Leicestershire Partnership NHS Trust

Management of Service Users who have Co-existing Substance Misuse and Mental Health Policy - 2023

The co-existing substance misuse and mental health policy is a clinical practice policy in working with service users who present with both substance misuse and mental health. It guides staff through the process from assessment to discharge.

Key Words:	Dual Diagnosis drugs, alcohol, naloxone, substance use.	
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1. QUICK LOOK SUMMARY

At the first assessment complete Assist lite for a base line substance assessment.
Ask patient if they are open to substance services if not ask if they would like a referral. Do the referral do not sign post.
Assess for withdrawal from alcohol or opiates.
Always follow prescribing protocols.
Seek advice from local providers.
Follow protocols for prescribing for maintenance and withdrawal.
Use GMAWS and COWS for withdrawal.
Ensure OST patients have Naloxone for leave, discharge and in the community.
Care plan substance misuse within mental health.
Offer harm minimization and relapse prevention advice.
Assess for blood borne virus.
Offer support and guidance.
Complete training around substance misuse including:
Assist Lite.
Naloxone.
Dual Diagnosis.

Sent for consultation.	
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1.2 KEY INDIVIDUALS INVOLVED IN DEVELOPING AND CONSULTING ON THE DOCUMENT

LPT Nurse Consultant – Dual Diagnosis

1.3 GOVERNANCE

Clinical Effectiveness Group.

1.4 EQUALITY STATEMENT

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It considers the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

1.5 DUE REGARD

The Trusts commitment to equality means that this policy has been screened in relation to paying due regard to the Public Sector Equality Duty as set out in the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

Please refer to Appendix 6 which provides a detailed overview of the due regard undertaken in support of this activity.

2.0 PURPOSE AND INTRODUCTION

Co-occurring substance misuse and mental health is described as one of the biggest challenges facing mental health services (Appleby L DOH 2018) with mental health clients having multiple complex issues with a higher risk of relapse and suicide. Mental health and substance misuse joined up services published ay 2019 PHE and Dickens et al 2022 recommends joined up services between mental health and substance misuse services with integrated working and training across mental health staff groups in substance misuse.

Better outcomes 2017 suggests co-occurring substance misuse and mental health is:

1.Everyone’s job. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.

2. No wrong door. Providers in alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point (page 9).

“During 2006-2016 there were 909 suicides per year on average by patients who had a history of alcohol or drug misuse, 56% of all patients who died - this percentage was higher in Scotland and Northern Ireland. Only a minority were in contact with specialist substance misuse services” (Appleby DOH 2018).

2.2 Substance misuse amongst individuals with mental illness has been associated with significantly poorer outcomes including:

• Worsening mental health
• Increased incidents of suicide
• Increased rates of violence
• Increased rates of homicide
• Increased use of in-patient services
• Poor medication adherence
• Homelessness
• Increased risk of HIV, Hepatitis infection
• Poor social outcomes including impact on carers and family
• Contact with the criminal justice system. (DH 2002)

2.3 This policy encourages staff to give consistent care and treatment in accordance with NICE guidance.

2.4 This document sets out Leicestershire Partnerships (NHS) Trust’s Policy and Guidance for staff on the care and treatment of a patient who has mental health problems (including those with learning disability and mental health problems) and co-occurring substance misuse and mental health.

2.5 The aim of this policy is to ensure staff can provide a professional service that maintains high standards of care and treatment in line with NICE Guidelines, ensuring dignity and respect, and enabling effective communication with families and other agencies. This policy should be used in conjunction with the clinical guidelines in the appendices and the following Trust policies found on the Intranet:

- Information Sharing Policy is in place with Turning Point
- Consent to Examination or Treatment Policy
- Confidentiality & Information Sharing with Carers
- Searching of Inpatients and their Property Policy (for all Mental Health and Learning Disability Inpatient Settings)
- Opiate substitute Detoxification Policy
- Naloxone guidance
- Alcohol Detoxification Guidelines

2.6 Co-existing substance misuse and mental health. This broad definition is intended to be inclusive so that the needs of the wide range of people with co-existing conditions encountering the Trust are considered regardless of the severity of their mental illness and/or their substance misuse problem.

3. POLICY REQUIREMENTS

These guidelines are designed for all clinical staff working with clients with co-existing substance misuse and mental health to be used in conjunction with national prescribing guidelines known as the orange guidelines (DOH 2017). The aim is to engage with clients to prevent avoidable deaths through substance misuse, and to improve mental health by engaging clients within treatment services and working with clients with both mental health and substance misuse issues in partnership with substance misuse agencies.

4. DUTIES WITHIN THE ORGANISATION

The Trust Board

The Trust Board has the responsibility to oversee this policy and for ensure that it is carried out effectively.

Trust Board Sub-Committees

Have the responsibility for ratifying policies and protocols through clinical governance and risk groups.

Responsibility of Clinical Staff

Consent

- *Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.*
- *In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:*

  - *Understand information about the decision*
  - *Remember that information*
  - *Use the information to make the decision*
  - *Communicate the decision*

Nurse Consultant for Dual Diagnosis

It is the responsibility of the Nurse Consultant for Dual Diagnosis to:

- Develop, monitor and implement the policy and clinical guidance for Dual Diagnosis
- Provide supervision for all Substance Misuse Workers
- Providing resource files electronically to be updated yearly
- Provide clinical guidance to co-existing substance misuse and mental health clients, training for staff
- Links to local/national Substance misuse agencies

Team Manager – Substance Misuse

- Provide clinical advice and care to inpatients with substance misuse issues
- Assisting and contributing to the management and organization of co-occurring substance misuse and mental health clients. Actively contribute to setting and maintaining high standards of mental health and substance misuse care
- Actively participate in the education, development, and supervision of other staff members.
- Work collaboratively and co-operatively with others to meet the needs of clients/service users and their families with Responsible for assessing, planning, implementing, and evaluating programmes of evidenced based co-occurring mental health and substance misuse problems care to a group of clients/service users
- Assisting and contributing to the management and organization of co-occurring mental health and substance misuse clients. Actively contribute to setting and maintaining high standards of mental health and substance misuse care
- To provide a lead within CMHT for co-occurring mental health and substance misuse problems Actively participate in the education, development, and supervision of other staff members
- Work collaboratively and co-operatively with others to meet the needs of clients/service users and their families in CMHT with co-occurring mental health and substance misuse problems.

Senior Substance Misuse Worker

- Provide clinical advice and care to inpatients with substance misuse issues this includes assessment using assist lite and other tools, care planning and risk assessment
- Attend relevant training
- Liaise with local substance misuse agencies
- Advise clinical staff on substance misuse issues
- Act as ward resource for Bradgate
- Work as directed by Band 7
- Assist ward staff in substance misuse queries

Substance Misuse Worker

- To offer substance misuse groups within inpatient settings
- To carry out assessments
- Attend supervision
- Liaise with local substance misuse agency
- Work as directed by Band 7
- Split role with Turning Point 2023/24

Service Directors and Heads of Service:

Are responsible for:

- Ensuring that policy changes, and new policies and guidance documents, are disseminated to the Managers and Team Leaders to operationalise
- Monitoring compliance in staff training required for the policy.

Managers and Team Leaders:

Are responsible for:

- Ensuring that there is a clear process for dissemination of this policy
- To ensure that the line manager(s) are clear in their roles and responsibilities in implementing the policy
- Ensuring that there is a process in place to allow staff to be released to meet training needs
- To ensure that each area has an identified link worker for dual diagnosis and have one day a month to carry out their dual diagnosis role.

