Policy:

MD 020 - Managing Substance Misuse and Harmful Substances in Bed-Based Services

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Summary of policy

The Trust has a legal responsibility to ensure that clinical areas are free of illegal substances. The policy aims to guide staff on the correct course of action to take if they suspect a service user is in possession or under the influence of a harmful substance.

Target audience	All clinical staff working in bed based services

Keywords	Substance, misuse, alcohol, police, bed based services

Storage

This is version 4.0 of this policy and replaces version 3 (November 2016). This version was reviewed and updated as part of an ongoing policy document review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

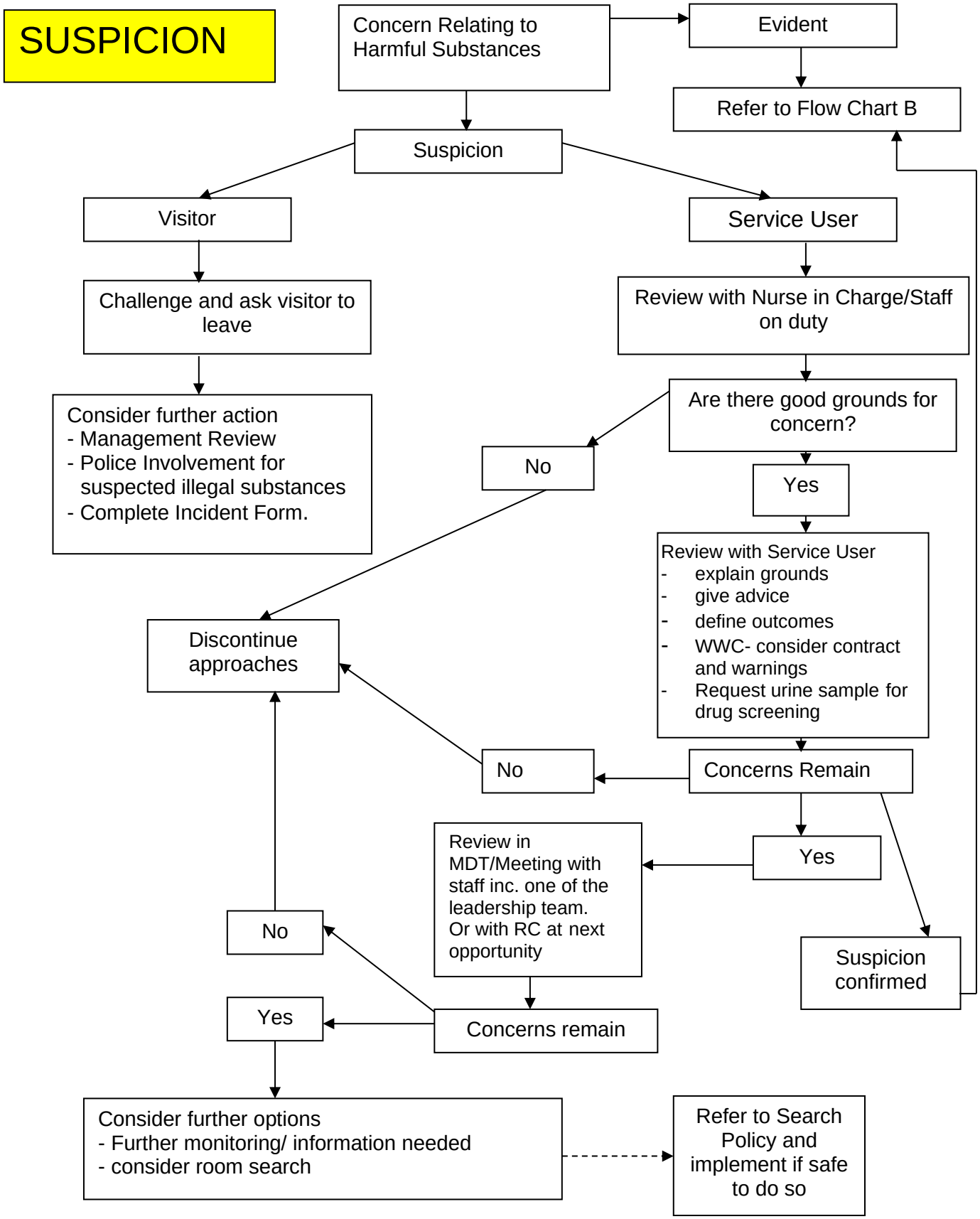
Any printed copies of the previous version (V3) should be destroyed and if a hard copy is required, it should be replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
3.0	Review / ratification / issue	Nov 2016	Full review completed
4.0	Review/ratification /issue	Nov 2019– April 2020	Full review completed

