# Policy and Guidance on the Management of Alcohol and Other Substances Subject to Misuse

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Abbreviations

A&E Accident and Emergency
® Registered trademark
BNF British National Formulary
BP Blood pressure
CD Controlled drug
CMHT Community mental health team
CPA Care programme approach
DOH Department of Health
DTs Delirium tremens
FBC Full blood count
IM Intramuscular injection
IV Intravenous injection
LFT Liver function test
PRN As required
PSI Psychosocial intervention
SSRI Selective serotonin re-uptake inhibitor
SWYPFT South West Yorkshire Partnership NHS Foundation Trust
TFT Thyroid function test
U+E Urea and electrolytes
MI Myocardial Infarction
SPC Summary of Product Characteristics
CNS Central Nervous System
ECG Electrocardiogram
BP Blood Pressure
1. Introduction

This guidance has been written to promote best practice and harmonise practices across the Trust. It has been developed in recognition that substance misuse among the severely mentally ill is commonplace and that mainstream psychiatric services are expected to take the lead responsibility for this service user group. The update is in line with the DOH guide – Dual Diagnosis in mental health in-patient and day hospital settings, 2006.

The guidance is a working document that is structured to be user friendly and auditable. Supporting documents will be referenced and available on each site or on request. Although the guidance should be viewed in its entirety the format enables staff to refer easily to each stand-alone section as required. It forms part of title of document Clinical Management of Service Users with Dual Diagnosis Policy. It acknowledges that across the organisation there are substance misuse services based in Barnsley where staff have more detailed guidance to support their practice.

1.1 Policy statement

The Trust has a responsibility to maintain an alcohol and illicit drug free environment for staff, service users and carers.

This policy provides a framework to assist staff in

1) Preventing and reducing substance misuse on in-patient wards
2) Implementing measures that are safe and effective for the service user, fellow service users, carers and other visitors should substance misuse occur
3) To provide effective care and management of service users who misuse substances, in a safe and therapeutic manner.

The policy recognises the following principles

- The Trust has a legal obligation to prevent substance misuse and substance distribution on their premises (Misuse of Drugs Act 1971)
- Substance misuse is more common (usual, rather than exceptional) amongst people with severe mental health problems and the relationship between the two is complex. Service users with a dual diagnosis often need help to manage their substance misuse problems. Realistic treatment goals need to be set. In the longer term these might focus on reducing the harm caused by substance misuse (in line with a harm minimisation approach) rather than achieving abstinence. In-patient admission may provide an opportunity for detoxification or for a period of abstinence from drugs. For some, however, stabilisation of drug use through substitute prescribing may be the most appropriate option.
- Mental health service users should have their drug and alcohol use assessed by the CPA process. Service users with a dual diagnosis and substance misuse disorder have complex needs including for example personality disorder or chaotic polydrug use.
- Motivational, engagement and harm reduction based care are the most appropriate forms of approach for people experiencing co-morbid substance misuse and severe mental illness on the basis of the current evidence.
• The extent of current substance use and related problems should be explored through screening questions.
• Service users should be asked about their past use of drugs and alcohol. Evidence suggests that self-reporting is, in most cases, a useful tool on in-patient/trust premises.
• The integrity of the care environment and safety of all those within it is of paramount importance. To this end the use of a private company who deploy a dog for the detection of substances has been utilized on occasions with agreement of the Ward Manager/General Manager/Practice Governance Coach/Clinical Lead. We have experience of Alpha Dog Services (07502140923); jay.robertson80@yahoo.co.uk and Corporate Search Ltd (07970061056). Please refer to the “The Searching of Patients and their Property” http://nww.swyt.nhs.uk/docs/Documents/171.doc
• The Intensive Home Based Treatment Team/ Approved Mental Health Professional will have determined the primary reason for admission, for treatment of a mental health problem. Detoxification, where necessary, will always be incidental to this.
• Any visitors suspected of having taken drugs or appearing intoxicated through alcohol/drug use will be asked to leave the building immediately, as all alcohol and illicit/non prescribed drug use on the Trust premises by visitors is forbidden.
• Service users should be made aware that alcohol and illicit substances are not permitted on Trust premises and if they do it will be removed and destroyed and the reasons for this explained. This can be achieved by;
  Staff passing on this information verbally
  Each ward/CMHT/unit displaying signs to this effect
  Ward/unit information booklets/leaflets explaining this
  Discussions taking place in ward meetings
  Staff re-iterating this information at key points during admission e.g. when leave is commenced

1.2 Confidentiality

It is important to seek a service user’s consent in sharing information with relatives/carers. There are occasions where it is considered necessary to give information about a service user to relatives without the service user’s consent. This decision should be agreed with the Multi-Disciplinary Team (MDT) and the rationale and agreement documented.

