SCOTTISH EXECUTIVE

Health Department
Directorate of Service Policy and Planning

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20 May 2002

Dear Colleague

**MANAGING INCIDENTAL DRUG MISUSE AND ALCOHOL PROBLEMS IN MENTAL HEALTH CARE SETTINGS**

**Summary**

1. Misuse of drugs and consumption of alcohol within care settings can increase the risks to staff and others and contribute to significant detrimental health effects on the individuals concerned. The attached guidance offers insights to safe care approaches for staff, residents and visitors.

2. The guidance does not impose a national structure or process but offers a range of issues to be considered in the preparation of local policies.

**Background**

3. The guidance promotes safe care, prevention and considered approaches to the care management of those with a drug misuse or alcohol problem in mental health care settings. The measures promoted have broad application to most continuing care settings.

4. Nicotine use is not covered given the separate local policies that will/may already be in place, however the guidance should be read with the (January 2002)"Plan for Action on Alcohol Problems, **(**www.show.scot.nhs.uk/sehd/mels/HDL2002_17.pdf).

**Action**

5. NHS Boards, Trusts, local authorities and others are invited to review their existing arrangements against this guidance. Those currently without specific guidance are invited to prepare local policies in consideration of the attached guidance. Recipients are invited to draw this letter to the attention of all in their area with an interest in these matters. The Scottish Commission for the Regulation of Care will need to be aware of this guidance in view of their regulatory role in respect of care settings.

6. This HDL and attachment are available on the SHOW website (www.show.scot.nhs.uk) on the Scottish Executive publications page.

Yours sincerely

**GODFREY ROBSON**
Director of Service Policy and Planning

**Addresses**

For action
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For information
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Chief Executive, COSLA
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# MANAGING INCIDENTAL DRUG MISUSE AND ALCOHOL PROBLEMS
# in
# MENTAL HEALTH CARE SETTINGS

## Introduction

1. Misuse of illegal drugs and alcohol can have a significant detrimental health effect on the individuals concerned. When misuse occurs in a care setting the risks to staff and others increase. This guidance offers insights to safe care approaches for staff and residents.

2. NHS Boards, Trusts, local authorities and independent sector providers are invited to review their existing arrangements against this guidance. Those without specific guidance are invited to prepare local policies in consideration of the advice in this document. This guidance does **not** impose a national structure or process but offers the range of issues to be considered in the preparation of local policies.

3. The aim is for each facility and service to have broadly consistent policies for the safe care management of those with substance misuse problems in mental health care settings, though the broad messages apply for all care settings.

4. Separate approaches and legal provisions apply for the supervision and care of children and young people and local consideration should be given to the preparation of separate policies and procedures to cover age sensitive care (paragraphs 17 and 18 refer).

5. Care providers have a clear responsibility of working within the law to help those already misusing substances; help prevent others from becoming involved or affected; and to provide a safe, supportive environment and care regimes. Local policies must comply with all relevant statutory responsibilities (Misuse of Drugs legislation, Health and Safety Regulations ECHR provisions etc) and for best effect all policies should be prepared on a joint agency, multi disciplinary basis in keeping with the objective of whole person care and support.

6. Arguably the most important staff protection issues are the provisions of Section 8 of the Misuse of Drugs Act 1971. In blunt terms, staff can be prosecuted if they knowingly allow drug offences to be committed on their premises. A fuller explanation together with a recent case example are offered at paragraph 58 and a summary of the legal provisions is set out at *Appendix 2.* The wider considerations include:

- The need for knowledge and skills in working with people who have separate or combined drug and alcohol problems;

- The regard that must be given to support, continuing care, substitute prescribing etc;
- The relationship between alcohol/drug misuse and psychiatric symptoms and disorders;
- The legal and ethical implications of drug testing, searching and confiscation;
- Arrangements for those who abuse the facility rules; and
- The grounds/circumstances/responsibility for involving the police and other agencies.

7. The Mental Health and Well Being Support Group report *Risk Management (2000)* recommended the appointment of local Risk Management Committees (RMCs) for the consideration of local risk. RMCs are perhaps best placed to lead local consideration of this guidance and prepare locally relevant responses. Whatever the local arrangements, the agreed policies should be regularly and formally assessed through the most appropriate available local management structure, for example, by the local Clinical Service Group.

8. The Mental Welfare Commission for Scotland has a statutory responsibility to protect the welfare of people with mental disorder. In drafting policies the Commission's role should be borne in mind and where appropriate they should be consulted. The Commission raised the issues covered in this guidance (most recently) in their 2000-01 annual report and highlighted the need for clear supportive procedures and information. These views are reflected in this guidance.

