cases the guiding principle is to seek prior consent wherever possible.

- 28.2 Should staff be unable to gain consent because of the patient's medical condition and an inventory of the patient's possessions is required for either of the above reasons then an examination can be made. Should the presence of illicit substances be suspected prior to its commencement, this search should be witnessed, and if discovered then staff should follow the guidelines set out below. Contemporaneous documentation must include the indications for the personal search, the complete inventory of items found and the names, designations and signatures of the staff involved.

29. INFORMING THE POLICE

- 29.1 Staff will use the following checklist prior to seeking police involvement (In the event of emergencies, normal procedure will apply):
- Is the patient able to understand the consequences of their actions, even though they are suffering from, or diagnosed as having, a mental illness?
 - Has the patient been informed of the consequences of their action?
 - Has the patient's view been expressed?
 - Why is the patient using substances?
 - Has a risk assessment been completed?
 - What risk factors have been identified?
 - What contingency plans have been made to manage the patient's presentation?
 - What is the plan for community support?

- What circumstances will result in the discharge of the patient?
 - What are the consequences of the patient being discharged?
 - Discuss what happens to the patient if re-referred?
 - What are the consequences to others due to the patient's behaviour?
 - What are the consequences of police involvement?
 - Can the patient be removed by the police?
 - Does the Consultant Psychiatrist agree the patient can be prosecuted?
- 29.2 Staff will discuss the situation with the Service or On Call Manager prior to police involvement.
- 29.3 Under the Misuse of Drugs Act 1971, those in charge of premises have a responsibility to inform the police if they believe that anyone is committing an offence on their premises.
- 29.4 All incidents involving supply of suspected illicit substances on Trust premises MUST be reported to the police. Equally, staff should co-operate with all police investigations and be available to attend court to give evidence if asked to. The patient or visitor should be fully informed of the decision to report to the police. If a patient is found with suspected illicit substances and refuses to hand them over or to be searched consider asking the police for assistance.
- 29.5 When reporting possession or supply of suspected illicit substances, staff are advised to call local police and not to dial emergency numbers, unless they feel that it is an emergency requiring an emergency response from the police.
- 29.6 When reporting to the police, it is important to inform the police of the amount of substances found and on the fitness of the patient to be interviewed (information given only on a need to know basis). Refer to the Confidentiality and Data Protection Policy and Sharing of Information Policy. It is then up to the police to decide on what course of action they should take.
- 29.7 Staff should then complete a Datix form. After reporting to the police, staff should quote the police reference number on the action taken section of the incident form.
- 29.8 If a detained patient is subject to special Ministry of Justice restrictions, e.g. under section 37/41 of the Mental Health Act, the Ministry of Justice should be informed by the Responsible Clinician if required to.
- 29.9 Where the police cannot attend within 24 hours, or if circumstances require, the suspicious substance and form should be noted in the CD register and locked in the Controlled Drug cupboard
- 29.10 If the police attend then the ward or area staff should co-operate fully with the officers. In some cases the officer may not need to know the

identity of the patient. However, if he/she does then staff should provide this information. In the investigation of an alleged criminal offence, confidentiality is unlikely to be a sufficient defence in law against disclosure.

- 29.10 Each case will be treated on its own merits and it is therefore not possible to indicate the precise action the police will take. However, the patient will never be questioned or removed from the ward or department if it is considered by the Responsible Clinician to be inappropriate on clinical grounds.
- 29.11 Following inquiries, the police officer will remove the suspicious substance directly from the ward or area where it was. The Controlled Drug Register should be signed by the police officer and the nurse or pharmacist witnessing the transfer. One copy should be given to the police and one copy filed in the patient's medical record.
- 29.12 Where patients who are not under the care of a Consultant are concerned e.g. at a health centre, or at an outpatient appointment, the GP or member of the Senior Management Team on-call should make the decision as to whether police involvement is required.
- 29.13 In all cases, the incident should be recorded on DATIX.

30. PATIENT CONFIDENTIALITY

- 30.1 Whilst patient confidentiality should not normally be broken, disclosure without the consent of the patient is appropriate in circumstances where it is considered to be necessary in the public interest.
- 30.2 Public interest means the interests of an individual or groups of individuals or of society as a whole, and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities that place others at serious risk – including driving whilst intoxicated.