All Medical, Nursing and Therapy Staff

Are responsible for ensuring that:

- Their knowledge and practice are in accordance with the policy and guidance
- Patients are clinically assessed to identify any co-existing substance misuse and mental health using Assist lite and other tools
- Liaise with LPT substance misuse workers lptsubstancemisuse@nhs.net
- They seek advice from the Consultant in Dual Diagnosis or Community Substance Misuse Provider (currently provided by Turning Point) when required
- Work with substance misusers with mental health issues on harm minimisation, relapse prevention and give overdose advice and refer onto substance misuse services with consent from the client. Referrals can be made online at http://wellbeing.turning-point.co.uk/leicestershire/professionals/
- Attend dual diagnosis training either face to face or through e-learning.
- Ensure care plans incorporate substance misuse even if client declines, it will still need to be risk assessed
- Refer all clients to turning point with consent on discharge, if declines document within notes
- Liaise with substance misuse workers at turning point regarding clients
- Ensure Naloxone is prescribed for all patients on opiate substitute prescribing prior to discharge as take home
- No opiate substitute medication to be given on discharge but transferred back to turning point
- Inform turning point 3 days before discharge of all clients requiring opiate substitute prescribing to be taken over
- Name of patient
- Dose given
- Time last dose given
- Discharge summary
- Send to: turningpoint.leicester@NHS.net

Responsibility of Clinical Staff

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- If the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

    - Understand information about the decision
    - Remember that information
    - Use the information to make the decision
    - Communicate the decision

5. SUPPORT FOR CARERS/FAMILIES

The families and carers of people with a dual diagnosis can be important partners in care delivery. They will require information and support to help them fulfil this role. Even in situations where service users do not consent to the active involvement of family/carers, Trust staffs still have a responsibility to consider their needs and a carer's assessment should always be offered.

Substance misuse issues should be considered in all carer's assessments. Particular attention should be given to the needs of young carers.

Carers should be offered information about the range of carers' agencies that can provide them with support (those with a mental health focus and those with a substance misuse focus). Information resources about support agencies are held within the Dual Diagnosis resource folder.

Carers should be offered information about substances, their effects and complications, impact on physical and mental health, and potentially dangerous interactions with prescribed medication. Substance misuse services turning point offer support to carers provide the number to the carer 0330 303 6000.

Carers can be at risk of harm from service users with dual diagnosis problems and should be made aware of who/which services to contact in case of an emergency.

Some carers will have substance use problems of their own. Where appropriate, information about local substance misuse service provision should be offered.

6. MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring and compliance will be reviewed by Heads of Service in mental health Assistant Heads matrons and team leads to evaluate progress and compliance.

7. PARTNERSHIP WORKING AND INFORMATION SHARING

7.1 Underpinning safe and effective care delivery is robust documentation and information sharing with all partners involved in care/treatment provision. Given the range of agencies likely to be involved sharing information in a timely manner is essential. The Trust electronic patient recording systems provides systems that facilitate information sharing across teams within the Trust.

7.2 The Trust Information Sharing and Confidentiality Policies should guide practice. It is good practice to obtain written consent from a patient before information is shared unless this is related to Safeguarding issues, or the patient poses a significant risk to others.

There is an information sharing agreement in place with substance misuse service Turning Point. Information regarding clients can be shared on this basis with consent of the client or through safeguarding concerns.

7.3 Careful consideration of what information is passed on to which organisations is required. A minimum requirement would usually be information about the nature of mental health and substance use problems and an assessment of risk.

7.4 During treatment (when consent has been given), as a minimum, external 'agencies' such as substance misuse services (including carers) should be invited to CPA/ Care Review meetings and given copies of care plans. Partner agencies should always be informed of significant changes in the service users' circumstances or care plans.
A list of useful contacts/ services is held within the Ward/Team Dual Diagnosis Resource, and this is updated yearly.

8. PROCESS

First assessment establishes what drugs and\or alcohol the client uses establish risk using Assist-lite tool in system one mental health assessments section.

ASSIT LITE, AUDIT SEVERITY OF ALCOHOL DEPENDENCE QUESTIONAIRE (SADQ-C) available on SystmOne:

- Drugs
- Do they need prescribing Opiate Substitute therapy (methadone, buprenorphine, buvidal)?
- First step ring turning point confirm if client is known to them or being currently prescribed
- Assess for withdrawal using Cows withdrawal scale
- for signs over a three-day initial period.

Guidance on Opiate Substitute Therapy

https://staffnet.leicspart.nhs.uk/download/14965/

- Is there a risk of drug use on the ward?
- Screen for opiates and other drugs
- Alcohol
- Assess for alcohol use using Assist Lite /AUDIT/SADQ
- Check for withdrawal using GMAWS tool
- Prescribing for detoxification in line with Trust guidelines
- Monitor for withdrawal
- Refer to substance misuse services is essential following detoxification.

9. TRAINING REQUIREMENTS

9.1 There is a need for training identified within this policy. In accordance with the classification of training outlined in the LPT Trust Learning and Development Strategy this training has been identified as role specific training via the trust wide training needs analysis. (Appendix 8).

9.2 Training must be booked through the Ulearn system. The U-learn system will identify who the training applies to, the delivery method, the update frequency, the learning outcomes and a list of available dates and locations where the training can be accessed.

9.3 A record of the staff training will be recorded on Ulearn for LPT staff and compliance should be monitored at the Directorate Workforce meetings.

9.4 Clinical Skills training in dual diagnosis, assist lite and Naloxone is available to all registered clinicians and Health care support workers in LPT. There is also access to eLearning on dual diagnosis provided following the initial face to face training as an update.

Specific training is required for all Doctors around prescribing guidance for opiate dependence/withdrawal using department of health drug misuse guidance (https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-managementand alcohol detoxification trust guidance.

10. CLINICAL GUIDANCE FOR THE CARE AND TREATMENT OF PATIENTS WITH DUAL DIAGNOSIS OF MENTAL HEALTH PROBLEMS AND COEXISTING SUBSTANCE OR ALCOHOL MISUSE IN INPATIENT SERVICES

Preventing Use

10.1 Prior to admission:

- All patients should be asked about substance use during assessment and for inpatient settings referred to the Substance misuse workers using lptsubstancemisuse@nhs.net for community referrals need to be made to Turning Point LLreferals@turning-point.co.uk

- The assessment prior to referral on should include the alcohol Assist lite, Audit Tool , SADQ on SystmOne. All Patients should have recorded care cluster 16 for Dual Diagnosis if presenting with psychoses and substance use.

- For Doctors when coding for diagnosis all patients should have secondary ICD substance misuse code for diagnosis if present.

- If a patient discloses substance use, a urine/saliva sample should offer to confirm substances use, especially if requesting pharmaceutical interventions or detoxification. Prescribing should only take place following advice from the Prescribing Drug Service (Turning Point)

- Refer all patients using substances to lpt.substancemisuse@nhs.net on admission

- If concerned about alcohol intoxication use an alcometer to establish if patient is intoxicated to enable staff to manage care appropriately

- All patients should be given the opportunity to talk to their named key worker/ health professional about issues related to substance use as part of their assessment and at any point during their clinical treatment.

- The patient can be offered referral to substance misuse workers in inpatient settings and follow-up by local drug and alcohol services on discharge. All patients must be offered referral to local substance misuse services.

- On discharge all patients to be referred to Turning Point.