**Prevention**

9. All residents and all visitors should be told that misusing alcohol or drugs is not permitted within the setting. Prevention is not the only option and must be considered as part of a broader pragmatic approach to the preparation of guidance. (For example, paragraph 25 offers guidance on available steps where rules are flouted). Steps toward "Prevention" include:

- forming a partnership agreement with those attending the facility that no illegal drug use takes place on the premises;
- directives for junior medical staff under training (repeated every six months for junior Doctors;
- creating a culture and environment which recognises the potential harm which drug and alcohol problems can cause the user (directly or through an effect of his/her mental condition) and others;
- emphasising the inappropriateness and dangers of drug and alcohol use on care premises;
- identifying those at risk for extra support/advice interventions;
- health promotion, occupational health services; and
- providing stimulating and socially supportive environments.

10. Delivering on these objectives relies on meaningful involvement of the service users and on relevant continuing staff training programmes that underpin the agreements and models adopted. Staff training and awareness programmes should

include the perspective of support and counselling available to staff who themselves may have a drug or alcohol problem.

**Single shared assessments**

11. Holistic care assessments should be organised on a single shared basis. (See latest guidance *Single Shared Assessment of Community Care Needs, November 2001*). Assessments should cover any drug or alcohol problems (what substances are being used, what amounts, how often, for how long, what method etc). To be most effective the motivation for lifestyle change must come from the individual. To help inform these decisions the damaging effect of drug and alcohol misuse (physical/mental health, social relationships, etc) should be explained sympathetically in each case. A supportive approach should be adopted explaining that disclosure is to inform care decisions and what help and advice are best (the report of the *Effective Interventions Unit on Assessment of People with Drug Misuse Problems*, to be published later this year, will be of particular use and relevance).

12. Underlying issues should be explored. Contributory factors can involve a whole range of social, psychological and physical factors which may also interact. It is also worth noting that substance misuse can be a strong predictor of suicide tendencies for all ages and both sexes.

**Involving other agencies**

13. Questions should be asked about continuing contact with specialist services or other support agencies. Where this is the case, and with the individual's permission these services should be invited to the joint care planning process. Specialist services may also be able to supplement individual assessments by conducting a more detailed in-depth review of individual cases or offer insights to the assessment processes adopted.

14. Steps should also be taken to determine whether the individual is subject to any current and relevant court order, restriction order or post (prison) release licence. Also relevant is whether supervision is in place by the criminal justice social work service and the terms that apply. (What "steps" can be taken - for NHS staff without breach to Caldicott and other provisions, must be determined locally, involving all network contacts **www.show.scot.nhs.uk/publications/ME/caldicott.manual.doc.** When this is the case Criminal Justice Social Work must be made aware of and be consulted on the care plan (the National Care Standards[1]- care homes for people with mental health problems, Standard 6 applies (**www.scotland.gov.uk/government/rcp**).

15. It would also be appropriate to invite the supervising social worker to attend care programme meetings, again with the individual's consent. When seeking to obtain or to share information with other agencies, staff must comply with organisational and professional protocols on confidentiality and information sharing.

[1] Scottish Ministers have issued national care standards for a range of care services including care homes for people with mental health problems and care homes for people with drug and alcohol misuse problems which the Scottish Commission for the Regulation of Care will take into account in its regulation of care services.

16. Collaboration between specialist services and the health and social care agencies is relevant in all cases but particularly so where there is a dual diagnosis of substance abuse and mental disorder. The Clinical Standards Board For Scotland, (CSBS) *Schizophrenia Standard 11* states that "Every person who has a diagnosis of schizophrenia has his/her misuse of alcohol and illicit drugs reviewed whenever needs are being assessed……and has access, where appropriate, to the specialist addiction services." A draft protocol on information sharing has been published by the Executive and is available at **www.show.scot.nhs.uk/ecare/draftprotocols/**

**Single shared assessment of the needs of children and young people**

17. Assessment should include full consideration of family responsibilities and circumstances and specifically the needs of any child or young person for whom the individual is responsible. Consideration should apply to any parental training, childcare or additional support that might help with the parenting role and family responsibilities.

18. If any suggestion arises that a child or young person is (or may be) in need, or at risk, then appropriate interventions should be organised without delay. In all such cases the local Child Protection Service should be informed immediately. Consent will remove concerns over any potential breach of confidentiality codes. Consent granted should be recorded in writing. The sharing of information without consent may be justified eg if it is to prevent harm to an individual. If time permits, the advice of the local Caldicott Guardian should be sought. When the situation is urgent, staff will have to make a professional judgement, weighing up the risk of harm to an individual and their duty of care to that person against rules on confidentiality. It should be borne in mind that confidentiality is not an absolute requirement and should not be seen as a barrier to information sharing when anyone is at risk of harm. A care plan should be drawn up as usual, but clarifying and distinguishing the mental health problem from the alcohol problem or substance misuse.