31. SUBSTANCE MISUSE CONTRACTS

- 31.1 If a patient repeatedly possesses or supplies substances despite this being part of his/her care plan, it might be necessary to draw up a contract with him/her specific for substance misuse linked to the care plan and risk assessment. Whilst these contracts are not legally binding on the patient this is another attempt to get some commitment into adhering to the ward operational procedures and/or to engage in therapeutic interventions in relation to their substance use. As part of the contract, it might be important to agree with the patient less restrictive interventions first e.g. agreeing that they will be searched each time they come back from leave and they will have a drug test done at random. (For a sample of substance misuse contract see Appendix B).

32. PLANNED DISCHARGE FROM THE WARD

- 32.1 It is possible some patients might still carry on using substances regardless of having taken part in/been given /offered:
- Information on posters and given a Ward information pack;
 - Health promotional information about the effects of drugs on health;
 - Appropriate help to deal with his/her drug and alcohol problems;
 - Searches and drug screening;
 - Care plans around substance misuse;
 - Contracts;
 - Police have been informed.
- 32.2 If an **informal patient** continues to use drugs, and it is felt by the MDT that their main problem is with substance use and that the mental illness can be managed better if the patient stops using substances then a **planned** early discharge may be an option. Normal discharge procedures apply (Note this is not the same as sending a patient home for continuously using substances without due consideration to their clinical presentation and the risks involved).
- 32.3 It is crucial that as part of this process the MDT considers the risk implications of the substance misuse in terms of increasing risk behaviours such as self-harm, suicide and violence prior to a decision to discharge. This should be clearly documented.
- 32.4 The discharge meeting should have a follow up plan. This might mean referring the patient to a drug and alcohol team if they are willing to engage with this service. Note that referral to a drug and alcohol team should not usually be the sole follow up plan and giving a patient the number to self-refer on discharge is wholly inappropriate. Substance misuse services need to be fully appraised of any mental health/risk issues and will then also be able to alert mental health services if the patient fails to engage on discharge.
- 32.5 Treatment plans and discharge arrangements for patients with substance use problems need to take account of the external environment, to which they are returning and include the risk of relapse. Relatives and carers should, where appropriate (i.e. with the consent of the patient), be involved in these arrangements.
- 32.6 For **all detained patients and some informal patients** who cannot be safely discharged to the community, an MDT review of their treatment and care will take place at the earliest opportunity as their needs may be more appropriately met elsewhere. This review may lead to their leave from the ward being temporarily withdrawn (if detained), and/or a limit on their visitors if appropriate and/or referral to a Psychiatric Intensive Care Unit or Low Secure for increased and more appropriate supervision.
- 32.7 Staff should consider care for this group of patients under the RCPA framework. Staff from services to be involved or likely to be involved in caring for the patient should be invited to the discharge Review meeting.

If a patient with drug or alcohol problems is discharged, rapid follow-up arrangements need to be agreed and put in place as part of the RCPA.

- 32.8 This group tend to be at high risk of deterioration of mental state and can be at an increased risk of suicide or of violence to others. For those who have undergone detoxification from heroin whilst an inpatient there is an increased risk of overdose shortly after discharge. Measures to minimise this risk should be put in place e.g. the patient should be provided with harm minimisation advice in relation to this.

33. CHILDREN, YOUNG PEOPLE UNDER 18 YEARS OF AGE AND PREGNANT WOMEN

- 33.1 If a parent/carer or pregnant woman is suspected, or found to be using illegal substances, consideration must be given as to the safety of the child or young person, and the risks posed to others on a paediatric area. A discussion with the Safeguarding Lead should occur and be documented in the RiO record. Social Services and the Police may need to be informed to ensure the safety of child/young person. In the case of a pregnant woman, the Named Midwife should be made aware in order to pass on information to assess the risk to the baby when born.