Where drug trafficking takes place it is an offence to fail to disclose to a police officer your suspicions or knowledge. This does not mean health care staff are obliged to conduct an enquiry or prevent trafficking or drug money laundering.

The decision to breach medical confidentiality should take place with the involvement of the clinical team and senior manager and take into consideration all relevant information such as public interest, nature of allegation and clinical issues.

Where a service user is under statutory supervision by the probation service, relevant information can be disclosed on an in-confidence basis, without the service user’s consent if necessary.
1.3 Professional supervision

Clinical supervision and reflective practice for all levels of staff is crucial in supporting them through the problems, challenges and solutions apparent with this service user group. A structured problem solving and coaching approach to practice and service development across agencies and disciplines would foster the development of dual diagnosis networks.
1.4 Definitions

**Substance** - in the context of this policy the term substance refers to illicit drugs, prescribed drugs used in a manner not intended by prescription, alcohol or any other substance used in a harmful manner or with harmful effects. Caffeine and tobacco whilst recognised as potentially harmful are not included.

**Misuse** - denotes problematic use, abuse, dependency, addiction or substance use disorder.

**Dual Diagnosis** - A mental health problem and a substance misuse problem, both of which require some form of intervention, and may or may not have been medically diagnosed.

2. Information leaflet

A substance misuse information leaflet containing legal and therapeutic information has been devised for service users, carers and visitors (see Appendix 4).

A substance misuse information leaflet should be given to all service users and their carer(s) at initial contact and on admission e.g. in A&E; in CMHTs; in early intervention services.

Substance misuse information leaflets should be available on the ward and reception areas of each Trust unit.

3. Assessment of substance misuse

Co morbid mental illness and substance misuse is common. Establishing cause and effect in the short term and even the long term can be difficult or even impossible.

All service users deserve to be treated with respect and should have access to mental health treatment on the basis of their mental health needs not the perceived causes.

3.1 Detection of substance misuse

Studies have shown that up to a third of service users with severe mental illness have significant additional misuse of drugs or alcohol. These prevalence rates may be higher in in-patient settings. Co morbid severe mental illness and substance misuse may be the norm rather than the exception. It is important therefore to have a high index of suspicion for substance misuse in severe mental illness services. Testing for substances does have a place where there is reason to consider that self-reporting may not be accurate.

3.2 Detection of mental illness

In drug and alcohol services approximately half of the clients suffer from mental illness, one in ten of whom have a severe mental illness. Most common though is depression or personality disorder. Screening and an index of suspicion in drug and alcohol services are recommended.
3.3 Ask the service user

The best way of detecting substance misuse is to ask the service user in an open and frank way. Service users will usually reveal their use of drugs and alcohol if asked sympathetically and if assured that negative consequences will not immediately follow. However the user will need to understand the constraints and frameworks we work within. Some degree of knowledge of common drugs using slang can be helpful, but is not vital. Ask the service user to explain any terms that are unclear and remember that slang can vary between various parts of the country and maybe misunderstood or misused by certain service users themselves. It is important to ask the service user about such matters whilst they are on their own and not in the presence of relatives or friends.

3.4 Testing for drugs and alcohol

3.4.1 Illicit drugs

It is not helpful to carry out screening tests without the full consent of the service user. Tests should only be carried out in such circumstances where the service user is incapable of consenting and where knowledge of substance misuse is vital to immediate short-term management (e.g. management of suspected overdose).

Urine toxicology is the recognised standard for detecting illicit drug use. The detection times in urine are significantly greater than detection times in blood and the detection methods are cheaper.