**Care/treatment/support planning**

19. Realistic, achievable treatment goals for the assessed care needs should be discussed and wherever possible agreed with the individual. In the short term these might focus on reducing the harm caused by alcohol problems and/or substance misuse (in line with a harm minimisation approach). Supportive counselling, anxiety management, detoxification and relapse prevention should be considered where required. Support and relevant (including substitute) prescribing should be considered where appropriate.

20. (Partnership) interventions to address any reasons for a person's substance problems that are treatable or amenable to intervention should form part of the treatment plan. These might include referral for a psychological intervention or participation in an anxiety management group, or helping the person to better structure her/his time to help alleviate boredom or remove/address other factors contributing to their drug or alcohol problem. (CSBS, *Schizophrenia Standard 10 "Social and Psychological Approaches to Care"* refers.)

21. Recognising the difficult accommodation and management issues, those specifically admitted for detoxification should, where possible be treated in separate accommodation by staff trained in the care philosophies for this client group. Thought should also be given on a case by case basis to the potential benefits that can be derived through contact with others who have been through the process.

22. Regular reviews of progress against treatment goals should be held involving the individual and preparation for discharge should start at the earliest point involving all the relevant agencies.

**Policies and practice**

23. All concerned will benefit from agreed local policies. It is important in these terms to have clear procedures to follow when inappropriate consumption of alcohol or possession of illegal substances is discovered on the premises. The terms must be explained and made available to all concerned, including visitors, as part of the pre and immediate admission/induction process. Staff should provide clear explanations of the establishment rules and of the need for all to receive care in a safe, substance-free environment.

24. Explanations should be backed up by written information on the policies in the form of leaflets and posters, and be available in community languages and alternative formats for those with sensory impairments and for those with literacy problems. Leaflets and other literature should also be available about the possible effects of substance problems on health e.g. how to address/reduce/remove the problem, available advocacy bodies and support networks etc. As before all these policies should be drawn up consulting all the relevant interests and be advertised within the premises and made available. The policies should be kept under regular review.

25. The implications of breaking these rules should also be explained, again set in context (NCS - *care homes for people with drug and alcohol misuse problems Standard 1 applies*). For example, visitors may be excluded from the premises if by their actions and behaviour rules are broken which endanger the care or safety of residents/patients or staff. Discharge or transfer of individuals may not always be possible or appropriate despite abuse of the facility rules (eg where there is a risk of suicide or they are a restricted patient etc). In such cases treatment and care plans should be re assessed with a view to any necessary added vigilance, supervision and support required.

26. A “Search and Safety Policy” prepared with Police involvement should also be in place and explained as part of the admissions process. In this regard it is reasonable to insist on holding in safe storage any item that causes concern, including any implement, matches/lighter, alcohol, drugs or other articles which could potentially do harm to the individual or others, or cause damage to property. Any search should be against a proven necessity for maintaining a safe and therapeutic environment. Any decision to conduct a search of an individual or premises should be considered in terms of the guidance offered at paragraphs 33-37.

## Non-consensual treatment

27. Compulsory treatment for people with mental disorder is currently governed by the Mental Health (Scotland) Act 1984. Under that Act a person is not to be treated as mentally disordered solely because they are dependent on alcohol or drugs. However, the Act may be relevant for people with mental disorders who also have alcohol problems or misuse drugs, including people with mental disorders (such as Korsakoff's syndrome) which are casually related to alcohol problems or substance abuse.

28. A person with a mental disorder complicated by alcohol or drug problems may sometimes be unable to take informed decisions about their finances or personal welfare, including treatment. In such cases the person may have a proxy (for example, a guardian or welfare attorney) under the Adults with Incapacity (Scotland) Act 2000 who has powers to take decisions about medical treatment on the person's behalf. If not, or if it is not reasonable or practicable to obtain the consent of the proxy, Part 5 of that Act allows medical practitioners to treat an adult who is not capable of consenting to the treatment in question.