34. TRAINING REQUIRMENTS

- 34.1 The Trust will ensure all staff are appropriately trained. New staff will receive Induction training, which includes Trust policies. Existing staff receive training appropriate to their level of responsibility as directed by their Service Manager.
- 34.2 Training is aimed at equipping staff with the skills to engage in therapeutic dialogue with patients about their substance use and not merely policing their use or referring to specialist clinicians. All qualified nurses and ward doctors should receive this training. It is the individual member of staff's responsibility to ensure they are competent to carry out duties requested of them. Any training needs should be raised with line managers during supervision/appraisal and incorporated into Personal Development Plans.
- 34.3 As substance use is so prevalent among mental health patients, detection, assessment as well as simple prevention and treatment interventions for harmful substance use need to be core skills for mental health clinicians.

35. EQUALITY IMPACT ASSESSMENT

- 35.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

36. MONITORING COMPLIANCE AND EFFECTIVENESS

- 36.1 Where monitoring has identified deficiencies or incidents, recommendations and action plans will be developed and changes implemented accordingly. The Best Practice for Substance Use Group will agree and monitor action plans and will provide assurance and escalate areas of concern/risk issues to the Clinical Governance Group. The Best Practice for Substance Use Group will provide quarterly reports to the Clinical and Social Care Effectiveness Group.
- 36.2 The daily implementation of this policy will be monitored regularly by Ward Managers and Team Managers.
- 36.3 Reporting and review of incidents relating to substance use on Trust premises through the Datix system and the Alcohol and Substance Use Best Practice Group.

37 RELEVANT CARE QUALITY COMMISSION (CQC) – REGISTRATION STANDARDS

- 37.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 8:	General
Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

- 37.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

- 37.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

38. COUNTER FRAUD

- 38.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

39. REFERENCES AND KEY DOCUMENTS

- LIEBLING, H. & MCKEOWN, M. (1995) Staff perceptions of illicit drug use within a special hospital. *In British Psychological Society. Criminal Behaviour, Perception, Attributions and Rationality. Issues in Criminological and Legal Psychology No. 22. Leicester: British Psychological Society.*
- WILLIAMS, R. & COHEN, J. (2000) Substance Use and Misuse in Psychiatric Wards: A Model for Clinical governance? *The Psychiatrist (24), 43-46*

Cross reference to other procedural documents

Consent to Examination and Treatment Policy

Consent and Capacity to Consent to Treatment Policy

Development & Management of Organisation-wide Procedural Documents Policy and Guidance

Hand Hygiene Policy

Learning Development and Mandatory Training Policy

Record Keeping and Records Management Policy

Risk Management Policy and Procedure

Staff Mandatory Training Matrix (Training Needs Analysis)

Search of Patients, Persons and Property Policy

Training Prospectus

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

40. APPENDICES

- 40.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A Category 'A'; 'B'; and 'C' Drugs – most commonly used for social purposes.

Appendix B Example of a Treatment Contract

Appendix C	Re/lapse Management Protocol.
Appendix D	Procedures to be followed in the event of a visitor (not a patient) exhibiting behaviour as described in Section 5.
Appendix E	Procedures to be followed in the event of a patient exhibiting behaviour as described in Section 5.
Appendix F	Position Statement for Alcohol and Drugs
Appendix G	Flow chart for suspected substance use/evidence of use by patient
Appendix H	Flow chart for possession/possession with intent to supply
Appendix I	Flowchart for knowledge of substance use of a visitor/substances found on a visitor

DRUG CLASSES AND PENALTIES

The United Kingdom Misuse of Drugs Act 1971 governs the class and penalties for drugs offences in Scotland. Drugs are graded into three classes - A, B, C. The grading depends on the amount of harm or potential for harm a drug causes individuals and society. The drugs which cause most harm are Class A, however all drugs have the potential to cause harm, even drugs in the lower classes. Penalties for possession and dealing in the three classes of drugs are as follows:

Class A Drugs (includes ecstasy, LSD, heroin, morphine, cocaine, methadone.) Up to 7 years imprisonment or an unlimited fine or both. Up to life imprisonment or an unlimited fine or both.

Class B Drugs (includes amphetamine, cannabis, dihydrocodeine.) Up to 5 years imprisonment or an unlimited fine or both. Up to 14 years imprisonment or an unlimited fine or both.