- Those on opiate substitute prescribing (buprenorphine/ methadone) prescribing must be returned to local substance turning point on discharge and no takeout methadone to be given. Ensure turning point know 3 days prior to discharge do not discharge patients on methadone at the weekend as there is no service after 1pm on Saturday. Naloxone must be prescribed on discharge and patient shown how to use it.

- Turning point require 3 days before discharge form and e-mail stating how much has been prescribed, when the last dose has been given and a discharge summary. This must be sent to: turningpoint.leicester@NHS.net

Substance misuse referrals and process of prescribing of opiate substitute treatment Admission and Discharge

- **On Admission**
- Check if patient open to turning point Tel:0330 303 6000 (mon/fri)
- Refer patient to lpt.substancemisuse@nhs.net include system one number substance used, length of use and client consent to referral current OST.
- For Advice on substance misuse (mon/fri) prescribing
- Andrew.ball@turningpoint.co.uk
- tel 07484 097409
- Saskia Bauweraerts 07890 066880
- Weekends on call Consultant
- prescribing guidance: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pd
- **Advice on substance misuse**
- lptsubstancemisuse@nhs.net
- 0116 295 3028

- **On Discharge**
- Invite substance misuse team to MDT who will feedback to turning point
- Notify lpt.substancemisuse@nhsnet and turningpoint.leicester@NHS.net
- Complete and send OST discharge form
- Avoid weekend discharge as turning point cannot accommodate prescribing at the weekend.
- Email discharge summary to: turningpoint.leicester@NHS.net
- Notify of date and time last dose of OST will be given and exact amount.
- Ensure Naloxone is prescribed on discharge for all opiate substitute treatment patients including methadone and buprenorphine

- All patients should be notified that substance use on Trust premises is not accepted practice. Posters should be clearly displayed explaining substance use is not allowed on Trust premises in all patient areas and advice alongside on where to access help. The Trust has a positive policy of searching to reduce the flow of controlled drugs into the premises. All staff should be aware of the Trust Checking and Searching Policy.

- Any concerns or suspicions of patients being in possession or concerned in the distribution of controlled drugs must be discussed with the Multi-Disciplinary Team (MDT) as soon as possible.

- Key Messages - Intoxication with any substance is potentially life threatening through direct effects of the substance or through an increased risk of suicide, violence and accidents (Appleby 2016).

- Emergency care can include maintaining airways and circulation, immediate transfer to Acute Physical Health Hospital Services should be arranged if there is a risk of respiratory depression or behavioural disturbance.

- Four main causes of drug related deaths are overdose, suicide, accidents and physical health complications.

- Increased awareness for staff and training in managing intoxication and the importance of taking a thorough history of substance use and toxicology analysis may increase awareness of risks as part of a baseline assessment.

10.2 On admission

- Routine urine drug testing can be carried out on admission for all new admissions with informed consent (see consent policy) to an acute mental health ward due to the high prevalence of substance misuse in this patient group and check with local substance misuse services for contact or key worker.

- All staff should familiarise themselves with drug/alcohol test screening kits and understand the implications of drug and alcohol use. This is available through the dual diagnosis training.

- Timing of tests should be agreed at admission with the team on duty and carried out by suitably trained staff.

- If a patient provides a positive test for either drug or alcohol a full substance misuse history is to be completed by key worker and the patient asked if they would consent to a referral being made to the substance misuse team or dual diagnosis consultant. Any discussion or referral must be documented in the notes and a care plan for substance use created.

- All registered staff should provide basic motivational and brief intervention work with patients.

- All patients should be informed of the possible dangers of using substances when prescribed medication is being used.

- Establish any links accurately between substances and mental health. This would include noting any change in behaviour once substance is no longer in the patient's system.

- All patients with substance misuse issues will have an array of physical health problems and will need to be assessed for physical health issues.

10.3 Physical Investigations

- Before any test, full informed consent should be obtained from the patient. Including screening for blood borne virus

- Blood screen by the doctor should include:

- Haemoglobin (FBC)
- Creatinine (U+E)
- Liver function tests (GGT)
- Hepatitis C & B with specific informed consent
- Test for HIV antibody with specific informed consent
- Magnesium levels

For OST prescribing carry out electrocardiogram (ECG) screen prior to prescribing methadone.[1,2] The point, of course, was to withhold methadone if ECG screening showed a prolonged QT interval (>500 Ms).

10.4 Guidance for the use of Urine Drug Screens

Drug screen tests are available within the Trust.

There are options available from multi-screen tests both urine and saliva:

- Multi-drug screen test panel (urine/saliva)
- To be used if a full screen is required
- Multi-drug screen test panel (urine/saliva)
- On admission all patients should be made aware of the drug screening procedure, and this is documented in the notes. If regular drug screening is being undertaken this should be documented in the care plan
- Before using a drug screen is clear of what a positive or negative result will signify
- Document the therapeutic / treatment gains for the patient having a drug screen
- If a patient says they have taken a certain drug – does the test still need to be carried out?
- Drug testing should be seen as an opportunity for harm reduction information giving and to assess the patient's level of motivation, otherwise the procedure could be viewed by the patient and the health care professional as punitive
- If a false positive or negative occurs repeat the test just once then if the result shows the same send the sample to the pathology laboratory. Certain clinical conditions may show a false positive
- There is cross sensitivity between certain medicines, check with the manufacturer. If a patient requires treatment for drug / alcohol use this should be provided whilst in services via appropriate agencies
- Search of ward / trust premises as per Trust Search Policy.

10.5 Prior to Leave

- As a condition of leave, agree frequency of testing and what substances are to be tested.

- Appropriate timing of testing before and after leave. All patients known to use substance should receive information on harm minimisation and Leave protocols should include harm minimisation messages and emphasis on remaining substance free.

- Reduce leave if substance misuse takes place and document within care plan, discuss why use took place and offer brief interventions and relapse prevention. Please refer to the Trust's Leave Policy.

- No methadone to be given for leave patient to return to ward each day.

- Naloxone to be prescribed when going on leave as take home.

- Doctors and Nurses to provide advice to patients regarding combining substances especially alcohol and benzodiazepines.

- Educate substance users and their families / carers on the risks of overdose and how to respond effectively especially when prior to discharge from hospital following a period of abstinence.

10.6 Dealing with Overdose

All services must have training in managing overdose and receive naloxone (opiate antidote) training. This is arranged via Ward request to the Dual Diagnosis Nurse Consultant.
Staff should be able to:

- Call an ambulance and competent preservation of the airway, support breathing and cardiac function as appropriate
- Suitable resuscitation training and equipment should be available
- If there are signs of hyperthermia arrange medical transfer to Accident and Emergency
- Establish (if history available) amount and type of substance used as well as time of last use
- Ensure the emergency trolley has naloxone and given to all patients on methadone on discharge.

What is meant by overdose?

This is when too much of a substance has been taken, whether accidental or intentional, prescription or over the counter medications, or legal or illegal drugs.

Overdoses can be harmful immediately or in the long term and can result in death. For this reason, it is important to be aware of how to keep yourself as risk free as possible and be aware of what steps to take if someone you are with takes an overdose (or you feel they may have taken an overdose).

Risks

A person is more at risk of an overdose after a period of not using any drugs. This may be through choice, a period in hospital or prison, poor health or any other reason. This is because when a person does not use any drugs, it may be that their tolerance to previously used drugs is lowered. This means that the same amount that was used previously may not be safe any longer.

It may be that a person may not have found their tolerance had decreased after a previous period not using drugs, but that does not mean it will be the same every time. Our bodies change with time, and the strength of drugs may be different.