The Trust has approved the use of the “Accusign” urine testing system for the detection of illicit and prescribed substances in urine. This is a “point of care” testing system giving immediate information on the levels of substances present in urine. The system uses a data express reader LSR-2000-P (DXpress Reader) and DOA-252-35 (AccuSign 5-Test HC/OPI/COC/BZO/AMP): These are held at

Wakefield
Trinity
Newton Lodge
Bretton centre
Calderdale
Elmfield House
Elmdale ward
North Kirklees
Ward 18
South Kirklees
Ashdale Ward
Barnsley
Beamshaw Ward

Further information available from
Talat Syed, Chirus Limited, Park House
15-23 Greenhill Crescent, Watford Business Park, Watford
Hertfordshire WD18 8PH
Tel: +44 (0)1923 212744, Mob: +44 (0)7748 653099, Fax: +44 (0)1923 244751
Email: tsyed@chirus.com, Web: www.chirus.com
3.4.2 Alcohol

Alcohol can be detected in urine or via a breathalyser. Longer-term alcohol use can be detected by blood tests such as those of liver function.

3.5 Assessment

A full drug and alcohol history should be taken from all the service users

The 'Alcohol-use disorders identification test' (AUDIT) was the first screening tool designed specifically to detect hazardous and harmful drinking (Saunders et al. 1993). It has been validated in a number of health and social care settings and across a range of drinking cultures (Reinert and Allen 2007). This 10-question screening tool asks about drinking frequency and intensity and covers experience of alcohol-related problems and signs of possible dependence. AUDIT can detect 92% of genuinely hazardous and harmful drinkers and excludes 93% of those who are not. It is regarded as the 'gold standard' screening questionnaire for detecting hazardous and harmful drinking and can be located through the following hyperlink.

http://nww.swyt.nhs.uk/clinical-supervisors/Pages/Resources.aspx

Alcohol dependence affects 7.4% of the general adult population (ONS, 2001) and misuse accounts for up to 21% of all acute psychiatric admissions (Chief Medical Officer’s Report, 2001). Alcohol’s relationship with psychiatric morbidity is complex, as it can be a primary, secondary or independent factor. Alcohol-free assessments are therefore helpful in clarifying diagnosis and furthermore, offer significant therapeutic value.

This should include details of all drugs used, amounts taken, route of administration, equipment used and whether the drugs taken are prescribed or used illicitly. Many drug users will use more than one drug and may drink alcohol to excess in addition to taking drugs. Previous and current contact with treatment services should be noted and corroborated with the substance misuse team.

It is useful to ask all service users how they fund their drug and alcohol use.

Normal alcohol limits
Males can consume up to 21 units of alcohol per week but no more than 4 units in one day
Females can consume up to 14 units of alcohol per week but no more than 3 units in one day

Binge-drinking
(ONS definition)
8 or more units for men and 6 or more units for women on at least one day in the week

Harmful drinking
(ICD-10 definition)
A pattern of alcohol use that causes damage to the mental or physical health of the user

Alcohol dependence
(ICD-10 definition)
A pattern of alcohol use characterised by 3 or more the following symptoms over 1 year: craving, difficulty controlling intake, withdrawal symptoms, tolerance, neglect of alternative pleasures and persistent use despite demonstrable harm
The aim of detoxification is to minimise the severity of withdrawal symptoms and prevent serious complications from developing. Over the past three decades, earlier recognition and prompt treatment have been effective in significantly reducing the associated mortality rate.

Particular note should be taken of drugs already consumed on the day of admission or assessment and if prescribed drugs are taken, of the name of the prescriber and the chemist at which the drugs are collected. Initial assessments should include eliciting questions relating to substance misuse and its harmful consequences.
Validated substance misuse tools are recommended when substance misuse is identified (see web link http://www.smmgp.org.uk/html/guidance.php).

Assessment of harm and motivation are pivotal and must be explored and recorded as discrete items.

**Complications**

These include Wernicke’s encephalopathy, transient hallucinatory experiences, confusion or delirium, toxicity or poisoning, tachycardia, physical trauma, severe tremors, seizures, infected injected sites, blood born viruses such as Hepatitis B, Hepatitis C and HIV. The complications can be dependant on the substance or substances misused.

**4. Management and treatment of substance misuse**

**4.1 Problems associated with co-morbidity**

The short term use of contracts may be helpful in the management of inpatients. It is important that the ward staff and the medical team and the service user fully understand the terms of the contract and are in agreement with it.

In certain circumstances service users may be discharged for substance misuse. Recourse to discharge for misuse should be carried out within a prior contract devised by the multidisciplinary team and service user and carer(s).