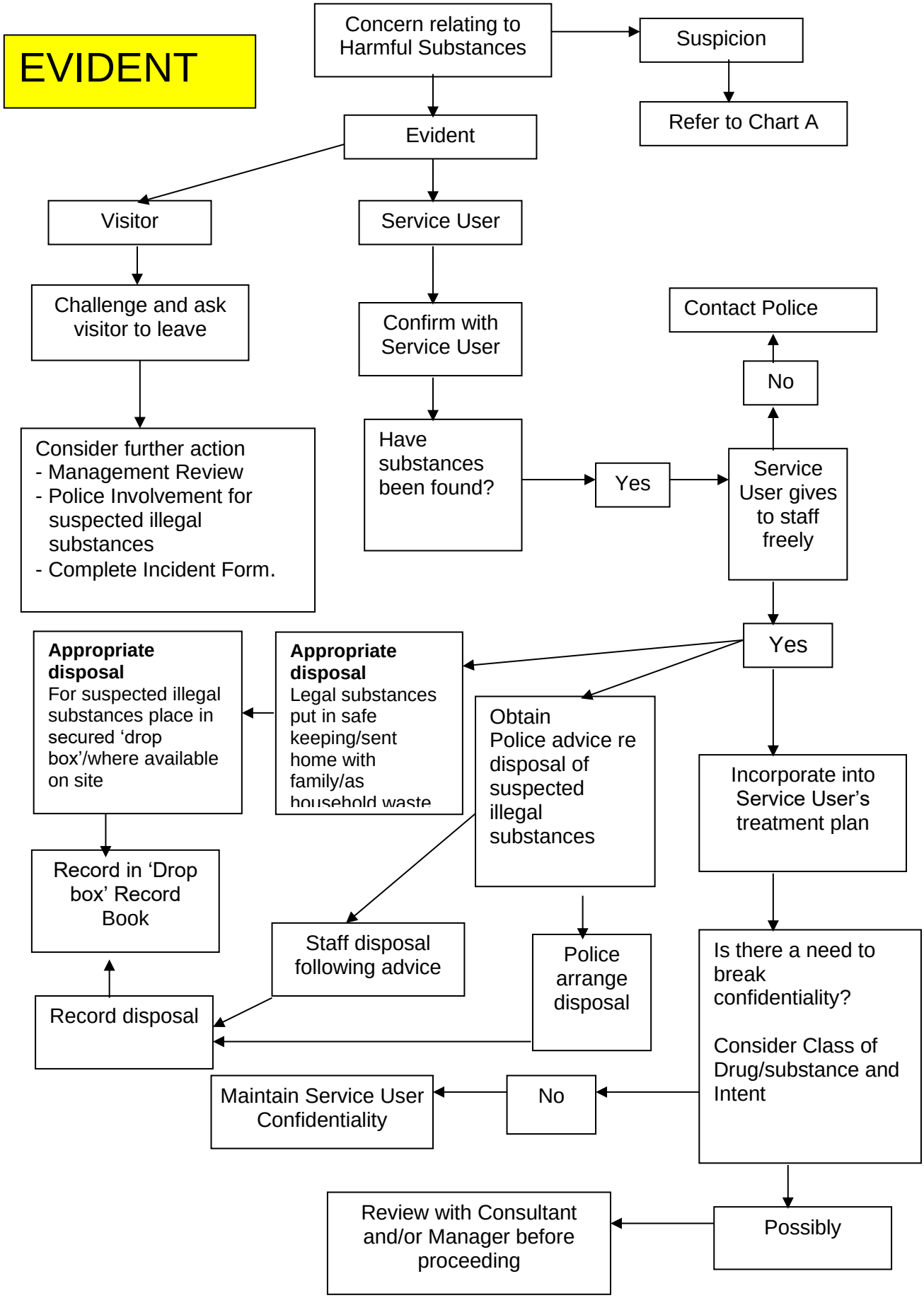
Contents

Flowchart A: Harmful Substances – Suspicion



MDT – Multidisciplinary Team
RC – Responsible Clinician

Flowchart B: Harmful Substances – Evident



1 Introduction

The Trust has clear responsibilities for providing an environment and culture that is best able to meet the health care function. Given this remit, the Trust and its employees have an obligation to provide a structure and guidance to promote behaviours and attitudes of healthy living and decrease behaviours and attitudes which are likely to be detrimental to the health of service users, staff and others.

