Dual diagnosis in mental health inpatient and day hospital settings

Guidance on the assessment and management of patients in mental health inpatient and day hospital settings who have mental ill-health and substance use problems

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Contents

Introduction

1. This guidance covers the assessment and clinical management of patients with mental illness being cared for in psychiatric inpatient or day care settings who also use or misuse alcohol and/or illicit or other drugs*. It also covers organisational and management issues to help mental health services manage these patients effectively. The key message is that the assessment and management of drug and alcohol use are core competences required by clinical staff in mental health services.

   The guidance aims to:

   - encourage integration of drug and alcohol expertise and related training into mental health service provision;
   - provide ideas and guidance to front-line staff and manages to help them provide the most effective therapeutic environments;
   - help mental health services plan action on dual diagnosis†.

2. The management of dual diagnosis is a significant concern for both mental health policy and practice. This was highlighted by the National Director for Mental Health, Professor Louis Appleby, in his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health[1]:

   > *Services for people with 'dual diagnosis' – mental illness and substance misuse – are the most challenging clinical problem that we face.*

3. The Healthcare Commission and the Royal College of Psychiatrists, in their *National Audit of Violence 2003–2005*[2], identified drug and alcohol use as the main trigger for violence in mental health services. It stated that:

   > *More must be done to support staff teams to address the problems caused by the use of alcohol and illegal drugs in inpatient services.*

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* Referred to in the rest of this document as 'substance use'.

† The term dual diagnosis here and in the rest of this document refers to a diagnosis of mental illness and a diagnosis of substance misuse disorder.

4. The House of Commons Select Committee on Health, in its Fourth Report in July 2000[3], stated that:

> *Given the high incidence of co-morbidity of mental disorder and substance misuse, and the link between substance misuse, mental disorder and violence, we believe it is crucial that greater priority be given to this group of patients ... We would also endorse the "practical steps" suggested by the Centre for Mental Health Services Development at King's College London, namely that the Department should:*
>
> - *require joint working and coordination between mental health and substance misuse agencies, to address the complex social and clinical needs of this client group;*
> - *require mental health services to take the lead for those people on enhanced CPA (Care Programme Approach) with a dual diagnosis;*
> - *include working with people with a dual diagnosis as a requirement within the remit of assertive outreach services.*

5. The need for concerted local action to provide for those with dual diagnosis has been set out in a number of policy, practice and research publications. Local Implementation Teams (LITs) have been supported by the National Institute for Mental Health in England (NIMHE) to implement the Department of Health's *Dual Diagnosis Good Practice Guide*[4].

Comments

6. The Department of Health is grateful to the wide range of contributors who have provided their expertise during the development of this guidance. Its publication now enables a wider audience to debate the issues set out and to help improve it.

7. Comments can be made on the document until end January 2007. We are particularly keen to receive examples of positive/safe practice in working with this client group, both in terms of service provision, local inter-agency working and in policy development between Drug and Alcohol Action teams (D(A)ATs) and LITs. The Department of Health will then consider comments received and determine whether the document needs to be revised and reissued.

8. Comments are welcome from a wide range of organisations, including patient and carer groups, health and social care statutory and voluntary bodies and organisations and other relevant stakeholders such as criminal justice agencies.

9. Comments should be sent to:
Dr. Sian Rees
Department of Health
Wellington House
London SE1 8UG
Email: sian.rees@dh.gsi.gov.uk

Scope

10. This guidance is relevant to mental health services provided by the NHS, social services, voluntary or private sector organisations. It is primarily aimed at inpatient and day care services; however, some issues will be of relevance to community services such as community mental health teams and to other settings, for example prisons.

11. It covers patients 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.

12. It also addresses the relationship between mental health services and the police on drug-related issues.

13. Although the guidance has a general relevance to all mental health provision, it does not specifically cover issues relating to the care and management of children or people with a learning disability.

14. This guidance sets out key principles and provides a checklist of the points that local policies and procedures should address. A number of hypothetical scenarios are provided for clarification.

Background

15. Substance use by mental health service users is a source of major concern. It can seriously affect the ability of services to assess, treat and care for patients safely and effectively. The use of non-prescribed drugs and alcohol can make symptoms worse and trigger acute illness relapse. On occasion, it can lead to self-harm or violence to others.

16. Research suggests that between 22 and 44% of adult psychiatric inpatients also have problematic drug or alcohol use, up to half being drug dependent[5]. Urban patient populations have higher prevalence figures than those in rural services. In high secure

hospitals, between 60 and 80% of patients have a history of substance use prior to admission[6]. It has been suggested that fewer than 20% of psychiatric inpatients receive treatment for their substance use.

17. Historically, mental health services have often evolved separately from drug and alcohol services. Many staff working in mental health services are not trained to assess and treat substance use. As substance use is so prevalent among mental health service users, simple prevention and treatment interventions for harmful substance use need to be core skills for mental health clinicians, with appropriate assistance provided by drug and alcohol specialists. Substance misuse specialists should continue to be responsible for providing assessment and treatment for the more severe and/or complex cases.

18. All service users have the right to receive care in a safe environment that is free from drug and alcohol misuse. This is an issue for all service users; those who currently have a substance use problem, those who have had a problem and those who have never had such a problem.

19. Mental health services are responsible for providing a range of services for those with a primary diagnosis of mental illness. The Department of Health Dual Diagnosis Good Practice Guidance[4] stated that:

> *Individuals with dual problems deserve high quality, patient focused and integrated care ... This should be delivered within mental health services.*

20. Since the publication of this guidance, NIMHE has been supporting LITs to help develop local mental health services to address dual diagnosis. However, in his five-year report on the implementation of the National Service Framework for Mental Health, Professor Louis Appleby, the National Director for Mental Health, found that in 2002 only 8% of LITs had produced a plan to do this and that this had risen to just 17% by the end of 2004[1]. This guidance will help to support further work in this area.

Service planning and needs assessment

21. The key message of this guidance is that dealing with substance use is a core competence required by staff within mental health services. This has a number of implications, which are set out below.

Commissioning

22. Mental health services need to include assessment and treatment of substance use as part of an integrated service including social care.

23. Commissioning agencies need to ensure that the assessment and treatment of substance use is addressed in all mental health service agreements and contracts.

24. This should be underpinned by local assessment of the types of substances being used by mental health service users. At present, mental health service users are most likely to receive specialised treatment if they have alcohol or opiate dependency problems. This may reflect the history and structure of substance misuse services, rather than an assessment of the drug and alcohol treatment needs of individual mental health service users or local populations.

Clinical governance

25. Clinical governance in mental health services should include a focus on substance use, such as provision of multi-professional training and setting standards for practice, audit, monitoring and reporting arrangements.