In certain circumstances it may be counterproductive or conflicting with the Mental Health Act Code of Practice to discharge a service user who has illegally misused substances or used legal substances in a harmful manner. Restrictions placed on visitors must be applied if this has a bearing on misuse.

From the Mental Health Act 1983 Code of Practice a visitor may be excluded from a ward on grounds of security. The behaviour of a particular visitor may be, or have been in the past; disruptive to a degree that exclusion from the hospital is necessary as a last resort. An example of such behaviour would be smuggling of illicit drugs/alcohol into the hospital. The decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the service user orally and in writing. Where possible and appropriate the reason for the decision should be communicated to the person concerned.

Drug treatment services can be called for advice on the management of individual service users and drug and alcohol advice in general. The following guidelines are suggested for the management of drug/alcohol users.

Interactions between substances and medication range from no effect, potentiation or diminution to toxic effects. Useful information can be obtained from the BNF Appendix 1: Interactions, the Psychotropic Drug Directory 2014 section 4.7 (S. Bazire) and The Maudsley Prescribing Guidelines 12th Edition, table 6.14. For further information a list of useful pharmacy contact numbers is available in Appendix 4.
4.2 Evidence based interventions

Research indicates PSI in severe mental illness are equally effective in co morbid service users as they are in people who are singularly diagnosed. Using psychosocial approaches are therefore recommended and wards should be supported in building capacity and capability through the PSI strategy group.

Approaches such as motivational interviewing and stage-wise treatment have been effectively applied to this service user group. Motivational interviewing (MI) principles and treatment strategies should be applied as routine. The implied training needs should be addressed within the dual diagnosis and the training and education strategies.

Staff are not expected to carry out PSI or MI until appropriate training has taken place and adequate support/ supervision is established. A local joint training needs approach will ensure these needs are met.

5. Pharmacological guidelines for the treatment of opioid dependency

The following guidance is supplementary to the guidance given by the local Drug Treatment Agencies. It is primarily to manage service users on admission wards. It also gives advice to community services. It is important that the dual diagnosis network for your locality is accessed. See Appendix 4.

Opioid dependency

Guidance is given on the use of methadone, buprenorphine and lofexidine. More information can be found in the Maudsley Prescribing guidelines. Prescribing guidance is also available from the local drug treatment teams.

5.1 METHADONE

See Summary of product characteristics (SPC) for methadone available at www.medicines.org.uk

This is normally used for service users who are currently prescribed methadone or have been accepted for treatment by the local drug treatment agency in accordance with their guidelines (see contact network).

Please liaise with your local specialist services before initiating/ re-titrating methadone/ buprenorphine treatment

5.1.1 Precautions

A number of different studies have shown that opioid detoxification is associated with a high death rate from overdose compared to other treatments. This is related to loss of tolerance to opioids. Opioid detoxification in an inpatient environment may carry with it more risks than outpatient detoxification. The VEdeTTE study (n=10,454), demonstrated that patients who had completed opioid detoxification in an inpatient environment were 4 times as likely to overdose as those who had failed to complete.
It is therefore very important that service users who have undergone inpatient methadone detoxification are given this and other harm reduction information on discharge.

There is considerable research evidence that the first 2 weeks of methadone treatment is a time of increased risk due to methadone toxicity. After this time, the risk of death due to opioid overdose during maintenance treatment falls to very low levels.

Risk factors for overdose during methadone induction:

- Low opioid tolerance
- Use of CNS depressants including alcohol and benzodiazepines
- Too high an initial dose
- Increases in dose that are too rapid
- Slow methadone clearance

Opioids induce respiratory depression and hypoventilation and sedative drugs (including alcohol) potentiate this effect.

With methadone, toxicity is delayed at least several hours after exposure and often after several days of treatment. The reason for the delayed toxicity is methadone’s long and variable half-life, measured at between 13 and 50 hours with chronic administration. Variation can occur between individuals and within an individual.

It takes 5 half-lives, or 3 to 10 days, for patients on a stable dose of methadone to reach steady-state blood levels. The slower it is cleared, the longer this process takes.