The misuse of substances may be detrimental to the health of the individual and is, in some circumstances, illegal. As a health care provider, the Trust is concerned that substance misuse may reduce the positive prognosis of an individual's treatment.

The Trust has a legal responsibility to ensure that the clinical areas are free of illegal substances.

The policy avoids taking a moral viewpoint and aims to guide staff on the correct course of action to take if they suspect a service user is in possession or under the influence of a harmful substance. It will also provide the reassurance to staff that they are not breaching their duty of care to the service user while fulfilling the legal obligations they may have under the Misuse of Drugs Act 1971, in relation to substances that are illegal.

In line with CQC guidelines relating to restricted items it is permitted to have a communication and removal procedure for substances which may cause harm (whether illegal or not) - refer to the Blanket Restrictions Policy and the Register of Blanket Restrictions.

2 Scope

This policy has been written to give staff confidence and guidance to help deter the use of harmful substances within the Trust's bed based services and enable them to take appropriate action where such use is suspected.

The policy aims to promote a thoughtful response to the misuse of harmful substances in all bed based areas

For prescribed Controlled Drugs – Staff should refer to the Standard Operating Procedures for Controlled Drugs.

3 Purpose

For the purpose of this policy, substances that are commonly misused are, for example, illegal drugs including khat, NPS (illegal highs) also alcohol, glue and non-prescribed drugs.

The misuse of drugs/substances may be detrimental to the mental and/or physical health and may have an effect on the behaviour of individuals and is, in some circumstances, illegal. As a health care provider, the Trust is concerned that substance misuse may further reduce the positive prognosis of an individual's treatment.

The Trust also recognises that the unchallenged misuse of substances by individuals receiving treatment from our services, can and will have an impact on other service users in relation to their individual feelings of safety, wellbeing and confidence in the services in general.

Tobacco is not included but all health evidence would state that tobacco is a harmful substance – See Nicotine Management and Smoke Free Policy (NM&SF).

Intended outcome

- To give information and guidance to staff in providing information to service users.
- To provide guidance to staff in dealing with harmful substances in bed-based services.

4 Definitions

Service User - any service user, patient, client, resident.

Person-in-charge - the person with overall responsibility for the shift in the service area at the time of the event.

Harmful Substances
Harmful substances, for the purpose of this policy, are defined as:

- Those drugs falling under Class A, B and C of the Misuse of Drugs Act 1971, which are supplied/used without prescription and/or outside of an individual's treatment plan.

- A large amount of an illegal substance may be described as:

  a) an amount of powdered substance larger than a teaspoon
  b) a herbal or resin larger than a dessert spoon.

NB: The Misuse of Drugs Act now includes khat (2014), Novel Psychoactive Substances (NPS) now known as illegal highs (2016) or 'fungus (of any kind) which contains psilocin or an ester psilocin'.

- Other drugs or substances which, although not illegal, are taken, outside of prescription, in order to alter mental state, for example glue.

- Alcohol taken contrary to a prescribed plan of treatment or the ward's policies.

Suppliers

A supplier (for the purpose of this policy) is anyone who gives or sells harmful substances to other persons. Within our services it is possible that service users may be suppliers to other service users or that service users may be given/sold harmful substances by visitors/others.

Users

A user (for the purpose of this policy) is anyone who uses harmful substances and continues their habit despite the negative impact on their physical and/or mental illness or social problems. The individual may use a harmful substance for a variety of reasons, which can include culture, effect experienced, behaviour, etc. The user may or may not be aware or accept the possible unhealthy effects of the substance s/he is using and the possible negative affect the substance may have on their treatment plan.

5 Detail of the policy - please refer to Section 7.

6 Duties

Ward/Unit Managers

- Ensure that this policy and guidance are applied within their sphere of responsibility
- Ensure that staff are aware and comply with their responsibilities (i.e. aware of what to report and how to report it).
- Ensure corrective actions are implemented.
- Provide support or access to support for staff, service users or others involved in incidents as appropriate.