26. Arrangements should specify clear lines of responsibility and accountability for the quality of clinical care, a programme for service improvement and policies aimed at managing risk and safety.

27. Based on information from local needs assessment staff should, as part of their induction and ongoing training, be made aware of what is known about the prevalence and type of drug and alcohol use among local people and service users.

Black and minority ethnic (BME) groups

28. Black and minority ethnic groups may not have ready access to and are often poorly served by mental health and drug and alcohol services. The pattern and type of substance use among the main local ethnic groups should form part of the cultural competence training of all mental health staff. The Department of Health's Black and Minority Ethnic Community Drug Misuse Needs Assessment Project, carried out by the University of Central Lancashire has amassed a great deal of information about the pattern of substance use by different ethnic groups. Improvements in assessment and management of substance use for BME groups should be delivered in the context of the Department of Health's action plan *Delivering Race Equality in Mental Health Care*, 2005[7].

Women

29. Service planning should also take account of the needs of women with mental illness and substance use. There may be different patterns of drug use among women than men and different service delivery options may be required. Local services should ensure that the general and specific needs of women with dual diagnosis are met. This broad requirement is set out in *Women's Mental Health: Into the Mainstream*, published by the Department of Health in 2002[8]. It states it is important that women are specifically asked about alcohol and substance use as it may remain hidden. It also stresses the importance that services address abuse of prescription medication, monitoring benzodiazepine prescribing, childcare needs and potential histories of violence and abuse.

Substance use and mental health treatment

30. It is clear that substance use may interfere with the assessment, treatment of and recovery from mental illness. Therefore, the assessment of need for specific drug and alcohol interventions within mental health settings should take into account the need for clinical staff to assist service users to reduce or manage their substance use, even if there are no currently identified problems.

31. 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.

32. More severe or complex substance use will require specialist interventions eg for opiate dependence, the management of severe cannabis dependence or for drug or alcohol use in the context of more complex problems. In these cases, integrated, joint or coordinated working with substance misuse services is likely to be required.

33. Working with patients who use substances often raises a variety of concerns for mental health staff, in particular worries about competence to deal with the issues, access to appropriate specialist services when needed and the legal and ethical implications of actions such as drug testing, searching service users and their belongings, discharging services users who do not adhere to boundaries and involving the police.

34. Mental health NHS trusts and social services directorates need to develop local policies and training to provide a framework within which these concerns can be addressed and staff can work safely. Policies and training needs should be audited regularly.

Clinical management

Assessment

35. Mental health service users should have their drug and alcohol use assessed as part of the Care Programme Approach (CPA). Service users with a dual diagnosis of mental illness and substance misuse disorder have complex needs, including for example personality disorder or chaotic polydrug use. Consequently, enhanced CPA processes may be most appropriate, although this should be decided according to each individual case.

36. The care plan derived from the initial comprehensive clinical assessment must be clearly documented, including assessment of the risks arising from substance use and appropriate risk management plans.

37. In assessing drug and alcohol use, it is not safe to assume that only one substance is being used. Just as many patients are diagnosed as having more than one mental disorder; many service users use a number of substances (polydrug use).

38. The extent of current substance use and related problems should be explored through screening questions. A number of simple enquiries can be revealing: for example, what substances is the individual using; in what quantities; how frequently; by what route; how long have they been using in this way; and do they see this use as problematic?

39. Screening questions should also be used to identify those service users who, although they currently do not have a substance use problem, are at potential risk from drug and alcohol use, for example, through social circumstances or contacts. Personalised educative and preventive interventions can then be included as appropriate as part of the care plan.

40. Practitioners should explore with the service user their understanding of the potential for substance use to damage their physical and mental health and how this links to their relationships and social circumstances. This exploration should include all drugs used and alcohol.

41. Service users should be asked about their past use of drugs or alcohol. Evidence suggests that self-reporting is, in most cases, a useful tool.

42. In discussing historical substance use, the relationship with the course of 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 that the patient is likely to need as part of their treatment.

43. Practitioners should explore with the individual why they use, or have used, alcohol or drugs. Approaches to address the issues most appropriately can then be incorporated into the care plan. For example, patients may use drugs or alcohol because:

- it helps them to cope with the symptoms of their mental illness (eg it blocks out voices or reduces feelings of anxiety);
- it is part of their lifestyle;
- it relieves boredom.

44. Initial and subsequent CPA assessments should always consider drug and alcohol use. Care needs to be taken to distinguish short-term issues, such as intoxication and withdrawal states, from longer-term issues such as chronic pyschosis in the context of polydrug use. This distinction may be particularly important for some service users, such as young black men, where concern has been expressed about the potential for overuse of drug-induced psychosis as a diagnosis.

Involvement of relatives and carers

45. Relatives and carers can provide valuable information as part of comprehensive assessment in the development of a care plan. Requesting and receiving information from them is not a breach of confidentiality where a patient has acknowledged their involvement in his/her care and has not actively refused consent to such discussion. Care should be taken in how this information is recorded, and information received from third parties should not be disclosed to the patient should they request a copy of their medical record.

Taking samples

46. 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. For most service users, screening questions which are sensitively administered will give an accurate indication of their drug and alcohol use. Screening questions are also of use as some substances are only detectable for a limited duration. Testing does, however, have a place where there is reason to think that self-reporting may not be accurate. For example, there is evidence to suggest that in the context of the criminal justice system up to 52% of those tested for illicit drugs under reported use[9]. A combination of individual assessment and biological testing may be the most useful approach in such cases.

47. If biological samples are taken, the following should be considered:

- Urine, blood or hair samples can only be obtained with a service user's consent, and they should always be given an explanation for the need for drug testing. Measures should be taken to minimise risk of faked urine specimens being provided. This may include supervision of the patient leading up to and during provision of a urine sample. If there is concern about provision of false samples other forms of testing are available, including blood testing, where monitoring may be easier.
- Sampling can be unreliable and hence caution is needed with regard to how any single result is used clinically. Care should be taken to ensure that the sample is pure and uncontaminated.
- Blanket testing of all service users, on a mental health unit for example, should not occur.

Involving other agencies

48. Information should be sought on whether the service user is in contact with other agencies, particularly specialist substance misuse services. If so, they should be contacted so that care can be either jointly planned or coordinated. Contact should only take place with patient consent, unless it can be justified in the 'public interest' (where the patient or a third party is at risk of harm) or there is a statutory duty, when confidentiality can be breached.

49. Specialist substance misuse services will usually only be needed to provide care for cases where the substances used commonly cause severe dependence (such as regular crack cocaine and opiate use) or for example the more severe or complex cases of cannabis or khat use. Arrangements for care for other substance use, including alcohol, will need to be assessed on a case-by-case basis. This assessment will need to take into account the willingness of the service user to engage with substance misuse specialist services or practitioners. All care should be provided by integrated working through a single care plan under CPA.