## Involving relatives, friends and carers

29. Involving relatives, friends and carers in an individual's treatment can be helpful. However where possible the views of the individual should be sought first. Requesting information from others is not a breach of confidentiality as long as the exchange does not disclose the location or type of care if this was not previously known. It is worth noting that the Mental Health Act requires the giving of information to relatives in certain circumstances, for example, emergency detention. Overall, such external input can further inform issues of care and public safety, (NCS-*care homes for people with mental health problems Standard 10(7,8) applies*). Again this permission should best be obtained in writing and placed on the record. The permission granted should be reviewed at regular intervals for currency. It is not always appropriate to tell the individual that their confidentiality is being breached, for example NHS Circular, PCA(M)(2002)4 "Sharing of Patient Information: Violent Patients", *states "..unless there are strong reasons not to do so (for example, informing the patient could cause a violent reaction), the GP should let patients know…..".*

30. Local policies should take into account the benefits of involving relatives, friends, carers and other visitors. Feedback should be a key component.

31. Factors to consider include:

- **Confidentiality**

  The general rules governing information sharing and the maintenance of confidentiality should always apply. Staff must comply with Data Protection and Human Rights Legislation on Privacy, Standards of Conduct set by their Professional Body and organisational rules for the protection of patient confidentiality. Unless acting to the contrary can be justified in law the

individual's informed consent should be obtained and recorded before sharing information with relatives and others.

The Royal Pharmaceutical Society GB MEP Guidance contains a useful guide on disclosure.

Wherever information is shared with others it should be made clear to those receiving the information that it is given in confidence. Regard should always be taken to the latest available guidance from professional bodies and others on confidentiality compliance. Advice from the local Caldicott Guardian may be helpful.

- **Information**

The policies and expectations in respect of those who use services, relatives, carers and visitors should be explained by staff. There is a clear role for advocacy here. Wherever possible a leaflet setting out these expectations should be made available in accessible language and format, particularly for those at admission stage.

- **Support**

Consideration must be given to the separate needs of relatives and carers. Sympathetic support and advice is often of value. Information about support organisations and networks for families and friends of those with a substance problem should be available **(**CSBS *Schizophrenia Standard 7*, "Information and Support to Carers" applies). There is also the right to a carer's assessment under the Community Care and Health (Scotland) Act 2002, the Carers Act.

- **Exclusion**

Visitors may be excluded from the premises if by their actions and behaviour reasonable facility rules are broken which could endanger the care or safety of residents/patients or staff (NCS - *care homes for people with mental health problems Standard 1; 3(4); and 9(1,2)* applies together with paragraphs 34, and 74 of this guidance).

32. Some visitors may themselves have substance misuse problems. As well as being aware of the potential difficulties this may cause, staff should be aware of the opportunities presented to provide information to them in an unobtrusive way about where they can access help.

**Searches**

33. Searching is a sensitive but important part of risk management/reduction and can be a significant contributor to creating and maintaining safe, therapeutic care settings. It is important for each facility to have an agreed “Search and Safety Policy” that not only addresses the particular needs of the facility design but also the client group and visitors. In preparing the policy facilities should have particular regard to

the advice available from the Mental Welfare Commission for Scotland, the Scottish Health Advisory Service, the Mental Health and Well Being Support Group Report on Risk Management and the broad protective principles of the Millan Committee Report.

34. Where items such as drugs or weapons are found the important issue for the Crown will be whether the seizure of the articles will be admissible in evidence. Clearly, this will be important in all cases where the police become involved and a report is submitted to the Procurator Fiscal. At present, any evidence found during the course of any such search will be subject to the normal criminal rules of evidence. Staff and management have a common law power to search patients and visitors for safety purposes on their own premises, a power akin to club stewards (Wilson v Brown 1996 SCCR 470).

35. Personal searches are a serious invasion of privacy and rights and sensitivity should be shown in this respect and in terms of legal, gender and cultural issues. Consent should **always** be sought (and recorded) and the reasons for the search explained clearly. Liaison services should be involved wherever possible. In cases **where consent is declined or otherwise cannot be obtained** (and where the situation is urgent), staff should refer to their agreed "Search and Safety Policy" which should cover such contingencies and which will be based around the duty of care for creating and maintaining a safe and therapeutic environment.

36. In general terms where consent is not given staff will be entitled to refuse admittance to visitors as they have the common law power to regulate their premises and ensure security of all concerned. The situation may be more complex where a resident for continuing care reasons cannot simply be excluded from the premises. In cases where consent is refused the choices will include, exclusion; police involvement; search without consent; or alternative care and supervision arrangements. (See paragraph 25). Searches without consent may cause difficulty as there is always the possibility of an allegation of a common law assault. Further, any item found may in the future be inadmissible as evidence. Clearly, actions taken will depend on circumstances but the staff response to a refusal must be reasonable, considered and proportionate. A search without consent could, for example, be justified where there are reasonable grounds for suspecting that the person has a significant quantity of a class A drug, or an offensive weapon, and where there is an element of urgency in the situation. While, as said, evidence obtained without consent is not always inadmissible, Courts will always consider the question of fairness in all the circumstances.