Person In Charge

- Ensure corrective actions are implemented
- Provide support or access to support for staff, service users or others involved in incidents as appropriate.

Individual Staff

- Ensure all incidents are reported before going off duty.
- Follow the guidance in this policy.
- Ensure the immediate safety of persons and environment, including assessment of the physical health of a person suspected or known to have used a harmful substance.
- Support improvements to work processes following incident investigations.
- Raise concerns as appropriate.

Multidisciplinary Team/Leadership Team

- Review individual incidents and wellbeing of service users.
- Review all incident data regularly as part of governance discussions.

7 Procedure

7.1 Guidance for Staff

7.1.1 Promotion of Policy Approach – Advice Upon Admission

As part of the admission process all service users will receive an explanation about issues related to substance misuse and use of harmful substances in line with this policy. Information should also be contained in ward handbooks. This is also supported by posters and leaflets related to restricted items as stated in the Blanket Restrictions Policy**.**

Some service areas may use expected standards of behaviour contracts with service users for example Wainwright Crescent.

7.1.2 **Service Users**

All service users should, on admission, be informed that they are required to hand in all prescribed and non prescribed medications (including substances, alcohol and tobacco) to the nurse in charge. All service users should be advised by their care team that they are strongly advised not to take any substances during their treatment, other than those prescribed, as they can have a detrimental and serious effect.

Any medications will be stored in the ward/unit medicine cupboard for disposal by Pharmacy.

Suspected illegal substances will be disposed as described in Section 7.8 of this policy.

Harmful (legal) substances - will be kept for relatives, etc, to collect and remove from the ward for up to 48 hours after which they will be disposed of. For alcohol refer to 7.8.8 of this policy.

NM&SF Policy advocates asking service users either not to bring tobacco in, or ask relatives/friends to take it back home, or we store it for return on discharge (see policy).

7.1.3 **Visitors**

All clinical areas encourage visitors to enable service users to maintain relationships with family and friends. While staff should not be intrusive while observing visitors they should be aware of the interactions and may need to take action if there is suspicion of use/supply of harmful substances. As such, the observation can be made less obtrusive if staff make themselves known to a service user's visitor.

7.2 Professional Responsibilities

7.2.1 All health care staff have a duty of care to act in the best interests of service users. The following areas are of prime consideration:

- The welfare of the service users;
- Acting in the best interests of service users;
- To maintain confidentiality.

NB if a service user is supplying harmful substances to other service user(s) our duty of care is greater to the other service users and not the supplier.

7.2.2 All professional bodies clearly state that the professional responsibilities in this area are not transferable and are not abrogated by delegation to another professional. The professional must at all times act in the service user's best interest and the law.

7.3 Maintaining Service User Relationships

It is acknowledged that an increasing number of service users have dual diagnosis issues (i.e. mental health problems and substance misuse problems) and this issue can be integral to the lives of the service user we are caring for. The multidisciplinary team must therefore recognise and own the issue of dual diagnosis being integral to service user care; and that we have a duty of care to help.

However, if the help offered is refused or counter-therapeutic behaviour persists, or if behaviour compromises the safety of other service users, then it may be necessary to review whether the current service setting is appropriate.

7.4 Suspicion of Substance Misuse (Service Users)

Given the legal and health issues surrounding substance misuse the following guidance aims to assist staff in taking action where use/supply is suspected. While such guidance cannot be expected to cover every eventuality, it is expected that staff will act in the best interests of the service user and the law.

7.4.1 If staff have any suspicion or concern about the use or possession of harmful substances then these should be recorded and included in clinical decision making and always reported to the nurse in charge of the ward.

7.4.2 There should be good grounds for the suspicion, such as concerns raised by other service users and/or observations of service user's behaviour or appearance. The grounds of concern should be confirmed by the person in charge.

7.4.3 Care should be taken not to accuse the service user of possessing or using harmful substances on the basis of suspicions only. However the apparent concern should be explored and reviewed with the service user by the appropriate member of staff. In most cases this will be the service user's named nurse/key worker, unless the person in charge feels that the issue needs to be reviewed sooner.