50. Specialist substance misuse services may be a useful source of advice/information, even if they are not directly involved in a service user's ongoing care. For example, they may be able to provide a more detailed/in-depth assessment of an individual's substance use.

51. Information should be sought about whether the patient is in contact with the probation service. When this is the case, and subject to the consent of the patient, the probation service should be consulted on the care plan if appropriate.

Care and treatment

Integrated mental health and substance misuse provision

52. Mental health inpatient or day hospital treatment should be seen as an opportunity to help service users address their substance use. Staff need to create a culture which acknowledges the potential harm that drug and alcohol use may cause to the service user and others. Staff in mental health services must recognise that it is an environment that can put individuals at a higher risk than usual of misusing substances.

53. Hence, mental health staff need to be competent in intervening in drug and alcohol use as an integral part of providing treatment and care. In a small proportion of cases, drug and alcohol services may need to take the lead in managing cases, for example for service users with a dual diagnosis who have been referred to mental health services. A range of opportunities for joint working appropriate to local need should be explored.

54. Mental health and substance use should be dealt with through a single care plan. Some services have found it beneficial for patient trust and involvement to deliver drug and alcohol treatment and prevention as a separate programme within mental health services, delivered by specialist staff. However the drug and alcohol treatment is delivered, it is essential that it is part of a fully integrated care plan centred on the health needs of the individual.

Substance use treatment goals

55. Realistic treatment goals need to be set. At least initially these might focus on reducing the harm caused by substance use rather than achieving abstinence. This might include the negative impact of substance use on the effectiveness of treatment and hence on recovery.

56. For some service users, stabilisation of drug use through substitute prescribing may be the most appropriate approach. This will require specialist substance misuse assessment and an integrated care plan.

57. Inpatient admission may provide the opportunity for detoxification/assisted withdrawal. The possibility of acute withdrawal problems and the risk of relapse after the service user returns to their usual environment will need to be considered as a part of an assisted withdrawal care plan. For heroin-dependent individuals, there is a high risk of overdose and death after leaving institutional drug-free settings as tolerance is lost.

58. If detoxification is part of a service user's inpatient care plan, it may be most appropriate for them to be treated in a ward whose staff have specific skills and philosophies for working with this client group.

59. Treatment goals should be reviewed regularly, involving the patient in the review. Specialist drug and alcohol teams may be asked to provide advice regarding treatment options, for example in cases where less specialised interventions have failed.

Information for patients, relatives and carers

60. Staff, patients and carers need to understand the health and legal implications of the presence of illicit drugs or alcohol on mental health service premises. Local policies and the rules in relation to drug and alcohol use – both on and off the premises – must be displayed clearly and made available to all service users and their visitors. It should be clear that non-prescribed drugs or alcohol are not allowed onto the premises. The consequence of contravening this policy should be clearly explained. Patients, their relatives and other visitors need to be aware of the search policy and, where controlled substances are involved, the local policy with respect to police involvement. Information about policies, as leaflets and posters, should be displayed prominently in English and other appropriate languages.

61. Where appropriate, patients, visitors and staff need to be provided with information about the effects of substance use generally and on mental illness in particular, including the potential impact on effectiveness of care and treatment. This should be tailored to local circumstances, addressing any known drug or alcohol use by the service user.

62. For example, where appropriate, patients, relatives and carers should be made aware of the continuing illegality of cannabis and that its possession remains a criminal offence. Following the reclassification of cannabis from a Class B to a Class C drug under the Misuse of Drugs Act, there is a risk that some members of the public may mistakenly believe that cannabis possession is no longer an offence. Although the penalties for possession reduced after reclassification, penalties for trafficking increased. It needs to be made clear that cannabis remains a prohibited substance under national and international drug laws, with criminal penalties for its possession, trafficking and use.

Management of incidents of substance use

Safe and drug free environment

63. Careful management of the environment is an important role for both clinicians and managers, especially in inpatient and day hospital settings where substance use can be highly problematic.

64. Action should be aimed at making wards drug and alcohol free rather than accepting that their presence is inevitable. Appendix 3 includes an outline of the case against the managers of a homeless day centre in Cambridge, who were successfully prosecuted under the Misuse of Drugs Act for allowing drug dealing to take place on the premises for which they were responsible.

65. Local policies should address the Trust's statutory responsibilities under Health and Safety Regulations, particularly with respect to carrying out regular risk assessments to ensure the safety of service users, staff and visitors.

66. In order to achieve this, mental health inpatient units and day hospitals need to have clear policies about searching visitors, patients, staff and premises and about the circumstances in which the police would be called to investigate an incident (see also sections on organisational issues and interagency working).

Incident management

Evidence

67. Awareness of drug or alcohol use may arise through observation of service user behaviour, third party reports, suspicion or rumour. More concrete evidence may be a servicer user's own report or substances being found on the individual or premises.

68. In the absence of concrete evidence, staff should be careful to avoid arriving at false conclusions. Preconceived ideas about substance use, such as cultural stereotypes, should be challenged.

69. Local policies should address the action to be taken in a situation where there are repeated suspicions, accumulating but inconclusive evidence, and the alleged user denies illicit use. For example, consultants, key workers and managers should meet to discuss management of the individual's care and explore different treatment and security options.

Review care plan, treatment and risk

70. If a service user is suspected of taking drugs or alcohol, the main concerns must be their treatment and the safety of others.

71. If a service user is detained under the Mental Health Act 1983, the provision and safeguards of that Act apply in the same way as to any other detained patient.

72. The physical condition and mental state of the patient should be assessed and their care plan reviewed by all those involved in their care.

73. Factors that will need to be taken into account include:

- the seriousness and extent of the problem, including any legal issues if controlled drugs or illicit substances are involved;
- the patient's mental state;
- the risk of harm to self and others;
- the patient's social circumstances;
- inputs 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/setting;
- the possibility of contacting the police;
- the potential for prosecution or other sanctions, such as warning letters, injunctions or anti-social behaviour orders.

74. The clinical circumstances are often complex when drug use is suspected or identified in inpatient or day hospital settings, so to assist a number of fictional case studies are provided at the end of this document. In addition, the following paragraphs outline some of the options available to the clinical team.

Increase observation and security

75. In some circumstances it will not be possible or appropriate to discharge the service user, even though they have been using drugs or alcohol. This will apply for example to service users who present a high risk of harm to themselves or others, or whose care plan may be seriously affected. In such cases, treatment and care plans should address the necessary vigilance and supervision to ensure ward and service users' security and safety.