37. In all cases and for all searches, care should be taken in order not to put staff or others at risk (for example, needle stick injury).

**Inter-agency Approach**

38. An inter-agency approach is best in developing a local policy for dealing with substance problems to oversee audit of incidents and monitor the effectiveness of agreed models. This may require the setting up of a new forum or could become an additional remit for the established Risk Management Committee (RMC), (*Risk*

*Management* report, 2000). The scale, type and/or trends locally will inform a co-ordinated approach to establishing communication systems and practice guidance.

39. Policies should be developed through the Drug and Alcohol Action Team in close collaboration with the agencies' legal advisors, Local Authorities, Criminal Justice Social Work, Police, specialist drug and alcohol services, NHS Primary Care Trusts, Local Healthcare Co-operatives LHCCs, Community Pharmacists, Community Mental Health Teams, voluntary organisations, users of services/carer representatives and Accident and Emergency department(s).

**Pharmacists**

40. Pharmacists are a valuable and integral resource for informing the development of pragmatic local policies. Their input will include advice and training on care management issues and the handling and storage of drugs (NCS - *care homes for people with a mental health problem Standards 5 (11,12) and 15 (7,11,14) apply*).

**Clinical Governance**

41. For health facilities and services the clinical governance structure should incorporate the drug and alcohol problem agenda eg by setting multi-professional standards, audit, training, monitoring and reporting protocols. 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, safety and procedures for dealing with unauthorised substances including recording, storing and where appropriate, disposal.

**Training**

42. Training should be a priority and best organised on a multi-disciplinary, multi-agency basis. Clear objectives and desired outcomes should be set and considered against the needs of adherence and delivery of the agreed local policies.

43. Training for qualified and unqualified staff should encompass the development of knowledge and skills in assessment and care/treatment planning for people with substance or alcohol problems.

44. Core Training programmes should cover:

- The need to address **stigma;**
- **Recording** and reporting requirements including awareness of the Caldicott and other protections on sharing of information;
- **An appreciation** of interactions between drugs, alcohol and mental disorder;
- **Relapse prevention;**
- **Attitudes** to drugs and alcohol and the people who use them. (Appropriate attitudes are the cornerstone of therapeutic activity);
- **Knowledge** of the main groups of drugs and other substances commonly associated with misuse, their appearance, and effects (both in use and withdrawal);
- **Preventative techniques;**

- The **effects** of substance problems on mental and physical health (with special attention to Hepatitis B and C, and HIV;
- The **relationship and interactions** between prescribed and non-prescribed drugs and alcohol, with regard to the distinction between drugs prescribed for substance misuse and for mental health treatment;
- An **understanding** of drug culture and the language used;
- **Knowledge** of statutory and non-statutory substance services, the input they can make and an awareness of when referrals and contact with such services may be appropriate;
- Knowledge of **clinical guidelines** and standards to inform practice;
- **Legal** issues around substance problems and interventions by care services;
- Knowledge of **models and techniques** which can be used when working with people with substance problems, for example, Prochaska and DiClementi's cycle of change, harm minimisation, relapse prevention, motivational interviewing;
- **Skills**, education and information given to individuals and their understanding of this;
- Management of **drug and alcohol withdrawal** (including substitute prescribing);
- **Safety,** including a clear understanding of the risks to the individual and others and an ability to incorporate this knowledge into standardised risk assessment procedures;
- **The Law** relating to controlled drugs-storage, recording, handling, reporting, disposal etc;
- **Audit/research and on going education;**
- **Professionally confronting** individuals and their visitors, and the management of aggressive and threatening responses from people who have been challenged; and
- **Safe and legal handling** of drugs.

45. Training could include opportunities for staff, at all levels, to spend time with specialist substance abuse or dependence teams and vice versa and include mechanisms to support staff including decision making and accountability. There should be a key role for the **Practice Development Nurse** in linking training to practice**.** *(Though not promoting or in any way validating specific training on these issues, there is an accredited course run by the University of Paisley, Centre for Alcohol and Drug Studies- "Co-morbidity: Alcohol, Drugs and Mental Health).*

## Supervision

46. Supervision (clinical and otherwise) is essential for helping all staff deal with the issues that can arise from working with people who have substance abuse or dependence problems. Properly managed supervision can provide a welcome space for expression and sharing of ideas, frustrations, concerns, problem-solving, development of knowledge and identification of training and other needs. The training and support needs of supervisors should not be forgotten. An agreed process of regular **supportive** supervision will benefit **all** staff. There should be a system in place for reflective practice and mechanisms for handling critical incidents - all designed to avoid a blame culture.