7.4.4 The reasons for the suspicion should be explained to the service user. If appropriate, the service user should have the opportunity to discuss related issues with members of the clinical team. Staff will then take measures to obtain evidence to support the suspicion (e.g. urine drug screen). The basis of this discussion, and any advice given to the service user should be documented in their clinical record.

7.4.5 The initial suspicion, and the information gained from the review with the service user should be reviewed with the service user's Responsible Clinician, Consultant and/or with a member of the leadership team at the earliest opportunity.

7.4.6 The conclusions drawn at this stage should be documented in the service user's clinical record.

7.4.7 If suspicion still remains, consideration may be given to undertaking a search of the service user's property, possessions and room in accordance with guidance provided in the Search Policy.

7.4.8 Flow Chart A at the beginning of this policy summarises action to be taken.

7.5 Action to be Taken Where There is Evidence of Substance Misuse (Service Users)

7.5.1 Any service user known to be using illegal drugs or harmful substances, on Trust premises, will be actively discouraged from doing so. The service user should be informed that continued use, or intent to supply will result in the involvement of the police. The Trust's incident reporting procedure should be followed. Where a service user is misusing substances and this is clearly significant in their care and treatment, this needs to be reflected in their collaborative care plan; and in their risk assessment and management plan. Consideration should also be given to referral to, or liaison with, the Substance Misuse Service where the service user meets the criteria for Dual Diagnosis (Mental Health and Substance Misuse) Protocol.

7.5.2 A full explanation of the (possible) adverse effects of behaviour associated with illegal or harmful substance use should be given to the individual in terms which s/he is able to fully comprehend. Associated concerns regarding the feelings and wellbeing of fellow service users should also be reviewed with the service user. Information regarding services available may need to be discussed with the service user. Staff should also be mindful of complications that could arise from a service user being intoxicated with substances and the possible physical effects this can have. A physical health assessment should be undertaken where there is evidence of substance intoxication.

7.5.3 Where possible, the individual should collaborate in the writing their care plan with their named worker and the team/multidisciplinary team, to address concerns identified through their behaviours.

7.5.4 Where it is impossible to write the collaborative care plan with the individual, a suitable plan should be drawn up by the team/multidisciplinary team, until such time as the individual is able to fully participate.

7.5.5 Contracts may be included within the collaborative care plan, to which the individual agrees to abide. Should the individual not agree, the possible repercussions should be explained to them and fully documented in the service user's clinical record. Behaviour contracts, as they relate to the misuse of substances, are included in the admission process of all service users to Wainwright Crescent.

7.5.6 Where behaviour in relation to repeated use of harmful substances persists, the following approaches should be considered:

a) That the individual service user is demonstrating behaviour that is deemed to be inconsistent with accepting and engaging in the treatment plan in place.

b) For service users on inpatient wards, consideration should be given to the service user's mental state and the appropriateness of detention under the Mental Health Act. For service users at Wainwright Crescent an incremental 'warning' (i.e. of discharge) system may be used following a discussion with one of the leadership team.

c) On an inpatient ward, if detention is not appropriate then consideration should be given to discharging the service user from the ward. At Wainwright Crescent, consideration should be given by the leadership team to discharging

the service from this facility.

d) Should discharge be considered appropriate, the clinical team must be clear that this does not mean an end to the provision of any necessary and appropriate support and treatment from other parts of the health and social care services, as highlighted by the service user's needs

e) Where discharge is implemented in these circumstances, all necessary and appropriate arrangements consistent with expected practice around discharge planning should be followed i.e. all service users should have a discharge plan and appropriate communication with the care coordinator, community mental health team and/or other agencies involved in their community care package.

7.5.7 Flowchart B at the beginning of this policy summarises action to be taken.

7.6 Visitors

7.6.1 The use or suspected use of harmful substances by non-service users on Trust premises will result in the person being asked to leave the premises by the person in charge. The grounds for such suspicion should have good cause.

7.6.2 If any difficulties are experienced, the person will be informed that the police will be contacted to attend the ward/unit. Should they not leave immediately, or if they return and continue their suspected activities, then police assistance should be requested immediately.