Locking of ward doors

76. The management, security and safety of patients is primarily ensured by means of appropriate staffing and good supervision. However, there will be circumstances in the short-term management of problems linked to substance use when at the discretion of the person in charge, doors on open wards may be locked. Inpatient units should have policies in place for this. The 1999 edition of the Mental Health Act Code of

Practice provides advice in paragraphs 19.24–19.27[10]. However, informal patients must be free to leave the ward, and if there is concern that a patient is endangering their own safety or the safety of others, consideration should be given to detaining them under the Mental Health Act 1983.

77. In some circumstances, consideration should be given to transferring the patient to a more secure setting.

Restriction or exclusion of visitors

78. Visitors who are known or suspected of supplying drugs or alcohol may, where appropriate, be banned from the mental health unit. 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.

79. Consideration should be given to compiling a nominated list of visitors for service users who have drug and alcohol problems. Where possible, this list should be agreed with the service user. In order to ensure that data protection is complied with, reasonable steps should be taken to inform individuals that their name has been included on such a list.

Post-incident review and recording

80. Following a substance use incident that raises serious concerns, a debriefing review should occur. These reviews should consider any clinical and/or management action required and if there are any training needs. Any staff concerns about intimidation or reprisals should be taken seriously and documented.

81. Policies for dealing with disposal of controlled substances should be agreed with the police.

82. Local policies should ensure that all incidents involving substance use are recorded in both the clinical notes and the general statement/incident forms. The report should include any actions taken regarding the discovery, storage or disposal of drugs. Any searches carried out should also be recorded. Separate recording forms may be required for personal searches or when substances have been confiscated. **It is important that the name of any informant is not included in the patient's record.**

Confidentiality

83. The general principles and rules governing information sharing and the maintenance of confidentiality apply. It is essential to seek a service users consent in sharing information with relatives. There may be exceptional occasions when it is necessary

in the public interest to give information about a service user to relatives without the patient's consent, for example if there is a serious risk of harm to the service user or others and the information is relevant to managing this. Services should refer to the guidance issued by the Department of Health in its publication: *Confidentiality: NHS Code of Practice*[11]. This issue is discussed in greater depth later in this guidance.

Support for carers and relatives

84. The concerns and needs of relatives and carers should be identified. Support and advice are often of value; for example, relatives may be worried about what to do if they are requested to bring drugs or alcohol onto the premises. Information about organisations that can provide further support to the families and friends of drug and alcohol users should be available. Examples include Families Anonymous, Adfam National and Al-Anon.

Discharge

85. 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 (ie with the consent of the patient), be involved in these arrangements.

Rapid follow-up

86. When a service user with drug or alcohol problems is discharged, rapid follow-up arrangements, such as within a week, need to be agreed and put in place as part of the CPA. 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, if possible, measures to minimise this risk should be put in place.

87. For severe and complex cases and when service users are willing to be referred, referral to specialist drug and alcohol services should be considered and should usually take place prior to discharge. Arrangements for discharge should still aim to provide an integrated plan. It is not appropriate in a discharge care plan to nominate a specialist substance misuse service to provide sole follow-up after discharge, without the explicit agreement of appropriate substance misuse practitioner. If it is not possible to confirm arrangements for follow-up prior to discharge, the mental health team must ensure follow-up until such plans, or an alternative discharge care plan, are agreed.

88. Mental health services will need to ensure that there is community provision to support service users with drug and alcohol problems that are below the usual threshold for support from specialist drug and alcohol services.

89. The discharge plan should be clearly written in the case notes and explained in full to the service user and family/carers where appropriate. The service user should sign the discharge summary and the CPA care plan. This care plan should be easily available and discharge notified to all practitioners who will provide ongoing care, including community services and the GP.

Organisation and management of services

Inter-agency working

90. Inter-agency collaboration is required to develop local policies that deal with drug and alcohol use in mental health inpatient and day hospital settings, to oversee anonymised audit of incidents and to monitor the effectiveness of the agreed approach. This may require the setting up of a new forum or could become an additional remit of an existing body. Whatever forum is used, the relationship with other mental health and substance misuse partnerships, such as D(A)ATs and LITs, should be agreed.

91. Policies should be developed in close collaboration with local authority social services, police, National Offender Management Service (including Multi-Agency Public Protection Arrangements – MAPPA), specialist drug and alcohol services, primary care trusts (including GPs and pharmacists), voluntary organisations, user/carer representatives and accident and emergency (A&E) departments.

92. Arrangements with the police should emphasise the seriousness of illicit drug use by people with serious mental illness and of the disruptive and dangerous impact of all substance use, including cannabis, on service users and mental health unit environments[12].

93. Agencies should work together to identify the scale of local problems and trends, and to agree a coordinated strategy to establish communication systems and develop practice guidance. Agencies may consider acting together to consult local legal advisers on the appropriateness of the intended strategy and action. Mental health services should check their policies with their own legal advisers.

94. Local policies should be drawn up with the involvement of users and carers. Pharmacists can also be a valuable resource for developing local policies and providing advice and training on safe and secure storage and disposal of drugs.

95. Policies should be regularly monitored and reviewed, including ethnic monitoring of their impact as required by the Race Relations (Amendment) Act 2000.

Liaison with Crime and Disorder Reduction Partnerships (CRDPs)

96. Liaison with local police, through CRDPs, is essential in devising some elements of local policies. Local D(A)ATs, in conjuction with CDRPs, and relevant stakeholders will need to agree arrangements for:

- reporting and monitoring possession and use of illegal drugs;
- collecting evidence and disposing of confiscated substances and paraphernalia.

97. It is vital that policies are effective and credible and that staff operating them are protected. Regular joint evaluation of their effectiveness should be undertaken.

98. Local policies agreed with the relevant D(A)AT partners and police should also cover:

- search plans for mental health service premises including if sniffer dogs are used;
- protocols for seizure, retention and destruction of drugs and paraphernalia;
- reporting procedures for patients, staff and visitors who have concerns about substance use;
- local police action on cannabis and other illicit substance use on mental health premises;
- protocols for reporting procedures for thefts and other offences relating to controlled and other drugs;
- information about the provision of witness statements and advice on giving evidence in court;
- protocols for support and debriefing, including continuing input, where staff are involved in a court action;
- protocols for reporting incidents where violence linked to drugs and alcohol is threatened or occurs.

99. Police crime prevention officers can help with staff concerns about safety. Chemist inspection officers and other staff with specialist knowledge of drugs should also be able to assist in the development and use of investigation protocols and training within local D(A)AT partnership areas.

Disclosure of information/confidentiality

100. English common law recognises the concept of a confidential relationship and the duty of confidence. The common law requires consent for disclosure of identifiable data. There are two main exceptions to the duty of confidence:

- Firstly, public interest can override the duty.
- Secondly, disclosure of confidential information may be permitted or required by statute or court order.