It could be that the drugs we are buying are not the drugs we think we are buying or may be mixed with other products that could cause harm such as overdose if this drug were unused previously.

Ways to stay safer

It is recommended that if a person decides to use drugs again after a period of not using drugs, it is advised that far less of the substance is taken and a period taken to assess the strength before using more.

<u>Remember – it is always possible to take more if desired; it is not possible to take less.</u>

Try to only buy from sources that are known and trusted. Buying drugs off the street can be extremely risky, as you may not know the person selling them or what you are buying. Try to tell someone where you are going when you go to buy drugs and tell them what you are using. Ideally have someone with you when you are using drugs so that they can call for help if it is needed.

Ways of taking the drug should also be considered. If a person uses the inject, the risk of an overdose is higher. The same goes for inhaling drugs. Drugs can go to your brain quicker this way. Swallowing is also risky, as it can take a while longer for the drugs to be absorbed into the bloodstream which can increase the risk of re-dosing which increases the risk of overdose.

Signs of an overdose

This is not an exhaustive list. Each person is different, and some people may not display any of the listed signs of an overdose.

Things to be aware of are:

- Vomiting
- Difficulty breathing
- Tense/panicky
- Agitated/aggressive
- Drowsy/falling asleep
- Overheated/dehydrated
- Loss of consciousness
- Difficulty walking
- Enlarged pupils
- Tremors
- Convulsions
- Hallucinations or delusions

What to do if you are with someone who overdoses

- The first thing is to call for help

- If you can ask someone else to call emergency team for inpatients or 999 f so that you can stay with the person, this is ideal, but if not ensure they are positioned on their side, so they do not choke on their own vomit and then go and call 999

- Keep talking to them to try to keep them awake

- If you are not already aware, try to find out what they have taken. Keep hold of any that is left over

- Place the person in the recovery position

- If taken opiates give Naloxone

- In the case of an opiate overdose - i.e., heroin, methadone or morphine, it is useful to know if the person you are with has a naloxone injection. Naloxone blocks the effects of opiates. It can be given by anyone.

Preparing Naloxone:

- Remove syringe and needle from package
- Attach needle to syringe
- 'Tap' ampoule to remove Naloxone from ampoule neck
- Carefully 'snap' ampoule
- Insert needle and draw up Naloxone – aspirate syringe
- Identify injecting site

Injecting Naloxone:

- Inject into the outer thigh, upper arm or outer part of buttock
- Hold needle (like a dart) 90 degree above skin
- Spread skin – insert needle into muscle (needs pressure)
- Slowly and steadily push plunger all the way down
- Remove needle and syringe
- Safely dispose of needle, syringe and used ampoule
- Continue to monitor vital signs
- If no change after 2-3 minutes
- Repeat an IM dose of Naloxone
- Place in recovery position
- Continue to monitor until paramedics arrive and/or 2222 crash team (in relevant areas)
- Monitor and record the number of Naloxone injections used
- There are 5 ampoules available in the white box making a maximum available dose of 2mg
- Continue until consciousness regained, breathing normally, medical assistance available, or contents of syringe used up.
- No more than 0.4mgs/1ml at a time. Maximum total dose 5mg
- Naloxone is shorter acting than most opiates (1 hour or less), Further doses may be required if respiratory function deteriorates.

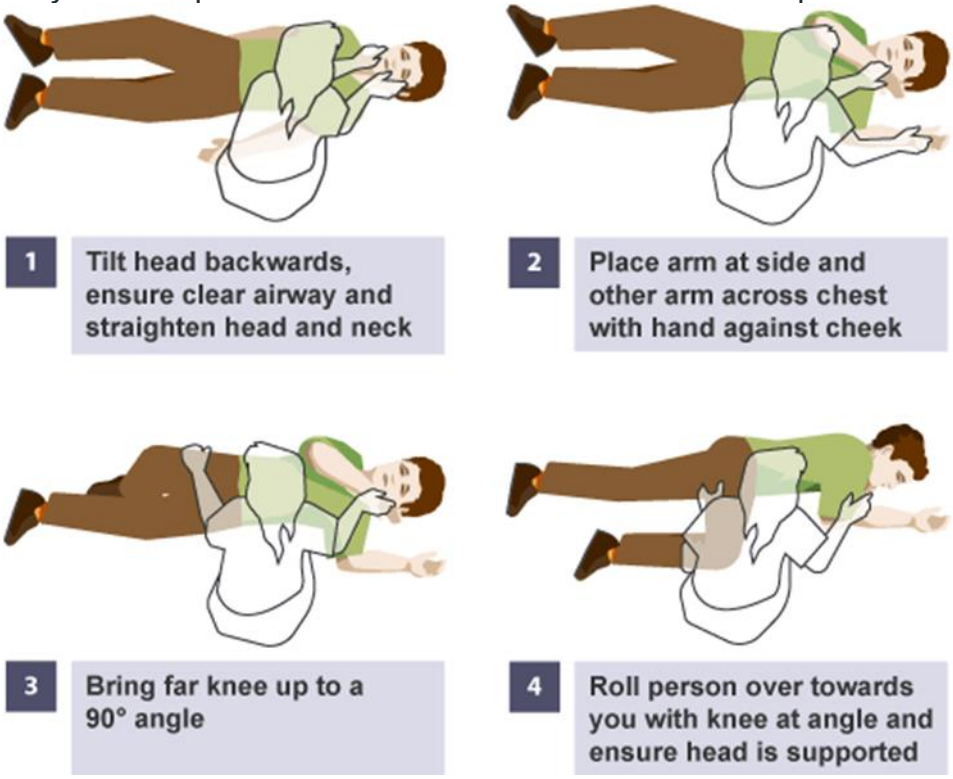
10.7 Patient is Unconscious and not breathing

- Follow the Cardio resuscitation process as per LPT policy
- Attending medics to assess and consider overdose
- Call 9999/2222
- Administer 0.4mcg/1ml Naloxone IM (or IV if suitably trained to do so)
- Repeat 3 cycles of 30 compressions and repeat the injection of 0.4mcg/1ml Naloxone
- Continue until breathing
- Transfer to UHL

Recovery Position Steps:

Taken from https://www.nhs.uk/conditions/first-aid/recovery-position/

- With the person lying on their back, kneel on the floor at their side
- Extend the arm nearest you at a right angle to their body with their palm facing up
- Take their other arm and fold it so the back of their hand rests on the cheek closest to you and hold it in place
- Use your free hand to bend the person's knee farthest from you to a right angle
- Carefully roll the person onto their side by pulling on the bent knee
- Their bent arm should be supporting the head, and their extended arm will stop you rolling them too far
- Make sure their bent leg is at a right angle
- Open their airway by gently tilting their head back and lifting their chin and check that nothing is blocking their airway
- Stay with the person and monitor their condition until help arrives.



Stay with the person. It is helpful if you can hand over to attending staff what you think the person has taken and hand over any that is left over.

In the case of an opiate overdose - i.e., heroin, methadone or morphine, it is useful to know if the person you are with has a naloxone injection. Naloxone blocks the effects of opiates. It can be given by anyone.

Preparing Naloxone:

- Remove syringe and needle from package
- Attach needle to syringe
- 'Tap' ampoule to remove Naloxone from ampoule neck
- Carefully 'snap' ampoule
- Insert needle and draw up Naloxone – aspirate syringe
- Identify injecting site

Injecting Naloxone:

- Inject into the outer thigh, upper arm or outer part of buttock
- Hold needle (like a dart) 90 degree above skin
- Spread skin – insert needle into muscle (needs pressure)
- Slowly and steadily push plunger all the way down
- Remove needle and syringe
- Safely dispose of needle, syringe and used ampoule.