To minimise the risk of toxicity you require:

- Careful initial assessment
- Identification of high risk patients
- Avoiding too high starting doses
- Avoiding too rapid dose increases
- Frequent monitoring during induction
- Supervised consumption
- Alerting patients and carers to the early signs of overdose

5.1.2 Side effects and precautions

As little as 40-50ml of methadone may produce coma and respiratory depression in a non-tolerant adult. There can be significant inter-individual variability in sensitivity to respiratory depression in opioid tolerant patients.

Withdrawal symptoms are often uncomfortable and can cause distress. Side effects associated with methadone treatment are:

- Breathing difficulties
- Low blood pressure
- Nausea and vomiting
- Constipation and difficulty urinating
- Drowsiness
- Mood disturbance
Take care when conducting methadone titration concurrently with Chlordiazepoxide-assisted withdrawal from alcohol. Chlordiazepoxide and methadone are both respiratory depressants.

5.1.3 ECG

High doses of methadone have been associated with the occurrence of torsade de pointes through prolongation of the QT interval causing cardiac arrest.

Any patient, who needs a prescribed, daily methadone dosage of 100ml or more should have an ECG done at the commencement of their treatment and a repeat done 2 weeks later.

Other risk factors for prolonged QT interval are as follows:

- Electrolyte disorders – hypokalaemia, hypocalcaemia, hypomagnesaemia
- Congenital or acquired QT prolongation
- Cardiomyopathy – in particular, presence of cardiac failure
- Sinus bradycardia
- Symptomatic rhythm disorders
- Concurrent medication known to prolong QT interval – antiarrhythmics, antipsychotics, antibiotics, antidepressants, antihistamines (N.B. if the patient is taking a medication in any of these groups, check the specific drug in the BNF to see if QT prolongation is a side effect)

Any patient with one or more of these risk factors should have an ECG done on the unit prior to starting methadone and then a repeat, 2 weeks later to check for QT prolongation.

If QT prolongation is present (raised QTc), there should be a further treatment discussion with the patient, informing them of:

- Possible risks of (continued) methadone treatment
- Alternative treatment options e.g. buprenorphine or assisted withdrawal
- Reduction in dose of methadone and repeat ECG

5.1.4 Service user currently prescribed methadone as an in-patient

- Methadone should normally be continued during the admission.
- It is important however that independent checks are made to ascertain whether the service user is being truthful about their treatment regime.
- It is dangerous to prescribe methadone without confirming the dose or seeking expert advice because the dose of methadone prescribed too many long term users would be lethal to a non-tolerant individual.
- Check regular dose prescribed with service user.
- Contact normal prescriber e.g. GP, local agency worker, prescription coordinator.
- Contact the community pharmacy where the service user collects the prescription to confirm the current dose and last collection date.
- Inform the usual community pharmacy and/or local services that the client is currently getting their methadone as an in–patient.
- There have been instances where clients have received both in and out- patient treatments.
• Ensure the usual pharmacy is informed of discharge arrangements.
• When prescribing starts particular note should be taken of any drugs the service user admits to have already used on that day.
• Methadone should usually be prescribed on a once daily basis.
• Normally no more than one day take home supply of methadone will be given on leave or discharge. Other arrangements may be made for weekends and bank holidays.

**Ensure arrangements are made prior to discharge according to the service user’s individual care plan as agreed with the local community substance misuse service in order to facilitate the safe transfer of clinical care.**

### 5.2 BUPRENORPINE

See Summary of product characteristics (SPC) for buprenorphine (Subutex) available at www.medicines.org.uk

This can be used for service users who are currently prescribed treatment or who have been accepted for treatment by the local drug treatment agency in accordance with their guidelines (see contact network). It may also be used for service users who start to have opiate withdrawal symptoms when their opiate intake ceases.

#### 5.2.1 Service user currently prescribed buprenorphine on admission

• Buprenorphine should normally be continued during the admission.
• It is important however that independent checks are made to ascertain whether the service user is being truthful about their treatment regime. Although less dangerous than methadone there can still be problems precipitated by prescribing an inappropriate dose.
• Check regular dose prescribed with service user.
• Contact normal prescriber e.g. GP, local agency worker.
• Contact pharmacy where the service user collects the prescription to confirm the current dose and last collection date.
• Inform the pharmacy that the client is currently getting their buprenorphine as an in-patient.
• There have been instances where clients have received both in and out-patient treatments.
• Ensure the usual pharmacy is informed of discharge arrangements
• When prescribing starts particular note should be taken of any drugs the service user admits to have already used on that day. Buprenorphine can precipitate opiate withdrawal symptoms in service users who have recently used opiates (6 to 12 hours for heroin, 24 hours for methadone).
• Buprenorphine should not be given more frequently than once a day. Some service users are stabilised on 2 day or 3 day regimes. Daily doses range from 12mg -24mg. Maximum single daily dose is 32mg.
• The service user must be supervised taking the buprenorphine, it is given sublingually and takes between three to eight minutes to dissolve.
• Normally no more than one dose of buprenorphine will be given on leave or discharge. Other arrangements may be made for weekends and bank holidays.