Class C Drugs (includes GHB, Temazepam, valium, temgesic.) Up to 2 years imprisonment or an unlimited fine or both. (This applies to Temazepam and valium if possessed without a prescription). Up to 14 years imprisonment or an unlimited fine or both

Section 7 of the Misuse of Drugs Act (1971) states, 'the person commits an offence if, being the occupier or concerned in the management of any premises, he knowingly permits any of the following activities to take place on those premises:

- producing or attempting to produce a controlled drug,
- supplying or attempting to supply a controlled drug to another or offering to supply a controlled drug to another,
- preparing opium for smoking,
- smoking cannabis, cannabis resin or prepared opium.'

Trust premises include wards, buildings or grounds which are occupied, owned or leased by the Trust and to which patients, visitors or staff may have access.

The definition of "substance" for the purposes of this policy will include the following:

- non-prescribed controlled drugs
- prescribed controlled drugs being misused
- associated substances – alcohol – volatile solvents
- substances with psychotropic effects, which may not be illegal or illicit

Team/Ward Managers should be aware of any areas within their premises which may be deemed liable to be used for substance misuse. Effective supervision of those areas should be made through regular staff checks or similar means as deemed appropriate. Regular audit should take place to identify areas within Trust premises that may be used to facilitate use or supply of substances (Department of Health 2006). Staff should also be aware that all buildings owned, leased or rented and the land it is associated with, and all vehicles (including staff own transport) that is used in conjunction with their duties, is considered trust premises.

SAMPLE OF PATIENTS SUBSTANCE MISUSE CONTRACT

The Trust aims to maintain an alcohol and illicit drug free environment for patients, carers, visitors and staff. While we provide care for individuals with substance misuse problems we do not tolerate the use, possession and supply of substances on Trust premises. The misuse of drugs and alcohol by patients in an inpatient mental health ward can seriously affect the ability of our staff to assess, treat and care for patients safely and effectively.

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

Somerset Partnership is committed to:

- Offering you an opportunity to discuss your substance misuse issues with your named worker and design a package of care tailored to your needs which are clearly laid out in a care plan.
- Providing safe and effective care to those who use our services as well as a safe environment for staff to work.
- **Please note - incidents of possession and all incidents of supplying of illicit substances will be reported to the police.**

In return we would appreciate:

- Your co-operation in adhering to the terms of this substance misuse contract at all times.
- You are signing this contract to show your commitment to engage in your treatment and to prevent you from possessing or supplying substances on Trust premises.

We therefore ask you to agree to:

- Abstain from drinking alcohol while an inpatient.
- Abstain from taking any drugs other than those prescribed by your ward doctor.
- Urine drug samples taken to screen for substance misuse or breathalyser testing for the consumption of alcohol as part of your care plan. **(we will ask for your consent each time you are asked to give a sample)**
- Personal searches of yourself and your property by nursing staff in accordance with the Trust Policy for conducting Personal Searches. **(we will ask for your consent each time before you are searched).**

By agreeing to sign this contract the understanding is that if you break the terms of the contract then agreed measures to help reduce your substance misuse will

be instigated and there will be an immediate review of your care plan with your full involvement.

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
- Referral to other services e.g. drug and alcohol services, detox unit, high secure unit, or other community services.

I agree to abide by this contract:

Signed by patient:

Date:

Witnessed by (any member of MDT):

Date:

Signed by the Responsible Clinician:

Date:

MANAGING RE/LAPSE PROTOCOL

Many of the patients have substance use (licit or illicit) as a feature of their way of managing difficult moods and life experiences.

Even when individuals are committed to abstaining from substance use in the future, they will often experience situations where they are tempted to use.

In order to support people in making positive change to their substance use, **we view lapses as a learning experience.**

By viewing lapse as a learning experience we are able to support people in understanding the situations and experiences that led to them lapsing and help them identify and develop strategies to protect against the likelihood of repeating this behaviour in the future. **A lapse is not sufficient reason to restrict an individuals future leave** (this would only be indicated where intoxication and the possible detrimental impact on mental health requires a period of monitoring for safety).

By viewing lapse as a learning experience we create an environment and culture where individuals are safe to disclose their drug use after leave without fear of negative consequence.

To support this process when an individual discloses substance use or tests positive for substance use, the following procedure should be worked through with client by the readmitting member of the staff team (after any intoxication has subsided).