10.8 Managing Intoxication and Driving

Assess for intoxication using an Alco meter for alcohol and provide patients with a safe environment to support recovery:

- If a patient asks for discharge whilst intoxicated, levels of intoxication need to be measured using an Alco meter if the patient refuses it must be documented
- Patients who appear intoxicated should not be discharged until they have been reviewed or no longer intoxicated due to the risk to themselves and others. The patient should be reviewed by the duty doctor and the co-ordinator informed.

For information regarding the Law in relation to driving and using drugs or alcohol, please refer to the Trust Policy and:

www.think.direct.gov.uk/drug driving
www.gov.uk/drink-drive-limit

10.9 Management of Alcohol Withdrawal is Required when a Patient:

- Is severely dependent on alcohol and therefore likely to have severe withdrawal symptoms.
- Suffers from a serious or life threatening medical or psychiatric condition e.g. pre-existing epilepsy, impaired liver function (high serum bilirubin, low albumin and impaired clotting) or is at risk of self-harm / suicide or aggression/violence
- Is currently having, or has in the past, had severe withdrawal symptoms or withdrawal complicated by alcohol withdrawal seizures or delirium tremens (DTs)
- Has any evidence of cognitive impairment. Compulsory admission under the Mental Health Act (1983) is not permissible when alcohol dependence is the sole diagnosis. However, in patients with delirium tremens compulsory admission may be appropriate
- See methadone detoxification policy for prescribing and alcohol detoxification policy.
- See Appendix for guidance on alcohol and methadone.

10.10 Use of Drug Dogs

The use of drug dogs should be restricted to concerns for patients' safety within the ward environment or issues related to dealing on wards by both patients and visitors. Advice to their use should be taken in discussions with the Trust Security Manager/local police officer. Drug dogs should only be requested when there are concerns about dealing within Inpatient units.

10.11 Leave Status

Patients should be reminded prior to leave that returning intoxicated is not acceptable practice and could lead to a review of their current care.
Leave should be reviewed should an individual repeatedly return to the ward intoxicated. Alco meters and drug testing kits should be used to establish if someone is under the influence of illegal substances to protect the patient, other patients and staff.

10.12 Disposal of Drugs

Drug Safes to be used as per Policy and Search Policy

The Trust has established a policy dealing with how the drugs are stored and passed over to the police. This is using drug safes in inpatient areas.

The Trust is continuing to ensure robust structures are in place in respect to the supervision of areas of the premises which may attract drugs use and dealing e.g., low light areas, toilets etc. also staff should monitor the activity of patients and visitors for signs of drug use or dealing. Attention should be given to patients returning from smoking breaks outside of the unit.

The police can provide advice and assistance with all issues in relation to controlled drugs. All incidents of drug dealing should be immediately reported to the police. The banning or excluding visitors suspected of being in possession or concerned in the distribution of controlled drugs should be discussed with the Service Manager and Local Security Management Team.

10.13 Action to be taken if a visitor is suspected of possessing a dangerous or illicit item

this policy does not make provision for the searching of visitors. Visitors must be asked not to bring bags on to Trust premises where staffs have concerns about dangerous or illicit substances being brought in.

All visitors will be discreetly observed whilst on Trust premises. A visitor suspected of carrying or supplying dangerous items will be challenged, and they will be asked to support staff to maintain a safe ward environment.

A visitor **must not** be searched, although their bags may be searched upon request if the visitor gives their consent. If a visitor refuses for their bags to be searched staff must consider whether it is appropriate for restrictions to be placed on their visits (e.g., observed visit only) or if they should be prohibited from visiting. Consideration must be given to the impact that this may have on the patient, and as withholding visitors is a significant infringement of the patient's rights, the decision must be carefully considered, and full agreement of the team must be reached.

A full record of the seizure of the drugs should be made in the Trust Drug Seizure Log and kept at the premises (along with an entry in the patient records).

10.14 Internal and external joint working arrangements for patients

To ensure effective communication within and between each area, regular contact needs to be made with local drug and alcohol partner agencies, and probation. This can be done by contacting each service on patient admission to check if the patient is open to substance services.

Arrangements for accessing expert advice in managing the care of this group are through the Nurse Consultant for Dual Diagnosis, Substance Misuse Workers in Inpatient areas and local drug and alcohol services who visit Inpatient services on set days. Additional support is available from substance services via the consultant psychiatrist.

On occasions there will be differences of opinion regarding which service(s) is best placed to lead the care delivery of an individual and/or the appropriate contribution of specific services to the care package. If, following initial discussion between staff directly involved in a particular case, differences of opinion are not resolved, a multi-professional meeting should be arranged. The meeting should be chaired by the consultant psychiatrist and the patients, carers and staff directly involved with the case, the team managers and consultant psychiatrists of the relevant teams, a social care perspective, as well as substance misuse workers and Nurse Consultant for Dual Diagnosis. The consensus view should be documented and reviewed through the care programme approach.

In line with care co-ordination when a Mental Health Team is not going to provide care within the framework for someone with a dual diagnosis the reasons for this will be explained following the assessment on the patient electronic record. Some people with a dual diagnosis have short periods of contact with services but tend not to maintain good contact or engagement despite having needs and being potentially at risk of self-harm, self-neglect, physical health problems, accidents, suicide and violence to others. They are often people with mild to moderate mental health problems who do not meet criteria for secondary mental health care and are unwilling or unable to access substance misuse services. Services need to work together to consider the needs of everyone, ensure that risk is carefully assessed, information shared (including with the person's GP) and a flexible and timely response taken when risk escalates or there are opportunities for engagement.

10.15 Clinical Care - Assessment

Assessment of current and recent substance use should be an integral component of mental health assessment (for inpatient wards this should be conducted on admission, or, if this is not possible due to the disturbed mental state of the person, as soon after as is feasible) (DH 2002, 2006, 2008, 2012 2017 AIMS. Nice Alcohol and Drug Guidelines). If the person does not use any drugs or alcohol this should also be recorded.

Risk assessment must identify the risks associated with mental health, substance use and the interaction of the two, and include risks posed to patients, their family and carers, children, staff (both on Trust premises and in users' homes) and others in the wider community. Risk assessment should therefore include determining the potential impact of different types of substance on violence, self-harm, suicide, self-neglect, abuse and exploitation, and accidental injury as well as risks specifically associated with substance use such as withdrawal seizures, delirium tremens, dangerous injecting practices, blood borne viruses, accidental overdose. The potential risks associated with the interaction of prescribed medication and non-prescribed, and/or illicit drugs, and/or alcohol, should be

considered. The risk to children with whom the patient is in contact must also be assessed related to safeguarding (Hidden Harm).

Where initial assessment indicates present or past substance use a substance use history should be taken by the Doctor or qualified nurse. The drug and alcohol history section on the Trust Risk Assessment outlines the main components of such an assessment.

The impact of substance uses on other assessment domains e.g., relationships, accommodation, education/employment, finances, forensic should be considered and, where relevant, documented.
Substance use, and the lifestyle which may be associated with it, can have a significant impact on physical health (including sexual health). This should be assessed and documented, and the appropriate physical investigations conducted e.g., liver function tests, hepatitis B and C testing.

The patient's reasons for, and perceptions of, use and motivation for change should be assessed. This will inform subsequent interventions.