**Ensure arrangements are made prior to discharge according to the service user’s individual care plan as agreed with the local community substance misuse service in order to facilitate the safe transfer of clinical care.**

NB buprenorphine is not detected in the urine when using standard opiate tests.
5.2.2 Initiating treatment with buprenorphine

Wait 12 hours since last dose of heroin or 24 hours since last dose of methadone – service user should be experiencing features of opiate withdrawal. Commence with an initial buprenorphine dose of between 4mg and 8mg depending on the extent of previous use of opiates. Titrate the dose according to response. Service users can normally be stabilised on doses between 12 -24 mg per day.

Other medication, particularly benzodiazepines should not be prescribed unless the service user was prescribed these on admission.

A long term management plan needs to be discussed as part of the care programme and if the treatment is to continue longer term arrangements need to be made for continued care with the appropriate locality services.

Ensure arrangements are made prior to discharge to ensure continuity of supply with the community-based provider. It is essential that these arrangements are made for the well-being of the service user.

5.2.3 Detoxification using LOFEXIDINE

Lofexidine should only be used where a service user has made an informed and clinically appropriate decision to follow this prescribing regime. This must be noted in the service user’s notes and in the care plan.

See Summary of product characteristics for Lofexidine (Britlofex) available at www.medicines.org.uk

Lofexidine
- reduces the effect of the excess noradrenaline (norepinephrine) in the person’s system during detoxification, and therefore reduces the severity of withdrawal symptoms in combination with other medications.
- is not addictive and it reduces the physical withdrawal symptoms.
- will not help with cravings, may cause dizziness, dry mouth and drowsiness.
- if stopped suddenly, may cause dramatic worsening of symptoms.
- can lower BP and can slow pulse (cause bradycardia).
- can cause prolongation of the QT interval.
- is suitable for the detoxification of opiates with a short half-life (heroin, dihydrocodeine) or a long half-life (methadone).

Monitoring
- Check BP and pulse prior to commencing treatment then re-check prior to each dose. If pulse goes below 50 do not give any more lofexidine until it rises and review dose regimen. If there is a marked reduction in BP do not give any more lofexidine until BP returns to near normal and review the dose regimen.

Starting dose 0.2mg (one tablet) four times per day increasing to a maximum three tablets four times per day and then gradually reduced to nothing. This is an example of a typical treatment regime.
<table>
<thead>
<tr>
<th>Day of detox</th>
<th>Morning Number of tablets</th>
<th>Lunchtime Number of tablets</th>
<th>Teatime Number of tablets</th>
<th>Night Number of tablets</th>
<th>Total Number of tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>1 (0.2mg)</td>
<td>1 (0.2mg)</td>
<td>1 (0.2mg)</td>
<td>1 (0.2mg)</td>
<td>4</td>
</tr>
<tr>
<td>Two</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Three</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Four</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Five</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Six</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Seven</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Eight</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Nine</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Ten</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

This may be varied for individual clients needs. Doses should be given at least four hours apart. Doses should be administered according to client need over the 24 hour period e.g. on awakening.

Other medication may be prescribed on an as required basis (PRN). Nitrazepam 5-10mg at night for insomnia
Diazepam 10mg up to three times daily for anxiety and restlessness
Buscopan (hyoscine butylbromide) 10mg up to four times daily for abdominal cramps
Loperamide One or two capsules up to four times daily for diarrhoea
Paracetamol Two 500mg tablets every four to six hours up to four times daily if needed for pain relief.