## Record keeping

47. Records kept should comply in all respects, including detail, storage and public notification, with the requirements of the Data Protection Act 1998. In particular staff should be aware of the rights of each individual to see their records. Records must be kept secure and access to any electronic record must be audited under the supervision of the local Caldicott Guardian.

48. The outcome of all care assessments must be documented clearly and in detail. All incidents involving substance misuse must be recorded in both the case notes and the general statement/incident forms (NCS - *care homes for people with mental health problems Standard 5(1) and 9(6) apply*). Reports must include any actions taken, by whom and when, including detail of any discovery of items or materials that could cause harm and subsequent storage or disposal arrangements, (see paragraphs 62 to 65). Any agreed searches must be recorded in similar detail. The process to be followed and the detail to be recorded should be cleared in the first instance with the police and legal advisers.

49. Where a third party has provided information but wishes to remain anonymous, that confidentiality request should be observed except in cases where there are statutory responsibilities (eg Child Protection, Misuse of Drugs Act 1971 (especially Section 8), Drug Trafficking Act 1994- see Appendix 3) or there is risk of harm.

50. Details should be recorded of any visitors refused access or removed from the facility. The detail to include the reason and date of exclusion. There will obviously be cases where the visitor's name is not known. The individual visited or to be visited should be advised in every case and an explanation offered.

## Criminal Justice System

51. If local policies are to be workable, legally compliant, effective and credible the advice of legal advisers, local police, procurator fiscal and criminal justice social work services is essential. This is particularly important in finalising arrangements for collecting evidence, co-operation and review of the efficacy of local agreements. Once agreed a regular joint evaluation of effectiveness and currency should be undertaken. These discussions on local policies should at the very least take account of:

- The policy for dealing with unauthorised (illegal) substances.
- Situations where materials discovered should be left for police handling and retrieval in terms of usable evidence;
- Arrangements for safe storage and recording;
- Appropriate reporting procedures;
- Information about the provision of witness statements and advice on giving evidence in court;
- The need for management support and debriefing, including further input, where staff are involved in a court action;
- The action to be taken in cases of threatened or actual violence/extortion/blackmail. (See paragraph 75); and
- Support for vulnerable witnesses (for example, other service users).

## Identifying the problem

52. Awareness of substance problems may arise through observation of behaviour, third party reports, suspicion or rumour or the more structured screening covered at paragraphs 59-61. More concrete evidence may be an individual's own report or substances found on the premises. Easily expressed but difficult in practice is the premise that without concrete evidence staff should be careful to avoid arriving at false conclusions**.**

53. In cases where suspicions continue but evidence remains inconclusive and the individual denies there is a problem, staff should meet to discuss and review safe care management arrangements and explore alternatives.

## Disclosure of information

54. There are a number of statutes and circumstances that **require** disclosure of information to the police. For example, it is an offence under Section 52 of the Drug Trafficking Act 1994 not to report as soon as reasonably practicable, *knowledge or even a suspicion* that a person is involved in drug money laundering. This refers specifically to knowledge or suspicion gained in the course of a person's employment. Section 8 of the Misuse of Drugs Act 1971 also refers.

55. While there is no general legal requirement upon care staff to assist police investigations, it is important to note on the health side that no medical or health care immunities have been granted**.** It follows that general statutory duties to supply information (such as those placed on “any person”) apply to all staff.

56. Whenever possible senior managers should be involved in the consideration and any decision to disclose information to the police. For the NHS the relevant senior manager is the Caldicott Guardian. Unless the situation is urgent, information should not be disclosed to the police without the police providing a Section 29 certificate which gives authority for personal data to be disclosed for the purposes of prevention or investigating a crime. When managers are asked for information by the police they should consider all relevant factors including the nature of suspicion/evidence/offence/allegation, the medical and other history and the public interest. In an emergency staff will have to make a professional judgement on whether to grant the police access to the information. The arrangements should be agreed with the local police, should also be well publicised within the setting and brought to the notice of all concerned*. (Appendix 1 offers case examples on disclosure of information).*

57. It is important that all staff be clear about individual confidentiality in situations involving drugs. In particular staff should be aware of the exemptions to the confidentiality provisions of the Data Protection Act 1998 which allow confidential information to be shared for the purposes of preventing or detecting crime and for the apprehension or prosecution of offenders.