7.6.3 Where the person is a service user's visitor, the service user will be informed of the reasons why such action has been taken. The Trust's incident reporting procedure should be followed. Other areas on the site should be informed of the incident. Should the persons be suspected of continuing such activities, during future visits, on the premises, the police should be contacted. The Ward/Unit Manager and/or Responsible Clinician or Consultant should be informed about what is happening and a discussion regarding the situation in terms of being detrimental to the service users mental health should ensue. A decision as to whether the visitor should be banned from Trust premises needs to be made. Where this affects particular service user(s), the reasons should be fully explained to the service user(s), by a member of the multidisciplinary team.

7.6.4 The individual concerned will be informed that they are banned from further visits until a review by the Ward/Unit Manager has been undertaken. The individual concerned will be informed of the outcome of this review, which may entail a continued ban or supervised visits, or no further action.

7.6.5 Consideration should be given as to whether the use or suspected use of harmful substances by an individual's visitor may lead to a safeguarding concern needing to be raised.

7.7 Supplying of Harmful Substances

7.7.1 If staff have any suspicion or concern about the supply of harmful substances, including from external sources e.g. in deliveries made to the ward, these should be reported to, and reviewed with, the person in charge of the ward/unit. The Trust's incident reporting procedure should be followed.

7.7.2 There should be clear and substantial grounds to support the belief and concern that a service user is supplying harmful substances to other service users. The grounds for concern should be confirmed by the person in charge.

7.7.3 Where it is evident that such concerns exist and are well founded, the service's duty of care to other service users will be regarded as overriding the duty of care to the individual service user concerned. Such continued actions by a service user are considered to be seriously detrimental to the safety and wellbeing of other service users. The following courses of action will be considered:

a) The active involvement of the police will be considered as an appropriate means to provide for and safeguard the wellbeing and safety of other service users. Following the involvement of the police, any consequential action arising for the service user concerned will be determined by the police. Clinicians responsible for the service user concerned may undertake and seek to advise the police as to the service user's circumstances, however, decisions regarding legal implications will be for the police to address.

b) Discharge from the ward/unit should also be considered. Outline guidance for the approach to be taken in response to this potential is contained within paragraph 5.6 of this policy. It is acknowledged that discharge may not be an option due to detention of the service user. Where this applies the MDT need to formulate a plan of care that adequately addresses the problem.

c) Where there is suspicion or evidence that harmful substances are being brought to the building including via deliveries, the advice of the police should be sought and appropriate action taken to safeguard the wellbeing and safety of the service users.

7.8 Disposal of Harmful Substances

NOTE: South Yorkshire Police have recommended that each site in the Trust should have available a drug 'drop box' for proper disposal of suspected illegal substances. The police have undertaken to empty these boxes on request. The boxes are at the following sites: The Longley Centre, Michael Carlisle Centre and Forest Lodge. There is a record book for the purposes of recording appropriate information.

7.8.1 Following the location of any illegal substances, or suspected illegal substances, the substance should be retrieved and placed in a secured drop box, where available. An entry should be made in the 'drop box' record book and signed by two qualified nurses. For services where there is no access to a drop box, substances may be stored in the medicine cabinet, and recorded as such, until police advice has been sought regarding disposal.

7.8.2 If the service user declines to surrender the suspected substance, the person in charge of the ward/unit will provide the service user with the option of surrendering the substance anonymously to a member of staff, or directly to the police.

7.8.3 Members of staff acting on behalf of the Trust are not authorised, under law, to possess illegal substances. This action is only supported pending appropriate and timely action to ensure that the suspicious substance is passed for safekeeping to an individual who is authorised to possess and arrange for its disposal.

7.8.4 Care should be taken not to directly handle any suspicious substances.

7.8.5 The appropriate Senior Manager and the service user's Responsible Clinician or Consultant, should be informed that a suspected illegal substance has been found within the ward/unit environment.

7.8.6 Substances which cannot be put in the 'drop box', e.g. large amounts. Members of staff are not authorised to dispose of large amounts (see Definition) unless it is done strictly in accordance with police instructions and guidance.

7.8.7 Police personnel should be notified when the drop box requires emptying **CONTACT SOUTH YORKSHIRE POLICE AND ASK FOR EXTENSION 4179 OR 4210** and an officer will attend to collect the substances. Staff should record in the record book when the box has been emptied.

7.8.8 There should be appropriate disposal of **legal substances** e.g. alcohol. If family members are not able to take them home these may be disposed of as household waste after 48 hours, or returned to the service user upon discharge dependent on an individual risk assessment. Tobacco will be returned on discharge.