5.2.4 Out of hours access/prescribing of Methadone/Buprenorphine

- Access is not available for these drugs outside normal pharmacy opening hours to patients newly admitted to an acute admission ward across the Trust, due to potential risks in relation to duplicate prescribing/consumption and serious risk of overdose.
- The ward team are expected to make alternative arrangements which could include confirming the ordinary prescribed dose as soon as the community pharmacists is open, and/or accompanying the individual to attend the extended hours community pharmacy if the patient is already attending for daily dispensing, and/or accompanying the patient to their home address to pick up their existing supplies.
- Where the patient is experiencing moderate/severe agitation, witnessed by the ward team, it may be appropriate to prescribe symptomatic relief using the above formulary, as 5.1.3, until a review of the patient has been carried out by the team following the framework of the Clinical Management Service Users with Dual Diagnosis and/or confirmation from the community drug services has been received.

6. Service users using stimulants

People who use stimulants (amphetamines or cocaine) will not usually show a true withdrawal syndrome though they may exhibit intense drug craving behaviour and can become quite depressed. Specialist advice should be sought if either of these
behaviours poses a problem for management (see contact/network directory).

Substitute prescribing of dexamphetamine is rare and is not supported by good clinical evidence. Therefore its use is not supported by the Trust. For further information please see Royal College of General Practitioners Guidance for working with Cocaine and Crack users in Primary Care.

7. **Pharmacological guidelines for the treatment of alcohol withdrawal**

The aim is to facilitate “emergency treatment” to clients who need to undertake alcohol detoxification in order to prevent harm. The treatment of choice is chlordiazepoxide. Oxazepam may be considered for service users with impaired liver function as it has a shorter half-life and may prevent build up in the system and excessive sedation. Please consult your local pharmacist for advice.

7.1 **Delirium Tremens**

Delirium tremens (DT’s) is a toxic confusional state that occurs when alcohol withdrawal symptoms are severe, and is often associated with medical illness. It is a life threatening condition with a mortality rate of 5%. The classic triad of symptoms includes:

- Clouding of consciousness and confusion
- Vivid hallucinations affecting every sensory modality
- Marked Tremor
- Other clinical features may include: Paranoid delusions, agitation, sleeplessness, Autonomic hyperactivity (tachycardia, hypertension, sweating and fever.)

Symptoms of DT’s typically peak between 72-96 hours after last consuming alcohol. Prodromal symptoms usually include night-time insomnia, restlessness, fear and confusion.

Treatment of DT’s requires early diagnosis and prompt transfer to the general medical setting where IV Diazepam can be given, medical disorders treated, fluids given and IV Perenteral B-complex (Pabrinex) can be given.

7.2 **Detoxification using CHLORDIAZEPoxide**

Over the initial phase of admission, up to 48 hours, chlordiazepoxide is to be written up on an as required basis. Up to 120mg oral in 10mg - 20mg divided doses in a 24 hour period. If higher doses than 120mg are needed within a 24 hour period, extra doses will need to be written up by the Consultant. Once the service user is stable, a reduction regime can be tailored from how much the person has utilised on an as required basis. See Appendix 7 – Alcohol Detoxification and Vitamin Supplementation Prescription Chart.

7.3 **Detoxification regimes**

The starting dose of Chlordiazepoxide should mirror the patient’s recent daily alcohol consumption as follows:
### 7.3.1 20 UNITS/DAY OR BELOW:

<table>
<thead>
<tr>
<th></th>
<th>8 am</th>
<th>12 pm</th>
<th>5 pm</th>
<th>10 pm</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>20 mg</td>
<td>20 mg</td>
<td>20 mg</td>
<td>20 mg</td>
<td>80 mg</td>
</tr>
<tr>
<td>Day 2</td>
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<td>20 mg</td>
<td>20 mg</td>
<td>80 mg</td>
</tr>
<tr>
<td>Day 3</td>
<td>20 mg</td>
<td>10 mg</td>
<td>20 mg</td>
<td>20 mg</td>
<td>70 mg</td>
</tr>
<tr>
<td>Day 4</td>
<td>10 mg</td>
<td>10 mg</td>
<td>10 mg</td>
<td>20 mg</td>
<td>50 mg</td>
</tr>
<tr>
<td>Day 5</td>
<td>10 mg</td>
<td>10 mg</td>
<td>10 mg</td>
<td>10 mg</td>
<td>40 mg</td>
</tr>
<tr>
<td>Day 6</td>
<td>10 mg</td>
<td>10 mg</td>
<td>10 mg</td>
<td>30 mg</td>
<td></td>
</tr>
<tr>
<td>Day 7</td>
<td>10 mg</td>
<td></td>
<td>10 mg</td>
<td>20 mg</td>
<td></td>
</tr>
<tr>
<td>Day 8</td>
<td>10 mg</td>
<td></td>
<td></td>
<td>10 mg</td>
<td></td>
</tr>
</tbody>
</table>