As well as patients themselves, carers, families and other service providers involved in the person's care should be invited to contribute to the assessment process.

Assessment is an ongoing process and needs to be reviewed regularly. For those subject to CPA, review of substance use must be part of the CPA process. When a formal diagnosis of mental or behavioural disorder due to substances has been made, in line with ICD10 criteria, and care cluster this should be recorded.

For in-patients they should be seen by Substance Misuse workers

Referral should be made to Substance Misuse Services.

10.16 Care planning and treatment intervention

Care planning must be a collaborative process with the patient and where appropriate, their carers. Substance misuse if identified must be included.

All patients should be asked about substance use on admission and urine/saliva screened for confirmation of type of substance. A full drug/alcohol history should be taken for all patients entering services.

All patients who are currently or have recently used substances, and those who have had problems in the past, must have a care plan(s) which addresses substance use. This may include one or more of the following: risk management plan, mental health care plan, physical health care plan, CPA plan, and crisis plan. Patients must be offered a copy of their care plan(s). All patients should be urine screened on admission if there are concerns that drug taking has taken place before e-prescribing. This is to ensure patients are using and for safe prescribing practice to take place.

Alcohol testing using a breathalyser should be used on ward as part of an admission if there are concerns that the patient maybe intoxicated and may pose a risk to themselves or others.

Treatment interventions should be matched to the patient's stage of change in line with the cycle of change (Prochaska and DiClemente 1986) and the four staged treatment model (Osher and Kofoed 1989).

While abstinence from substances would usually be the preferred goal for patients with mental health problems, many will be unwilling or unable to attain this. An approach based on engagement, harm reduction (to the person themselves, those with whom they have contact, and the wider community) and motivational enhancement is therefore an appropriate initial goal (DH 2002, 2006).

A key component of harm reduction is health education. All clinical staff should be able to offer health education on the potential impact of substances on physical and mental health (Hughes 2006) in line with best practice guidance (e.g., NICE 2007, Alcohol Effectiveness Review). Each Trust site should have health promotion information. These should be offered to patients and carers and could be used as a basis for discussions during individual work and as a resource in groups.

Where computers are available for the use of patients, websites which provide information, advice and self-help regarding substance use should be bookmarked as 'favourites' so that they can be easily accessed.
These sites should include:

- www.talktofrank.co.uk
- www.dualdiagnosis.co.uk
- www.drugscope.co.uk
- Lifeline and alcohol concern
- NHS Choices

All sites should have information available about local substance misuse services, what they offer and their referral criteria. Substance misuse services should have information about local mental health services and how they can be accessed and should be aware of services provided by Local Authorities and voluntary and private organisations.

when pharmacological interventions are indicated prescribing must be in line with best practice guidance (e.g., NICE substance misuse and psychoses 2011 NICE 2007, NICE guidance (b) c)) and Guidelines on the Clinical Management of Drug Dependence (DH England and the devolved administrations 2017) 2007 Maudsley, as there are likely to be several agencies involved in care delivery. Care plans must clearly document each person/agencies contribution to the overall care plan. This should link to policy on alcohol and substance abuse for patients and visitors.

For people subject to Care co-ordination , substance use must be routinely considered in care co-ordination reviews.

When patients are being transferred within, or referred on from, Trust services plans must include provision for continued care/treatment of their substance use (for those in mental health services) or their mental health issues (for those in substance services). When patients have provided consent, copies of care plans must be forwarded to partner agencies and carers

When people with opiate problems are being discharged from inpatient services they must be informed about the risk of overdose.

Concerns over prescribing must be discussed with substance misuse service consultant or nurse consultant for dual diagnosis.

No prescribing should take place until a check with other prescribing services, for example the GP has been carried out to ascertain current prescribing regime.

Local substance services must be informed with 3 days notice that a patient needs prescribing for on discharge. Complete Ost discharge form and send to turning point with discharge summary.

When patients are being discharged from Inpatient wards, a clear plan must be in place to ensure that a 7 day follow up takes place.

For prescribing of methadone drug services must be given 3 days notice of discharge, to enable them to provide methadone on discharge. No takeout opiate substitute medication including methadone, buprenorphine.

Give naloxone for all opiate substitute patients on discharge and show them how to use it prior to discharge.

11. CLINICAL GUIDANCE FOR THE CARE AND TREATMENT OF PATIENTS WITH DUAL DIAGNOSIS OF MENTAL HEALTH PROBLEMS AND COEXISTING SUBSTANCE OR ALCOHOL MISUSE IN COMMUNITY SERVICES

11.1 Preventing Use:

All patients should be asked about substance misuse in the community to assess for risk and be able to offer referral to Substance Misuse Services.

Brief interventions should be offered to all patients using substances within the community. Brief interventions are the first point in offering patient an opportunity to reflect and change current practice. Check if patient is open to local Substance Misuse Services

11.2 Managing People Who Are Intoxicated

When conducting home visits or outpatients' appointments patient should be asked to refrain from using substances in front of staff and if intoxicated review if the visit/ appointment is appropriate as therapeutic work will be difficult to conduct if the patient is intoxicated. Offer the patient another appointment.

Key Messages – minimum
Intoxication with any substance is potentially life threatening through direct effects of the substance or through an increased risk of suicide, violence and accidents (Appleby 2016).

Emergency care can include:

Maintaining airways and circulation, immediate transfer to the Leicester Royal Infirmary hospital should be arranged via ambulance if there is a risk of respiratory depression or behavioural disturbance.

Four main causes of drug related deaths are overdose, suicide, accidents and physical health complications.

Good Practice should include taking a thorough history of substance use and toxicology analysis may increase awareness of risks as part of a baseline assessment.

Increased awareness for staff and training in managing intoxication:

- Risks associated with administering depot medication / delivering medication if people are likely to be intoxicated as part of a dependency on a substance. Assess for intoxication prior to giving depot medication. If patient intoxicated do not administer and give once patient is no longer under the influence anything from 4 to 24 hours later.

Crisis Team assessments should include drug/alcohol assessment and all patients should be seen to assess this risk. If intoxicated at the time of assessment a time should be arranged to see the patient when they are no longer intoxicated within a 24-hour period.

Utilise contingency planning / patient plans of what they would like to happen should they use substances and are admitted to a ward.

11.3 Dealing with Overdose

All registered staff must have training in managing overdose and receive naloxone training.
This should include:

- Rapid ambulance call and competent preservation of the airway, support breathing and cardiac function as appropriate
- Suitable resuscitation training.

11.4 Management of Alcohol Withdrawal is required when a Patient

- Is severely dependent on alcohol and therefore likely to have severe withdrawal symptoms
- Suffers from a serious or life threatening medical or psychiatric condition e.g., pre-existing epilepsy, impaired liver function (high serum bilirubin, low albumin and impaired clotting) or is at risk of self harm/suicide or aggression/violence
- Is currently having or has in the past had severe withdrawal symptoms or withdrawal complicated by alcohol withdrawal seizures or delirium tremens (DTs)
- Has any evidence of cognitive impairment. Compulsory admission under the Mental Health Act (1983) is not permissible when alcohol dependence is the sole diagnosis. However, in patients with delirium tremens compulsory admission may be appropriate.

11.5 Internal and External Joint Working Arrangements

To ensure effective communication within and between each area, regular contact needs to be made with local drug and alcohol partner agencies, and probation. This can be done by contacting each service on patient admission to check if the patient is open to substance services. Arrangements for accessing expert advice in managing the care of this group are through the nurse consultant for dual diagnosis, substance misuse workers and local drug and alcohol services who visit inpatient services on a set day each week. Additional support is available from substance services via the consultant psychiatrist.