7.8.9 Service user confidentiality should be maintained in most circumstances. The exception to this will be influenced by the subsequent category of the illegal substance, and concerns relating to intent to supply. Any potential decision that over-rides service user confidentiality, through informing the police, can only be taken following consideration by the service user's Responsible Clinician or Consultant and the Ward/Unit Manager or Senior Manager.

7.9 Alcohol Misuse

It is Trust policy that alcohol is not consumed on Trust premises or grounds.

It is acknowledged that patients may consume alcohol while on leave from the ward/unit. However, excessive use of alcohol is detrimental to patients' physical and mental wellbeing. The issue of excessive use of alcohol should be addressed as outlined in Sections 7.1.2, 7.4, 7.5 and 7.7 of this policy.

On return from leave alcohol will be put into safe keeping/disposed of as in Section 7.8.8 of this policy.

8 Development, consultation and approval

This is version 4.0 of this policy and replaces version 3.0 (November 2016). This version was reviewed and updated as part of an on-going policy document review process. Part of this update included mapping the draft onto the current policy document template and updating the contents.

Consultation took place within clinical operations during November and December 2019. Further consultation and verification took place via the Service User Safety Group (SUSG). The policy was verified by the Chair of SUSG on 12 December 2019, prior to being sent for ratification.

9 Audit, monitoring and review

All incidents where the presence of harmful substances are confirmed, are to be treated and managed as an incident under the Trust Incident Reporting & Investigation procedures. The relevant and associated documentation is to be completed in respect of this. Alcohol or substance will be recorded as a contributory factor where appropriate, e.g. substances found, where alcohol has been consumed prior to an incident, etc.

9.2.1 Monitoring of incident data via the Acute Care Forum Patient Safety Sub-Group and/or other Directorate meetings where incidents are reviewed.

9.2.2 Ongoing issues in respect of this policy will be reviewed through existing liaison forums established between the Trust and South Yorkshire Police.

9.3 Individual Directorates with responsibilities for inpatient care should consider the need to audit standards as part of their service improvement plans.

9.4 This policy should be routinely reviewed at least every three years, or before this if sufficient concern exists. The formal policy review will consider the appropriateness and effectiveness of the outlined approaches based upon:

a) information regarding prevalence based upon incident reporting;
b) issues highlighted through existing liaison forums;
c) other sources of feedback, such as complaints, service user forums, national reports/ guidance subsequently published;
d) lessons learned from incidents.

Monitoring Compliance Template

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Policy content including duties and process	Review of policy	Clinical Operations Crisis and Emergency care Network	3 yearly	Clinical Operations Crisis and Emergency Care Network	Clinical Operations Crisis and Emergency Care Network	Clinical Operations Crisis and Emergency Care Network

10 Implementation plan

Action/Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	
Make team aware of new policy, including the need to include alcohol/substance on incident forms, where it is a 'contributory factor'	Ward Manager		
Check staff awareness through supervision	Ward Manager	Next session following issue.	

11 Dissemination, storage and archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
3.0	Nov 2016		Nov 2016 – via Communications Digest	
4.0	May 2020	May 2020	May 2020	

12 Training and other resource implications

All teams providing care for service users should be familiar with the standards within this policy.

Training programmes for staff in these teams should refer to these standards.

Specific training is not required, but the standards should be referred to in other relevant training, e.g. Dual Diagnosis (Mental Health and Substance Misuse).

Also staff to be advised to add alcohol/substances as a 'contributory factor' to incident forms, where this is appropriate (see Section 9.1).

13 Links to other policies, standards (associated documents) and references

Incident Reporting & Investigation Policy
Personal Search Policy
Liaison with Police
Dual Diagnosis (Mental Health and Substance Misuse)
Waste Management
Standard Operating Procedures for Controlled Drugs
Nicotine Management and Smoke Free Policy
Discharge Policy (In-patients)
Blanket Restrictions Policy
Register of Restricted Items (per area/ward)

References

Misuse of Drugs Act 1971
MHA Code of Practice 2015

14 Contact details

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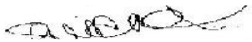
Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: 	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age			
Disability			
Gender Reassignment			
Pregnancy and Maternity			

Race			
Religion or Belief			
Sex			
Sexual Orientation			
Marriage or Civil Partnership			

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date