## Offences on facility premises

58. Under the Misuse of Drugs Act 1971 (particularly, but not exclusively Section 8) those in charge of premises have a responsibility to inform the police if they believe that anyone is committing an offence on their premises. Managers may be liable to prosecution if they allow such activity to take place on their premises. It would be useful if all those in contact with the setting and service were advised of these legal requirements in clear terms. *All concerned will wish to be aware of the background and progress with the "Wintercomfort" case. Wintercomfort is a Cambridge based charity providing day care and support. In 1999 eight drug dealers were convicted for trading heroin at the Wintercomfort day centre. The owner and manager were also arrested (under the provisions of the above mentioned Section 8) and were later convicted with "knowingly permitting or suffering the supply of a Class A drug", notwithstanding the authorities accepting that they had not been involved in, or benefited from, the dealing.*

## Drugs and alcohol screening

59. While drugs and alcohol screening can be a helpful part of the assessment process and in developing treatment plans, individuals need to be told why the tests are being conducted and what action will be taken on the results.

60. Samples of saliva, urine, blood or hair for screening purposes can only be obtained with the individual's informed consent (receipt of which should be recorded in writing). The individual should always be told that the purpose is for drug screening. Sampling can be unreliable. The "oral/boccul" test offers a further screening option. Validation of the source and time of sampling are important issues and need to be managed sensitively. Care should be taken that the sample is pure, uncontaminated and reliably labelled (with the individual's name, the date and time of sampling, details also of the person receiving and sealing the sample etc). The results either way will inform discussions and decisions on therapeutic interventions. The provisions of the Adults with Incapacity Act will apply for those too ill to give informed consent. The need for a local protocol agreed with all concerned is shown here.

61. Testing may be particularly beneficial in cases of known or suspected drug or alcohol misusers as part of their agreed individual care plan. There will be treatment and wider management and others considerations to be made in terms of results shown

## Destruction/safe disposal of drugs

62. It is good practice to destroy illegal drugs (safely and under supervision) that are not handed to or required by the police. Regulation 26 of the Misuse of Drugs Regulations 2001 states that such drugs may only be destroyed with the authority of, in the presence of and in accordance with any instructions given by an authorised person (as defined in the regulations). Local pharmacist and police advice is recommended in every case.

63. The local Pharmacist should be involved in developing a protocol for cases where drugs are to be legitimately destroyed. The protocol should be prepared in accordance with Regulation 26 which requires the written record to include:

- Particulars of the date of destruction;
- The quantity destroyed; and
- The date and signatures of all concerned with the disposal and the authorised witness person.

64. Substances suspected of being Schedule 1 Controlled Drugs (Misuse of Drugs Regulations 2001) should be handed to the police for disposal a detailed record of such transactions should also be maintained. Police advice should be sought where doubt exists over the legitimacy of possession of a prescribed drug.

**Other Drugs**

65. The destruction of any other drugs in terms of the locally agreed policy must be recorded and be signed and dated by all involved including the senior member of staff in whose presence the drug is destroyed.

**Statutory defence to a charge of unlawful possession**

66. Section 5(4) of the Misuse of Drugs Act 1971 provides the circumstances for a defence for staff who take possession of an individual's illegal drugs.

67. The Section provides only two exceptions; that it shall be a defence for the accused to prove that s/he took possession of a controlled drug to prevent another committing a crime or for the purpose of delivering it into lawful custody. (The Royal Pharmaceutical Society GB guide is helpful here).

68. S/he must also prove that as soon as possible after taking possession s/he took all such steps as were reasonably open to him/her to destroy the drug(s) or to deliver to lawful custody as appropriate to circumstances.

**Returning confiscated items**

69. Confiscated non-prescribed controlled drugs should **never** be returned. Other confiscated substances legitimate outwith the facility (drugs previously prescribed, medication bought over the counter and alcohol) cannot be destroyed without the owner's informed and express consent (which should be recorded). Alternatively such items should be returned to the owner at the time of discharge. Advice should be given to the owner if concerns attach to the amount or type of items returned.

**Increased surveillance and security**

70. Discharge or transfer may not always be possible or appropriate despite abuse of the facility rules. In such cases treatment and care plans should be re assessed with a view to any necessary added vigilance and supervision required. Precipitate discharge or transfer should not be undertaken lightly. However, if the point is reached where discharge or transfer is becoming the only realistic option every step

should be taken in advance of the final decision with regard to continuing care and support necessary to maintain the individual after transfer/discharge. Such pre-planning must include the GP, Housing Agency, Social Services, family/carer. For restricted patients this extends also to the Scottish Executive and other necessary agencies as part of a whole person care package.

**Management of those found in possession**

71. If an individual is suspected of or found taking illegal substances the first concern must be treatment and safety. Local policies should ensure that the physical and mental health of the individual be re assessed immediately in the light of the findings**.** The responsible medical officer, the Community Psychiatric Nurse, the care co-ordinator, the local treatment service and other relevant parties should meet without delay to discuss and agree the most appropriate forward care plan.