101. Hence, where there is not a statutory obligation to disclose or a court order necessitating this, there is a balance to be struck between protecting the privacy and confidentiality of individual patients, and protecting other patients, staff and the wider public.

102. There is established guidance from the Department of Health and professional regulatory and defence bodies. Local policies should take account of the Department of Health's advice in *Confidentiality: NHS Code of Practice*[2], the Nursing and Midwifery Council's code of professional conduct[13], the General Medical Council's guidance on confidentiality[14].

103. Although there is no general legal requirement upon healthcare staff to assist police investigations, no specific immunities have been granted for medical or healthcare staff. Therefore, where general statutory duties to supply information (such as those placed on 'any person'), these apply to doctors and to other healthcare staff in the same way as other members of the public.

104. Senior managers, including the Caldicott guardian of the organisation, should be involved in decisions to disclose information to the police, and the decision should be discussed with the clinical team. The team will need to consider all relevant factors, including the nature of the offence/allegation, the patient's medical history and the public interest.

105. Staff need to be aware that the disclosure of information to the police may breach the duty of confidentiality owed to individual service users. Each case needs to be considered very carefully before such action is taken. There is also a strong public interest in protecting and maintaining confidence in the duty of confidentiality for the healthcare system overall.

Searching patients

106. Searching is important where there is a risk to the safety of the service user or other service users. If a serious offence may have been committed and there is time, it is advisable to contact the police with a view to obtaining their assistance or advice.

107. Personal searches are a serious invasion of service users' privacy and rights. Consent should always be sought and the reasons for the search must be clearly explained. If consent cannot be obtained chapter 25 of the 1999 edition of the Mental Health Act Code of Practice 1983 should be followed for detained patients. Particular sensitivity should be shown with respect to gender issues.

108. Service users should not be searched by staff without their valid consent, except in clinical emergencies or where it is considered that there is good evidence to suspect that the individual is in possession of controlled drugs, in which case searching should adhere to local policies agreed with the police. Consent under duress is not valid consent. If there is evidence that drug dealing is occurring, then consideration should be given to seeking police assistance as agreed in local multi-agency policies. Care should be taken when searching in order not to put staff at risk (eg of needle stick injury).

Destruction and disposal of drugs

109. Pharmacy-controlled drugs stock specified in Schedules 2, 3 and 4 of the Misuse of Drugs Regulations 2001 should be destroyed in accordance with the requirements set out in the Regulations. Where a drug is destroyed in accordance with these Regulations, the record must include:

- particulars of the date of destruction;
- details of the quantity destroyed.

110. The record should be signed by the authorised witness person in whose presence the drug is destroyed.

111. Illegal drugs listed in Schedule 1 of the Misuse of Drugs Regulations 2001, should be handed to the police for disposal, unless other arrangements have been agreed with the police in the local multi-agency policy.

112. Although there is no legal requirement to do so, illegal drugs that are not handed to the police should also be destroyed once it is determined they are no longer required (for example as evidence). This should be done as soon as possible in a similar manner to the requirements for pharmacy-controlled drugs set out above.

113. Non-prescribed drugs must also be destroyed as soon as possible once it is determined they are no longer required, in line with local policy guidance.

114. Section 5(4) of the Misuse of Drugs Act 1971 provides a defence for people such as hospital staff who take possession of patients' illegal drugs. Under this Section it is a defence for the accused to prove that they took possession of a controlled drug to protect a patient from harm or prevent another from committing a crime of unlawful possession or for the purpose of delivering it into lawful custody. They must also prove that as soon as possible after taking possession, they took all such steps as were reasonably open to them to destroy it or to deliver it into lawful custody. The clearest example is that of a nurse finding a patient in possession of a cannabis

cigarette. The nurse is entitled to take the cigarette and either cause it to be destroyed in accordance with the Misuse of Drugs Regulations 2001 and local policies agreed with the police or hand it over to a police officer.

Returning drugs and alcohol to patients

115. Non-prescribed controlled drugs should never be returned to patients. Other substances which they have held lawfully cannot be destroyed without a service user's consent, and they have the right for such items to be returned to them at the time of their discharge. This includes drugs previously prescribed, medication bought over the counter and alcohol. However, local policies should be developed to focus on documentation and security. Wherever possible, service users should be encouraged to allow staff to dispose of substances such as prescribed controlled drugs or alcohol. Their consent should be obtained in writing. Disposal must be fully documented and witnessed by a senior member of staff. The document recording the destruction must be signed by the senior member of staff in whose presence the drug is destroyed.

Staff training

116. Substance use within mental health service populations will often not require the skills of a specialist service. However, for mental health staff to develop and maintain the knowledge and skills in assessing such patients and in motivating behaviour change, the involvement of specialist substance misuse services in ongoing training and support can be very useful.

117. Workforce development and education directorates may need to develop specific programmes to supplement local training initiatives. Wherever appropriate, training should be multidisciplinary and multi-agency, and include qualified and unqualified staff. Local training needs analysis should identify who needs training and include assessment of the need for update training to maintain an appropriately competent workforce.

118. Training should encompass the development of knowledge and skills in assessment and care/treatment planning for patients in mental health services who use drugs or alcohol, as stated in the Chief Nursing Officer's review of mental health nursing[15]. Appendix 4 lists some of the key elements that can be included in training programmes for mental health services staff.

119. Training should include opportunities to spend time with specialist drug and alcohol teams (statutory and non-statutory). As well as the specific knowledge and skills that may be gained, communication links can be developed along with an appreciation of the benefits of liaison with such services.

120. Mental health services staff should be made aware of any data on the prevalence of drug and alcohol use in the setting where they work. This should include information about the substances commonly used locally, including those used by service users from BME groups.

121. Where there are significant local BME populations, consideration should also be given to providing opportunities for mental health service staff to spend time with relevant voluntary sector organisations that deal with drug and alcohol issues. Arrangements should be made to work with representatives of local BME communities to enable staff to understand ways of helping address the specific concerns of those communities.

122. Clinical supervision is an essential strategy for supporting staff to deal with the variety of issues, including violence, which may arise from working with people who use substances. For example, supervision may provide a space for expression of frustrations, sharing of ideas and of problem-solving strategies, development of knowledge and identification of training needs. Regular supervision needs to be available to both qualified and unqualified staff.