1. Work through the information sheet *Understanding lapse and relapse* with the client
2. Work through the handout *Relapse Prevention: understanding triggers to re/lapse* with reference to the specific event they are reporting
3. Identify specific ways of managing the situation differently in the future (the handout *Using Constructive Relapse-Preventive Thinking* may be helpful)
4. Document the lapse and the strategies in the RiO progress notes and risk information screen
5. Where a risk issue relating to mental health and/or personal safety is identified is leave might be restricted for a period of 48 hours – this should be appropriately documented in the RiO notes
6. Review the coping/management strategies prior to next S17 leave
7. Review the success of strategies after next S17 leave – provide positive feedback where strategies have been used successfully, where the strategy did not work review and refine it by working through the handout *Relapse Prevention: understanding triggers to re/lapse*

UNDERSTANDING LAPSE AND RELAPSE

Definitions:

Lapse - A lapse is using alcohol/drugs for a short time (maybe as a 'one off' or for a short period over a couple of days) without returning to a previous daily/habitual/dependent pattern of use.

Lapses can occur when you have experienced a feeling, thought, or ritual associated with your past addiction. They often occur because people have not been able to implement an appropriate coping skill to drinking or using drugs.

A lapse is very different from a relapse in that you have not returned to the abusive use of the substance/behaviour – but you have just got closer to relapsing. If you do not make use of healthy coping skills when faced with a lapse, you are much more likely to relapse.

Relapse - A relapse can be defined as a return to behaviour which has been previously stopped. For the alcoholic, a relapse means drinking alcohol again. For the cocaine addict, a relapse is the use of cocaine again.

Relapse prevention and lapse management help you identify the process of relapse and to develop coping skills to implement before your relapse process progresses to the point of a full relapse.

Triggers -In the past, you probably associated your behaviour with a set of life experiences including people, places, feelings, thoughts, and rituals. Some of these experiences were directly connected to your addiction (for example, if you smoke cigarettes, you can probably identify several experiences such as finishing dinner and getting up in the morning as directly related to increased cravings for cigarettes). These experiences which are closely connected to your addiction are called *direct linkages*.

Many other experiences are less easily identified as being connected to your addiction but result in just as powerful of a craving/desire to return to your addiction. These experiences are referred to as *remote linkages* (and often include uncomfortable mood states or thinking patterns, conflict with others).

High Risk Situations - When we put ourselves in contact with a trigger we are in what is generally referred to as a *high risk situation*.

We can plan for high risk situations by identifying the connection between the linkage event and the addiction. We need to understand triggers to drug/alcohol use, then we can either avoid the triggering event, or substitute a healthier behaviour for the addictive behaviour.

RELAPSE PREVENTION: UNDERSTANDING TRIGGERS TO RE/LAPSE

1. Was the use a lapse or a relapse?

2. What were the triggers?

- Where were you?

- What time was it?

- What were you doing?

- Who were you with?

- How were you feeling just before you felt like drinking or using drugs?

- What were you telling yourself just before you started to drink or use drugs?

3. What did you do?

4. What else could you have done?

- 1.
- 2.
- 3.
- 4.
- 5.

5. What else could you have told yourself (to help yourself resist the temptation to use)?

- 1.
- 2.
- 3.
- 4.
- 5.

6. How do you feel now about what happened?

7. What will you do differently in the same circumstances/situations in the future?

Think of as many alternatives actions to use as possible:

- 1.
- 2.
- 3.
- 4.
- 5.

Be specific:

When.....happens,
I will.....

When.....happens,
I will.....

When.....happens,
I will.....

When I feel.....,
I will.....

When I feel.....,
I will.....

When I feel.....,
I will.....