On occasions there will be differences of opinion regarding which service(s) is best placed to lead the care delivery of an individual and/or the appropriate contribution of specific services to the care package. If, following initial discussion between staff directly involved in a particular case, differences of opinion are not resolved, a multi-professional meeting should be arranged. The meeting should be chaired by the consultant psychiatrist and the patients, carers and staff directly involved with the case, the team managers and consultant psychiatrists of the relevant teams, a social care perspective, as well as substance misuse workers and Nurse Consultant for Dual Diagnosis. The consensus view should be documented and reviewed through the care programme approach.

In line with Care coordination guidance (DH 2022), when a mental health team is not going to provide care within the Care co-ordination framework for someone with a co-existing substance misuse and mental health the reasons for this will be explained following the assessment on the patient electronic record Some people with a dual diagnosis have short periods of contact with services but tend not to maintain this despite having needs and being potentially at risk of self-harm, self-neglect, physical health problems, accidents, suicide and violence to others.

They are often people with mild to moderate mental health problems who do not meet criteria for secondary mental health care and are unwilling or unable to access substance misuse services. Services need to work together to consider the needs of everyone, ensure that risk is carefully assessed, information shared (including with the person's GP) and a flexible and timely response taken when risk escalates or there are opportunities for engagement.

The Trust expects adherence to the standards set out in the following sections which are recognised as core components of good quality care for people with a dual diagnosis and essential for identifying and managing risk.

11.6 All Registered Staff Clinical Care - Assessment

Assessment of current and recent substance use should be an integral component of mental health assessment (for inpatient wards this should be conducted on admission, or, if this is not possible due to the disturbed mental state of the person, as soon after as is feasible) (DH 2002, 2006, 2008, 2012 AIMS. Nice Alcohol and Drug Guidelines PHE 2019). If the person does not use any drugs or alcohol this should also be recorded.

Risk assessment must identify the risks associated with mental health, substance use and the interaction of the two, and include risks posed to patients, their family and carers, children, staff (both on Trust premises and in patients' homes) and others in the wider community. Risk assessment should therefore include determining the potential impact of different types of substance on violence, self-harm, suicide, self-neglect, abuse and exploitation, and accidental injury as well as risks specifically associated with substance use such as withdrawal seizures, delirium tremens, dangerous injecting practices, blood borne viruses, accidental overdose. The potential risks associated with the interaction of prescribed medication and non-prescribed, and/or illicit drugs, and/or alcohol, should be considered. The risk to children with whom the patient is in contact must also be assessed related to safeguarding (Hidden Harm).

Where initial assessment indicates present or past substance use a substance use history should be taken by the Doctor or qualified nurse. The drug and alcohol history section on the Trust Risk Assessment outlines the main components of such an assessment.

The impact of substance uses on other assessment domains e.g., relationships, accommodation, education/employment, finances, forensic should be considered and, where relevant, documented.

Substance use, and the lifestyle which may be associated with it, can have a significant impact on physical health (including sexual health). This should be assessed and documented, and the appropriate physical investigations conducted e.g., liver function tests, hepatitis B and C testing.

The patient's reasons for, and perceptions of, use and motivation for change should be assessed. This will inform subsequent interventions.

As well as patients themselves, carers, families and other service providers involved in the person's care should be invited to contribute to the assessment process.

Assessment is an ongoing process and needs to be reviewed regularly. For those subject to CPA, review of substance use must be part of the CPA process.

When a formal diagnosis of mental or behavioural disorder due to substances has been made, in line with ICD10 criteria, and care cluster this should be recorded.
Referral should be made to substance misuse services.

11.7 Care Planning and Treatment Intervention

Care planning must be a collaborative process with the patient and where appropriate, their carers. Substance misuse if identified must be included.

All patients should be asked about substance use on admission and urine/saliva screened for confirmation of type of substance. A full drug/alcohol history should be taken for all patients entering services.

All patients who are currently or have recently used substances, and those who have had problems in the past, must have a care plan(s) which addresses substance use. This may include one or more of the following: risk management plan, mental health care plan, physical health care plan, CPA plan, and crisis plan. Patients must be offered a copy of their care plan(s). All patients should be urine screened on admission if there are concerns that drug taking has taken place before e-prescribing. This is to ensure patients are using and for safe prescribing practice to take place.

Treatment interventions should be matched to the patient's stage of change in line with the cycle of change (Prochaska and DiClemente 1986) and the four staged treatment model (Osher and Kofoed 1989)

While abstinence from substances would usually be the preferred goal for patients with mental health problems many will be unwilling or unable to attain this. An approach based on engagement, harm reduction (to the person themselves, those with whom they have contact, and the wider community) and motivational enhancement is therefore an appropriate initial goal (DH 2002, 2006).

A key component of harm reduction is health education. All clinical staff should be able to offer health education on the potential impact of substances on physical and mental health (Hughes 2006) in line with best practice guidance (e.g., NICE 2007, Alcohol Effectiveness Review). Each Trust site should have health promotion information. These should be offered to patients and carers and could be used as a basis for discussions during individual work and as a resource in groups.

Where computers are available for the use of patients, websites which provide information, advice and self-help regarding substance use should be bookmarked as 'favourites' so that they can be easily accessed.

These sites should include:

- www.talktofrank.co.uk
- www.dualdiagnosis.co.uk
- www.drugscope.co.uk
- Lifeline and alcohol concern.

All Community Teams should have information available about local substance misuse services, what they offer and their referral criteria. Substance Misuse Services should have information about local mental health services and how they can be accessed and should be aware of services provided by Local Authorities and voluntary and private organisations.

When pharmacological interventions are indicated prescribing must be in line with best practice guidance (e.g., NICE substance misuse and psychoses 2011 NICE 2007, NICE guidance (b) c)) and Guidelines on the Clinical Management of Drug Dependence (DH England and the devolved administrations 2017) 2007 Audley As there are likely to be several agencies involved in care delivery, care plans must clearly document each person/agencies contribution to the overall care plan. This should link to policy on alcohol and substance abuse for patients and visitors.

When patients are being transferred within, or referred on from, Trust services plans must include provision for continued care/treatment of their substance use (for those in mental health services) or their mental health issues (for those in substance services). When patients have provided consent, copies of care plans must be forwarded to partner agencies and carers

Concerns over prescribing must be discussed with Substance Misuse Service consultant or Nurse Consultant for Dual Diagnosis.

No prescribing should take place until a check with local services has been carried out to ascertain the current prescribing regime.