Buildings and environment

123. Regular audit should take place to identify areas that are hidden from view and provide opportunities for patients, visitors or staff to supply drugs or alcohol. The audit should address movement in and out of the buildings, against a possible standard of limiting access to one entry or exit point where feasible. Use of technology, such as swipe cards that can be variably programmed depending on the service user, could be considered. Attention should be given to the design of reception areas to maximise surveillance, control entrances and to help prevent access by unauthorised people. If CCTV is installed, its use should be covered by local policy. The use of dedicated visiting areas and lighting to aid observation are of value.

Terms and abbreviations

The following terms are used in this document:

CDRP	Crime and Disorder Reduction Partnership
Controlled drugs	Drugs controlled under the Misuse of Drugs Act
D(A)AT	Drug (and Alcohol) Action Team
Dual diagnosis	Mental illness together with drug and/or alcohol misuse disorder
Substance use	The use of alcohol and/or psychoactive drugs that have not been prescribed to patients (including drugs prescribed to another patient) and that have potential to cause them harm, but excluding tobacco
LITs	Local Implementation Teams, set up to plan and monitor the implementation of the National Service Framework for Mental Health
NIMHE	National Institute for Mental Health in England

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Training scenarios

Example 1	
Scenario	A, aged 25, has a four-year history of schizophrenia. He is admitted under Section 3 of the Mental Health Act suffering from a relapse after not taking anti-psychotic medication. Prior to admission he had threatened a neighbour with a knife because he believed that the neighbour was plotting to kill him. This incident has been reported to the police and they are investigating. A has smoked cannabis three or four times a week since he was 16. Three days after admission he goes off the ward and brings back a small quantity of cannabis. A fellow patient reports that A has sold him some of the drug. They are seen smoking it on the ward balcony.
Treatment	There has been insufficient time for treatment to be effective. A needs hospital treatment.
Risk	There was a considerable risk to A's neighbour prior to admission and the risk is still present.
Search	A search of A and his possessions needs to be carried out for the safety of the patient and other patients on the ward. Chapter 25 of the Code of Practice should be followed.
Police involvement	Although only a small amount of cannabis was involved, A sold it to another patient. This puts other patients at risk and ward managers may be liable to prosecution under Section 8 of the Misuse of Drugs Act 1971 if they allow activities such as the smoking of cannabis to take place on healthcare premises. Staff should consult with senior managers and decide whether the dealing is serious enough to justify breaching the patient's confidentiality by reporting this to the police. If it is reported, given A's history of schizophrenia, the investigating officer should submit a report to the Crown Prosecution Service seeking advice as to whether A should be prosecuted, cautioned or no further action taken.
Disposal	If the incident is reported to the police, any cannabis seized must be given to the police as evidence. This should be done as soon as possible and in any case within 24 hours. If the incident is not reported to the police, the cannabis should be destroyed under procedures agreed with the police.
Management	Cancel any unescorted leave. Consider level of observation. If problems recur, movement to a locked ward may be warranted if patient cannot be safely cared for in an open ward environment. Monitor success of plan. Increase security/restrictions if the problem persists.
Supporting notes	A has a psychotic illness and needs treatment. He has been a risk to his neighbour and discharge presents too great a risk. He presents a risk to other patients by supplying them with cannabis. Referral to the police may become necessary unless steps can be taken to manage the risk of a recurrence on the ward. The addition of restrictions on and monitoring of the patient through their care plan should be the primary means of reducing the risk to others.

Example 2	
Scenario	M, a 31-year-old man with a history of bipolar affective disorder, is admitted voluntarily with a depressive illness. Prior to admission he had made plans for suicide. Four years ago he made a serious suicide attempt and was in an intensive care unit for five days. During his admission he had improved and no longer had suicidal ideas. He has a past history of occasional cannabis use (a small amount two or three times per year). His sister visits him and gives him a small quantity of cannabis. He says it is to help him relax and sleep. The nursing staff become suspicious after M appears drowsy and his room smells of cannabis. He consents to being searched and the cannabis is discovered. He accepts that he has broken the hospital rules.
Treatment	M's treatment is well under way and has been partly successful.
Risk	Although there was a risk on admission M is no longer suffering from suicidal thoughts. However, he may be at risk if he relapses in the future.
Search	Because he is not detained under the Mental Health Act, M can only be searched if he consents. However, encouragement is often successful.
Police involvement	Not necessary. M is not supplying others and the quantity is small. There is little risk to others and insufficient grounds to break confidentiality. Reporting the incident to the police, with a view to arrest and/or possible prosecution, may damage the therapeutic relationship.
Disposal	Disposal should be carried out in line with local policies agreed with the police. For those drugs listed in Schedule 1 of the Misuse of Drugs Regulations 2001, this is likely to mean handing them over to the police. In other cases where they are not required as evidence, local policies agreed with the police may enable them to be destroyed locally, subject to suitable documentation and supervision.
Management	M should be reassessed by the multi-disciplinary team (MDT) in a review of his care plan. Given the seriousness of risk when he was ill, care should be taken that his recovery is not put at risk by early discharge. However, if the reasons he has not yet been discharged are not considered crucial to his continued recovery, it may be of value to arrange his discharge at this time. It is likely to be important that this is not experienced by him as punitive, but staff need to make clear to him that the behaviour itself was unacceptable in the ward environment. It is important in this case that a positive therapeutic relationship is maintained. The care coordinator should arrange for M to be followed up at home.
Supporting notes	M's treatment is well under way, if he is no longer at immediate risk and his recovery is sufficient, earlier discharge may not hinder recovery. If this is the case, he should be discharged promptly, failure to do so may create a culture of tolerance on the ward that would put vulnerable patients at risk. If M remained an inpatient after careful review by the MDT, but his sister was uncooperative, then she might need to be banned from visiting under a local policy. This must have a time limit and appropriate conditions. In carrying out its review, the MDT will need to consider the balance of risk between the treatment and care needs of the patient, including visits by relatives and carers, and the need to protect other patients.

Example 3	
Scenario	S is a 45-year-old woman suffering from an episode of paranoid schizophrenia. She is admitted informally. She has started a higher dose of antipsychotic drugs but still has delusions. On a previous admission she has punched her social worker in the face. Shortly after the night staff come on duty, she appears in the sitting room smelling strongly of alcohol and mentions to a nurse that she has cannabis in her room. When asked if her room can be searched, she refuses and says that she has a knife and will stab anyone who attempts to search her belongings.
Treatment	Although this has been started it has not yet had effect.
Risk	S has been violent in the past and the threatened use of a weapon is a further risk.
Search	While S is an informal patient she cannot be searched under the provisions of the Mental Health Act.
Police involvement	S should be reported to the police. There is a clear risk to others because of both an unknown quantity of drugs and the possibility of a weapon. There is evidence that the hospital premises are being used by the patient to keep controlled drugs. If staff suspect the patient has stored the drugs inside hospital property, they can authorise the police to search. Such authorities must be in writing. The officers will possibly expect staff to sign a notebook. In these circumstances the patient and any belongings not stored in the hospital can be searched under Section 23(2) of the Misuse of Drugs Act 1971.
Disposal	Controlled drugs and offensive weapons would be given to the police as evidence. Any alcohol found would be confiscated. S would be asked to allow it to be destroyed, but if she refused then it would be returned to her at the time of discharge as it remains her property.
Management	S should be assessed for detention under the Mental Health Act. If this is implemented, she should not be granted Section 17 leave until her condition has improved. Closer observations or a move to a locked ward should be considered.
Supporting notes	S has a psychotic illness that needs treatment. She presents a risk to others but the immediate risk cannot be assessed without a search being carried out. This could be done using the Mental Health Act if the assessment concludes that she should be detained. The possibility of the use of weapons and the past history of violence makes involvement of the police more appropriate.