USING CONSTRUCTIVE RELAPSE-PREVENTIVE THINKING

- 1. Thought Stopping:** I'm not going to think about that; I've already made my decision.
- 2. Thought Substitution:** I'm in danger - I'd better be alert; I think I'll call Bob; I think I'll plan my day.
- 3. Debating/Disputing/Challenging Your Addictive Voice:** Where is the evidence? Is this thought or belief true or valid? How does this thought or belief serve my best interest?
- 4. Coping Statements:** This feeling will eventually pass; It's hard, but not too hard; Condemn the behaviour, not the person.
- 5. Positive Affirmation:** I have said no to myself before - I can do so again; I'm going to treasure my sobriety; Even if I have lapsed, I can accept myself.
- 6. Review of Goals (Desirable Outcomes):** I want to stop drinking - it's my goal; I have already decided that I want to keep my relationship with my wife; I want to go home sober.
- 7. Review of Negative Consequences (Undesirable Outcomes):** Eventually, I will lose my job; I can't take two drinks without taking several more and getting drunk; My relationships will suffer.
- 8. Do Written Homework (Problem Sheet, ABC Sheet, or Drinking Sheet).**
- 9. Refraining:** Look at the situation from another angle or another person's viewpoint. Look at the benefits of choosing not to engage in the addictive behaviour.
- 10. Rational-Emotive Imagery:** Imagine yourself behaving or feeling differently about the situation. Close your eyes and practice responding to someone in a different, more rational, more effective manner.

**VISITORS SUSPECTED OF BEING UNDER THE INFLUENCE OF
SUBSTANCES**

1. Careful consideration should be given to the following factors at the outset:
The nature and severity of the substance misuse, the risk this poses to the patient and others and the likelihood of repetition.
2. A senior clinician, usually the Ward Manager or Nurse-in-Charge, should exercise their judgement as to whether the matter is of a serious nature, taking into account factors in Section 5:
 - If it is felt the matter is not serious in nature, then a warning and an explanation to the person involved may suffice
 - When the matter is felt to be more serious they should implement a ban on that person visiting Trust premises until further notice
3. The Police should be requested to assist in the removal of any person who has been asked to leave Trust premises and refuses to do so or who is disruptive due to intoxication.
4. If a person suspected of substance use is a member of Trust staff, the line manager of that person or on-call manager should be informed immediately.
5. A Datix form must be completed and forwarded to the line manager, who will process it in accordance with the Trust's Procedure for Incident Reporting.

APPENDIX E

PATIENTS SUSPECTED OF BEING UNDER THE INFLUENCE OF SUBSTANCES

Patients admitted to hospital for treatment or a substance misuse problem should have a written agreement or contract as part of their care plan. This should include the checks to be made within treatment e.g. breathalyser or urine samples, and the steps to be taken if there is continuing substance use.

The procedure to be followed in the event of a patient exhibiting behaviour as a result of substance misuse.

1. Careful consideration should be given to the following factors at the outset:

- The nature and severity of the substance misuse, the risk this poses to the patient and others and the likelihood of repetition.
- The patient's diagnosis, mental state, care planning including risk assessment and Mental Health Act status
- The involvement of the Police and or other agencies

2. The clinical team must conduct a clinical review as a matter of urgency involving the key clinical staff in that patient's care and this review must include a review of the patient's care plan and objectives. This care plan should be re-assessed and any action clearly recorded in the notes. The revised care plan must include the following:

- an appropriate risk assessment and risk management plan, including information on managing the risk of overdose and offer appropriate interventions where appropriate
- explanation and education for the patients
- measures that need to be put into place to reduce the risk of recurrence for example drugs/alcohol education, detoxification/substitute prescribing, urine testing and support
- measures to restrict access to substances, this might include a ban on persons visiting, increased level of observation
- reduction in leave or transfer to a more secure environment following further assessment of mental state and risk.
- an action plan to be followed if there is a recurrence of the behaviour, this may need to take the form of a contract with the patient setting out the likely outcome of further substance misuse

POSITION STATEMENT FOR ALCOHOL AND DRUGS

Somerset Partnership NHS Foundation Trust is keen to protect the welfare of all **patients** admitted to this ward.