12. FRAUD, BRIBERY AND CORRUPTION CONSIDERATION

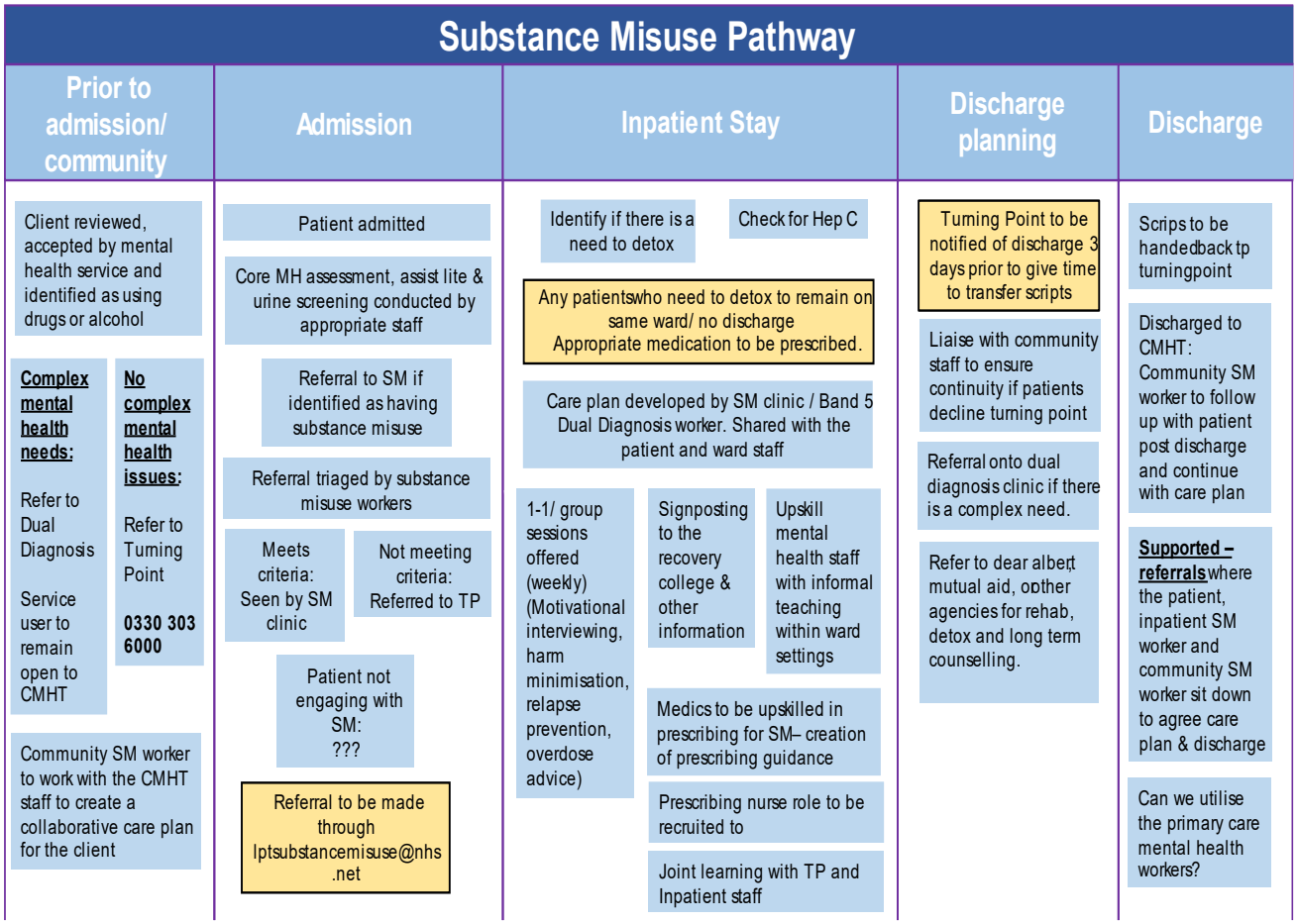
- The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

13. APPENDICES

Appendix 1 Flowchart(s)



Appendix 2 Training Requirements

Training Needs Analysis

Training topic:	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) x Role specific ☐ Personal development
Directorate to which the training is applicable:	x Mental Health ☐ Community Health Services ☐ Enabling Services x Families Young People Children / Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	*All clinical staff*
Regularity of Update requirement:	One off training
Who is responsible for delivery of this training?	Nurse Consultant Dual Diagnosis and inpatient substance misuse team.
Have resources been identified?	No
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	x ULearn ☐ Other (please specify)
How is this training going to be monitored?	Team lead/managers/matrons

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	X
Respond to different needs of different sectors of the population	X
Work continuously to improve quality services and to minimise errors	X
Support and value its staff	*X*
Work together with others to ensure a seamless service for patients	X
Help keep people healthy and work to reduce health inequalities	X
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	x

Appendix 3 Due Regard Screening Template

Section 1			
Name of activity/proposal	Substance misuse		
Date Screening commenced	01/01/23		
Directorate / Service carrying out the assessment	Dual Diagnosis		
Name and role of person undertaking this Due Regard (Equality Analysis)	Lois Dugmore Nurse Consultant		
Give an overview of the aims, objectives and purpose of the proposal:			
AIMS: To reduce harm associated with substance use Engage service users with local substance services			
OBJECTIVES: Reduce harm			
Section 2			
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details		
Age	Open to all over 18		
Disability			
Gender reassignment			
Marriage & Civil Partnership			
Pregnancy & Maternity			
Race			
Religion and Belief			
Sex			
Sexual Orientation			
Other equality groups?			
Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes	No		
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.		
Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Low risk, activity currently being carried out for last 20 years. Part of NHS guidance to engage substance use service users. Shared risk with substance services.			
Signed by reviewer/assessor	Lois Dugmore	Date	01/01/23
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Helen Perfect	Date	01/01/23

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Co existing substance misuse policy**	
Completed by:	**Lois Dugmore**	
Job title	**Nurse Consultant**	**Date 06/06/23**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Helen Perfect**
Date of approval	**01/02/23**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 5 clinical assessment


OST 2 SBLD.docx


ALW 12.docx


Alcohol Detoxification Guidan


OST discharge form.docx

ASSIT LITE, AUDIT SEVERITY OF ALCOHOL DEPENDENCE QUESTIONAIRE (SADQ-C) available on System 1.

14. REFERENCES AND ASSOCIATED DOCUMENTATION

Department of Health Dual diagnosis Good Practice Policy (2017) Better care for people with co-occurring mental health conditions alcohol/drug use conditions Public Health England
Drug Strategy (2017) HM Government
Drug Misuse and Dependence UK Guidelines of clinical management 2017 PHE\DOH
Safeguarding hidden harm
Safeguarding Children and Young People: Roles and competencies for Health Care Staff. Intercollegiate document (Royal College of Paediatrics and Child Health, 2010).
http://fflm.ac.uk/upload/documents/1290784237.pdf
Munro, E, The Munro review of Child Protection: Final Report. A child-centred system.
http://www.education.gov.uk/munroreview/
A child-centred system, The Government's response to the Munro review of child protection (DFE, 2011)
https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00064-2011Appleby L. 2016 National Confidential Enquiry into suicide and Homicide
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www.gov.uk/drink-drive-
https://www.research.manchester.ac.uk/portal/files/77517884/REPORT_NCISH_2018_Report.pdf
https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

15. VERSION HISTORY LOG

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Implemented	Details of Significant Changes
5	2004	First version
6	2007	Change in national policy
7	2010	No change
8	2013	Minor change with policy
9	2016	No change
10	2019	No change
11	2023	Change in policy national

Signatures for relevant staff to sign
I confirm that I have read and consider myself to be sufficiently trained in the above Standard Operating Procedure with regards to my individual roles and responsibilities Signature of Trainee …… Date ……
I confirm training in the above SOP was delivered as recorded above and that the trainee may be considered sufficiently trained in their roles and responsibilities Signature of Trainer …….. Date …… .
Additional Notes & Signatures
Signature of Trainer (where appropriate) I confirm training in the above SOP was delivered as recorded above and that the trainee may be considered sufficiently trained in their roles and responsibilities Signature of Trainer …… Date ……

https://www.research.manchester.ac.uk/portal/files/77517884/REPORT_NCISH_2018_Report.pdf