Example 4	
Scenario	P is a 31-year-old man with an eight-year history of schizophrenia, admitted under Section 3 of the Mental Health Act. He has been imprisoned in the past for grievous bodily harm and prior to admission took two community psychiatric nurses hostage for three hours, threatening them with a garden fork. His antipsychotic drugs have been restarted but he is still suffering from delusions of external control and is overactive and threatening. Another patient reports that he has been smoking cannabis. Staff assess the information as being reliable. He refuses to be searched.
Treatment	This has been started but is not yet effective.
Risk	P presents a considerable risk if not closely supervised.
Search	P needs to be searched because of the risk to himself and other patients and staff. He can be searched under the Mental Health Act. Guidelines in paragraphs 25.1–25.9 of the Mental Health Act Code of Practice should be followed.
Police involvement	If the amount of cannabis found is small and apparently for personal use, then the police would not generally be involved unless it would be useful as part of managing P's treatment (eg related to his aggression) or breaches his parole conditions.
Disposal	Disposal should take place under the local policy agreed with the police. It must be documented and witnessed.
Management	The patient presents a risk to others and cannot be discharged, but supervision and security must be addressed to protect other patients and staff. There should be a review of Section 17 leave and nursing observation. The possibility of locking the ward using paragraphs 19.24–19.27 of the Mental Health Act Code of Practice or transfer to a locked ward should be considered if P cannot be safely cared for in an open ward.
Supporting notes	P has a long history of severe mental illness and high risk of aggressive behaviour. The treatment has not yet had an effect and he presents a serious risk to other patients and staff. Hospital managers may be liable to prosecution under Section 8 of the Misuse of Drugs Act if they allow cannabis to be smoked on hospital premises.

Example 5	
Scenario	C is a 33-year-old man who has suffered from schizophrenia since his first year as an undergraduate. He was admitted to hospital then and has had repeated admissions since. He drinks heavily depending on the amount of money he has available. He does not see this as a problem. His delusions recently became more intrusive and he became disinhibited. He had little insight and was admitted to hospital under Section 3 of the Mental Health Act after taking his clothes off in a park and threatening a woman. He then slipped off the ward and came back drunk carrying a plastic bag. When asked what was in the bag he became very threatening.
Treatment	C's antipsychotic medication has been increased but his mental state has not yet improved. He refuses any help for his alcohol abuse.
Risk	C presents a considerable risk to others if not closely supervised.
Search	C needs to be searched because of the risk to himself, other patients and the staff. He can be searched under the Mental Health Act. Guidelines in paragraphs 25.1–25.9 of the Mental Health Act Code of Practice should be followed.
Police involvement	Alcohol is not an illegal substance and the police do not need to be involved.
Disposal	If alcohol is discovered, it should be taken away from C because of the need for safety. However, alcohol is not an illegal drug and cannot be disposed of without his consent. He should be persuaded to allow the staff to dispose of it. If he refuses, it should be returned to him when he is discharged. Disposal should take place under the local policy. It must be documented and witnessed.
Management	C presents a risk to others and cannot be discharged, but supervision and security must be addressed to protect other patients and staff. There should be a review of Section 17 leave and nursing observation. The possibility of locking the ward using paragraphs 19.24–19.27 of the Mental Health Act Code of Practice or transfer to a locked ward should be considered.

Example 6	
Scenario	N is a 52-year-old woman who is admitted voluntarily after becoming severely depressed following the break-up of her marriage. She also has a history of recent alcohol abuse. Following admission, her mood improves. Although she still feels that she would like not to wake up in the mornings, she no longer has suicidal ideas or plans. She smells strongly of alcohol one evening, and the nursing staff think that she has been drinking in her room.
Treatment	N has responded to anti-depressant medication and counselling, which has concentrated on her marriage and her alcohol abuse.
Risk	Although N has improved, she is still at risk in the longer term and is particularly at risk during the first weeks after discharge.
Search	N should be asked if she has been drinking and, if so, to hand over any alcohol in her possession. If she refuses her room needs to be searched because she may become more drunk and at risk. She should be asked to allow her room to be searched. If she continues to refuse and is not considered at any immediate risk, further discussion may be needed when she is sober. If she refuses to allow the search when sober, consideration should be given to reviewing her care plan and even to her discharge. Risk of relapse of depression and suicide would need to be weighed against other risks linked to her continued drinking and hiding alcohol on the unit.
Police involvement	This incident is not linked to violence and alcohol is not an illegal substance. Therefore the police do not need to be involved.
Disposal	If alcohol is discovered, it should be taken from N because of the need for safety. However, alcohol is not an illegal drug and cannot be disposed of without her consent. She should be asked to allow the staff to dispose of it. If she refuses, it should be returned to her when she is discharged. Disposal should take place under the local policy. It must be documented and witnessed.
Management	As N is not detained under the Mental Health Act and there is no suspicion that she may be in possession of an illegal drug, she cannot be searched without her consent. If there is a serious and immediate risk to her health or the health of other patients, then this could be carried out under common law.
Supporting notes	N should be advised of the inappropriateness of consuming alcohol and reminded of the harmful effects and serious consequences if repeated.

Appendix 1: Legal obligations to disclose non-confidential information – *Hunter v Mann*

A case in which a doctor was prosecuted and convicted for refusing to release information about one of his patients is that of *Hunter v Mann* (1974) 1 QB 767. In this case, a doctor was asked by a patient to treat the patient's girlfriend, who had been in a car accident. The doctor advised both patients to inform the police, but did not raise the matter of whether he might disclose their identity if approached. He did later receive a visit from the police in connection with a stolen car which had been involved in an accident in which both driver and passenger had run away. The doctor refused to release the information about his patients on the basis that this would be a breach of professional confidence. Section 168(2) of the Road Traffic Act 1972 (now Section 172 of the Road Traffic Act 1988) stated that:

> *any ... person ... shall if required ... give any information which it is in his power to give and may lead to the identification of the driver.*

The doctor was prosecuted and convicted under this section in the Magistrates' Court. His appeal was dismissed by the Divisional Court on the basis that he was not being asked to disclose any confidential information, but merely information which might lead to identification.