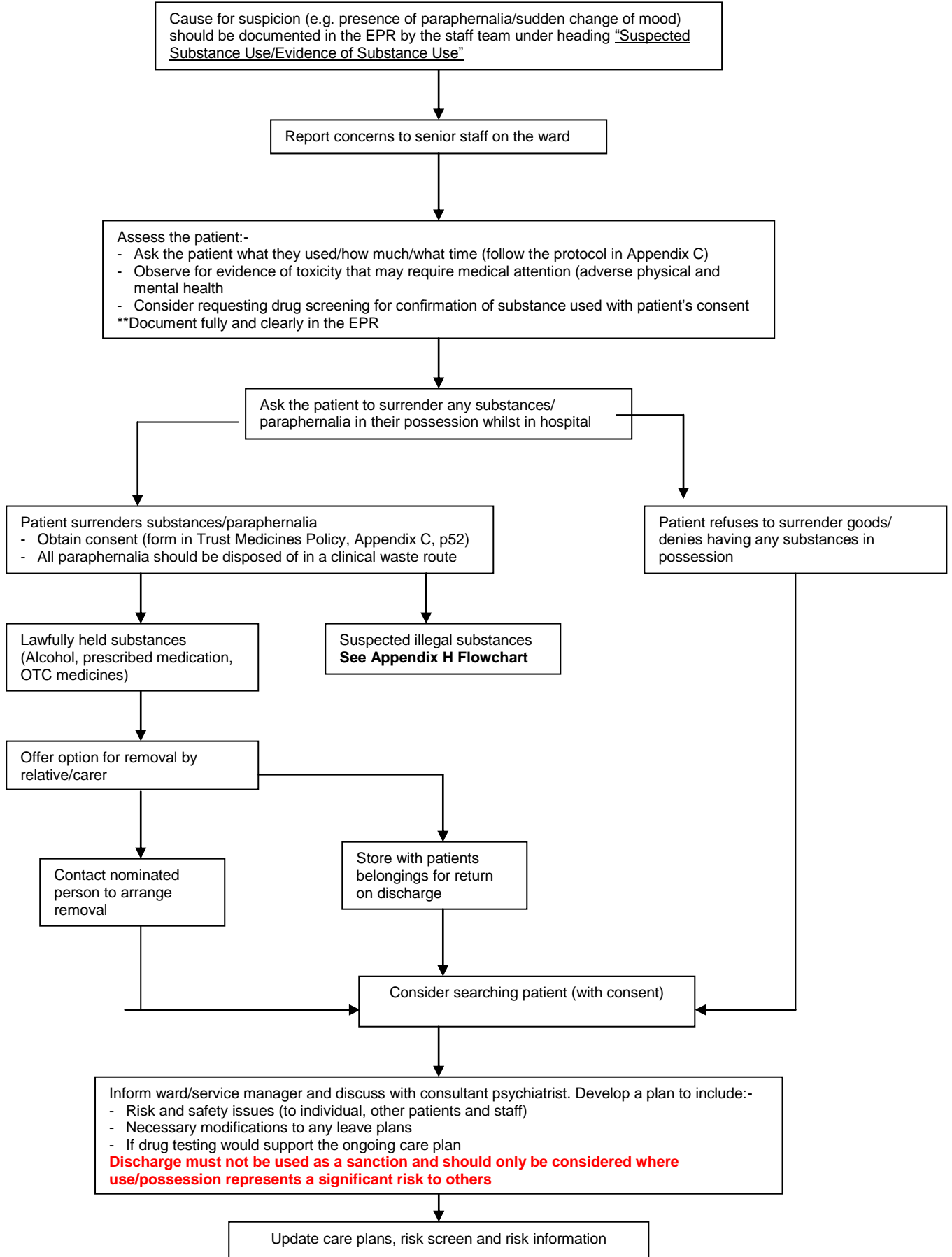
- 1 No alcohol, unprescribed or illegal substances are to be brought in or used on the ward.
2. Any **patient** found to have returned to the ward under the influence of such substances or brought them into the ward will have their future plans discussed with their Consultant and Care Co-ordinator. This may lead to discharge from the hospital
3. Any **visitor** found to have brought in such substances (for their own use or for others) or to be observed under the influence of such substances may have their right to visit the ward withdrawn. In the case of **illegal** drugs, this may be reported to the Police.
4. Any **illegal** drugs found on the ward will be reported to the Police.
5. Any drugs or alcohol found or handed in to staff will be **disposed** of.
6. Patient confidentiality will be preserved at all times

Police Contact Numbers:

Non-emergency 24 hours – 0845 4567000 / 101

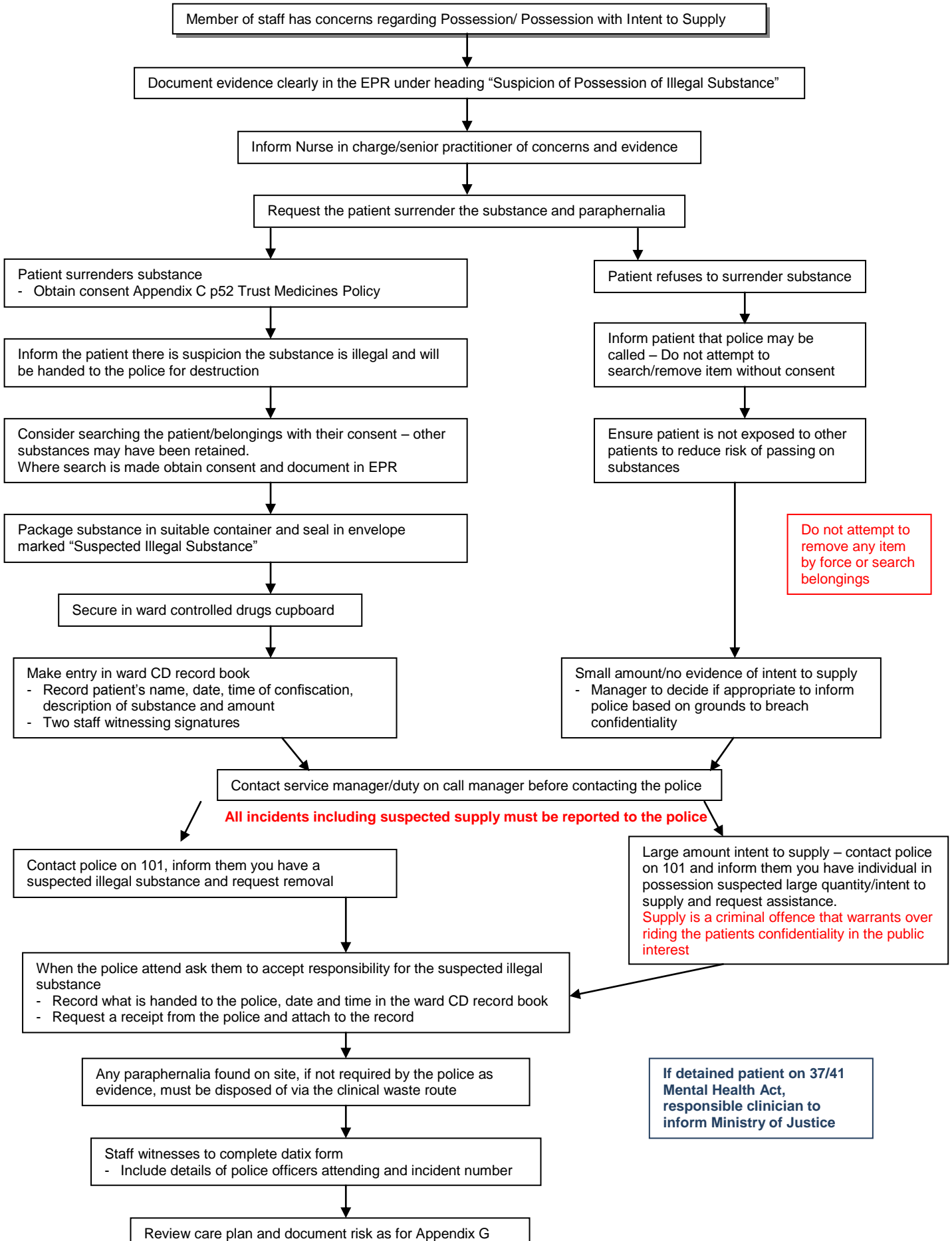
Queries relating to policy or procedures (drug strategy) 01275 814576 or 01275 816628

Flow Chart For Suspected Substance Use/Evidence Of Use By Patient



If discharge is effected: Ensure rapid follow-up plan is in place prior to discharge, inform GP, offer referral to specialist substance misuse service

Flow Chart For Possession/Possession With Intent To Supply



Do not attempt to remove any item by force or search belongings

All incidents including suspected supply must be reported to the police

Large amount intent to supply – contact police on 101 and inform them you have individual in possession suspected large quantity/intent to supply and request assistance.
Supply is a criminal offence that warrants overriding the patients confidentiality in the public interest

If detained patient on 37/41 Mental Health Act, responsible clinician to inform Ministry of Justice

Knowledge Of Substance Use Of A Visitor/Substances Found On A Visitor