72. The following factors among others will need to be taken into account:

- The individual's mental/physical state and social circumstances;
- The seriousness and extent of the problem, including potential evidence of possession, trafficking, or other offences;.
- The risk of harm to self and others, including child protection issues;
- Relatives and 'Carers' input;
- Future care options if a recurrence including the patient's fitness for transfer to another room/facility/discharge. Such consideration must assess risk (Precipitate discharge or transfer should not be undertaken lightly - see paragraph 70);
- Revised observation and supervision arrangements;
- A review of leave and or visiting arrangements for any detained patient; and
- Police involvement.

**Physical and other security**

73. Significant contribution can be made to the management, security and safety of all in the facility through appropriate staffing levels, training and where possible facility design - see paragraph 76.

**Restriction or exclusion of visitors**

74. Visitors known or suspected by staff of using/selling/conveying illegal drugs in the facility should be reported to the police. Where visitors are refused in advance this should be confirmed in writing to the individual concerned including an explanation of the consequences of contravening the ban. The person to be visited should be informed also.

**Debriefing**

75. All substance and alcohol incidents should be followed by a staff debriefing review incorporating the managerial, security, care and training dimensions. Any concerns about intimidation and reprisals should be examined thoroughly with police advice and involvement sought wherever this is considered appropriate.

## Facility design audit

76. A facility design audit should take place on a regular basis to identify where by design or other means expose to scrutiny those areas hidden from open view. Such reviews should be a regular feature of the facility year and be informed by practice and case experience (the *Risk Management Report (2000)* refers). The audit should also address movement in and out of the facility, if possible (in terms of health and safety and other statutory requirements) limiting entrances and exits to one point. Reception areas enhance the opportunities for control of entrances and help prevent access by unauthorised visitors but also present a vulnerable area for staff the protection of whom should be a priority. The use of dedicated visiting areas, an imaginative use of mirrors, CCTV (though contentious) and lighting are options worth exploring.

## Close

77. As stated earlier the guidance offered here is to inform local practice **not** to dictate it. Local arrangements should however have regard to the range of considerations that have been set out and never compromise the wider and particular legislative arrangements that apply to these important care and safety matters.

**APPENDIX 1**

## Legal Obligations to Disclose Information – Hunter v. Mann

A doctor was prosecuted and convicted for refusing to release information about one of his patients in the case of Hunter v. Mann (1974) 1 Q.B.767. The doctor had been asked by a patient to treat the patient's girlfriend who had been in a car accident. The doctor advised both parties to inform the police, but did not raise the matter of whether he might disclose their identity if approached. He was contacted later by 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 an identification.

## Legal Obligations to Disclose Information – W v. Egdell

Disclosure can be justified if it is considered to be necessary in the public interest. W v. Egdell (1989) 1 All ER1089, involved a 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 Edgell, 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 Edgell, 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 Edgell 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 2**

## Summary of Section 8 of the Misuse of Drugs Act 1971

'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 apply 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, 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 would be argued that a hospital manager, knowing that a patient is smoking cannabis inside a marquee in hospital grounds, will be guilty of an offence contrary to Section 8 (d). Unfortunately, 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 3**

## Meaning of Drug Trafficking

In Section 1(3) of the Drug Trafficking Act 1994 'drug trafficking offence' means any of the following:

a) An offence under Section 4(2) or (3) or 5(3) of the Misuse of Drugs Act 1971 (production, supply and possession for supply of controlled drugs)
b) An offence under Section20 of that Act (assisting in or inducing commission outside United Kingdom of offence punishable under a corresponding law)
c) An offence under:

- Section 50(2)or (3) of the Customs and Excise Management Act 1979 (improper importation)
- Section 68(2) of that Act (exportation)
- Section 170 of that Act (fraudulent evasion)

d) An offence under Section 12 of the Criminal Justice (international Co-operation) Act 1990 (manufacture or supply of substance specified in Schedule 2 to that Act)
e) An offence under Section 19 of that Act (using ship for illicit traffic in controlled drugs)
f) An offence under Section 49, 50 or 51 of this Act or Section 14 of the Criminal Justice (International Co-operation) Act 1990 (which makes, in relation to Scotland and Northern Ireland, provision corresponding to Section49 of this Act)
g) An offence under Section 1 of the Criminal Law Act 1977 of conspiracy to commit any of the offences in a) to f) above
h) An offence under Section 1 of the Criminal Attempts Act 1981 of attempting to commit any of those offences
i) An offence of inciting another person to commit any of those offences, whether under Section 19 of the Misuse of Drugs Act of at common law and includes aiding and abetting, counselling or procuring the commission of any of the offences in a) to f) above.