Appendix 2: Legal obligations to disclose confidential information – *W v Egdell*

Disclosure can be justified if it is considered to be necessary in the public interest. In the landmark case of *W v Egdell* (1989) 1 All ER 1089, the patient was detained in a secure hospital without limit of time following the knifing of five people and the wounding of two others. Ten years later he applied to a Mental Health Review Tribunal to be discharged or transferred. This application was opposed by the Secretary of State. The solicitors on the part of W instructed Egdell, a consultant psychiatrist, with a view to preparing a report which could be used in support of the application. In fact, the report strongly opposed the application, and expressed concerns at the patient's likely release or transfer. The consultant psychiatrist assumed that W's solicitors would place the report before the tribunal. This was never done, as the solicitors withdrew the application, but Egdell, on learning that a report had not been disclosed, contacted the medical director of the hospital and eventually forwarded to them a copy of the report in order that W's further treatment could be assessed. The hospital then forwarded a copy to the Secretary of State, who in turn sent it on to the tribunal. On discovering the disclosure of the report, W issued a writ against Egdell seeking an injunction restraining the use of the report, and damages for breach of confidence. This application was refused on the basis that the duty of confidentiality to the patient was subordinate to the public duty to allow the proper assessment of W's mental condition. On appeal, the Court of Appeal came down in favour of the disclosure of the report, given the number and nature of the killings and the need to provide those responsible for W's treatment and management with the fullest relevant information concerning his condition.

Appendix 3: Legal obligations under Section 8 of the Misuse of Drugs Act 1971 – the 'Cambridge Two'

Example: The 'Cambridge Two'

This case was widely publicised and has caused some concern among practitioners. For that reason it is set out as an example in this guidance.

In 1999, Ruth Wyner, Director, and John Brock, Day Centre Manager, of Wintercomfort, a homeless hostel in Cambridge, were successfully prosecuted under Section 8 of the Misuse of Drugs Act for knowingly permitting the supply of heroin to take place on the premises for which they were responsible as managers. They were sent to prison for four and five years respectively. The convictions were upheld on appeal. In his sentencing remarks, the judge said that that the message for other similar hostels was:

> *... to reinforce the necessity for managers of such hostels to do all in their power to ensure that the supply of drugs does not take place on their hostel premises.*

According to the judge, part of the context for this conviction and sentence was that:

> *There were up to 10 dealers a day operating on and within the premises. They were there for the sole purpose of their trade. We saw them on video plying their trade, often in particular locations on the premises, and frequently in the presence or within the view of staff members.*

Summary of Section 8 of the Misuse of Drugs Act

'It is an offence if the occupier or person concerned in the management of any premises knowingly permit or suffer any of the following activities to take place on those premises:

a) Producing or attempting to produce a controlled drug

b) Supplying or attempting to supply a controlled drug, or offering to do so

c) Preparing opium for smoking

d) Smoking cannabis, cannabis resin or prepared opium.'

Definition of 'person concerned in management'

According to one authority, 'management' imports the notion of control over the running of the affairs of an enterprise, venture or business. In order to be concerned in the management, it is enough to share, or assist in, the running of the premises.

Definition of 'premises'

The word 'premises' is not defined in the Misuse of Drugs Act, and the courts have experienced difficulties in applying the word to actual situations. A definition of 'premises' is contained in Section 23 of the Police and Criminal Evidence Act 1984. It includes 'any place and, in particular, any vehicle, vessel, aircraft, hovercraft, tent or movable structure'. It also includes any offshore installation as defined in Section 1 of the Mineral Workings (Offshore Installations) Act 1971.

A further useful definition of the word is to be found in Section 12 of the Criminal Law Act 1977. This states that 'premises' means any building, any part of a building under separate occupation, any land ancillary to a building, or the site comprising any building or buildings together with any land ancillary thereto. Clause 187 of the Draft Criminal Code Bill contains an identical definition.

Based on these definitions, it could be argued that a hospital manager, knowing that a patient is smoking cannabis inside a marquee in hospital grounds, is guilty of an offence contrary to Section 8(d). The courts have yet to rule on this point. Similarly, the legal position is unclear if a hospital manager knowingly allows passengers to smoke cannabis in a hospital minibus.

Definition of 'knowingly permit' and 'suffer'

The words 'permit' and 'suffer' mean the same thing. Both words clearly imply knowledge of the relevant activity. (See Thomas (1976) 63 Cr App R 65.)

In addition to the statutory obligations placed on managers by Section 8 of the Act, managers are encouraged to contact police in cases where drug trafficking offences have been committed on hospital premises. 'Drug trafficking offences' are defined in Section 1 of the Drug Trafficking Act 1994, and include:

- production;
- supply, and possession with intent to supply;
- importation and exportation of controlled drugs.

Appendix 4: Substance use and mental health service staff – issues important for training

Attitudes

- An exploration of attitudes to drugs and alcohol and the people who use them.

Knowledge

- Knowledge of the main groups of illicit drugs and other substances which are used by the local population (including BME groups), including their appearance and effects (both in use and withdrawal).
- The potentially hazardous effects of substance use on mental and physical health, including blood-borne viruses such as hepatitis B and C, and HIV.
- The relationship and interactions between medication and drugs and alcohol.
- An understanding of drug culture and the language used, for example to describe drugs of misuse and the paraphernalia used in their preparation.
- Knowledge of statutory and non-statutory drug and alcohol services and the input they can provide, an awareness of when referrals to these services may be appropriate and how this can be done.
- Knowledge of clinical guidelines and standards.
- The models and techniques that can be used when working with people with substance use problems, for example motivational approaches, harm minimisation or relapse prevention.

Skills

- Giving information to and educating service users (eg on the effects of their substance use on physical and mental health, the interaction between medicines and drugs and alcohol) and the ability to check their understanding of this.
- The identification and assessment of drug and alcohol use and problem use, including intoxication and withdrawal.
- Management of substance use, which includes the use of simple approaches to improve motivation and encourage behaviour change, to prevent relapse and minimise harm.
- Management of intoxication and detoxification/assisted withdrawal.

Safety

- Clear understanding of the risks of a service user's substance use to themselves and to others and an ability to incorporate this knowledge into standardised risk assessment procedures.
- The ability to confront service users and their visitors sensitively, and manage any aggressive or threatening responses.
- Principles and procedures for correct and safe handling and disposal of drugs and any paraphernalia associated with drug use.

Notes

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