### 7.3.2 20–30 UNITS/DAY:

<table>
<thead>
<tr>
<th></th>
<th>8 am</th>
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<th>5 pm</th>
<th>10 pm</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>30 mg</td>
<td>30 mg</td>
<td>30 mg</td>
<td>30 mg</td>
<td>120 mg</td>
</tr>
<tr>
<td>Day 2</td>
<td>30 mg</td>
<td>30 mg</td>
<td>30 mg</td>
<td>30 mg</td>
<td>120 mg</td>
</tr>
<tr>
<td>Day 3</td>
<td>30 mg</td>
<td>25 mg</td>
<td>30 mg</td>
<td>25 mg</td>
<td>110 mg</td>
</tr>
<tr>
<td>Day 4</td>
<td>25 mg</td>
<td>20 mg</td>
<td>25 mg</td>
<td>20 mg</td>
<td>90  mg</td>
</tr>
<tr>
<td>Day 5</td>
<td>20 mg</td>
<td>15 mg</td>
<td>20 mg</td>
<td>15 mg</td>
<td>70  mg</td>
</tr>
<tr>
<td>Day 6</td>
<td>15 mg</td>
<td>10 mg</td>
<td>15 mg</td>
<td>10 mg</td>
<td>50  mg</td>
</tr>
<tr>
<td>Day 7</td>
<td>10 mg</td>
<td></td>
<td>10 mg</td>
<td>5 mg</td>
<td>25  mg</td>
</tr>
<tr>
<td>Day 8</td>
<td>5 mg</td>
<td></td>
<td>5 mg</td>
<td></td>
<td>10  mg</td>
</tr>
</tbody>
</table>

### 7.3.3 30–40 UNITS/DAY:

<table>
<thead>
<tr>
<th></th>
<th>8 am</th>
<th>12 pm</th>
<th>5 pm</th>
<th>10 pm</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>40 mg</td>
<td>40 mg</td>
<td>40 mg</td>
<td>40 mg</td>
<td>160 mg</td>
</tr>
<tr>
<td>Day 2</td>
<td>40 mg</td>
<td>40 mg</td>
<td>40 mg</td>
<td>40 mg</td>
<td>160 mg</td>
</tr>
<tr>
<td>Day 3</td>
<td>40 mg</td>
<td>35 mg</td>
<td>40 mg</td>
<td>35 mg</td>
<td>150 mg</td>
</tr>
<tr>
<td>Day 4</td>
<td>35 mg</td>
<td>30 mg</td>
<td>35 mg</td>
<td>30 mg</td>
<td>130 mg</td>
</tr>
<tr>
<td>Day 5</td>
<td>30 mg</td>
<td>20 mg</td>
<td>30 mg</td>
<td>20 mg</td>
<td>100 mg</td>
</tr>
<tr>
<td>Day 6</td>
<td>20 mg</td>
<td>15 mg</td>
<td>20 mg</td>
<td>15 mg</td>
<td>70  mg</td>
</tr>
<tr>
<td>Day 7</td>
<td>15 mg</td>
<td></td>
<td>15 mg</td>
<td>10 mg</td>
<td>40  mg</td>
</tr>
<tr>
<td>Day 8</td>
<td>10 mg</td>
<td></td>
<td>5 mg</td>
<td></td>
<td>15  mg</td>
</tr>
</tbody>
</table>
PRN Chlordiazepoxide 10-20mg should also be prescribed for breakthrough withdrawal symptoms. Adjustment of regular doses may be considered in response to frequent PRN usage or side effects. The maximum cumulative dose of Chlordiazepoxide over a 24 hour period (regular plus PRN) should not need to exceed 250mg where this is thought necessary a consultant in substance misuse must be consulted (The Maudsley Prescribing Guidelines 11th Edition). If higher doses are required, physical observations should be monitored more frequently and senior medical staff should be consulted.

7.4 **Alcohol withdrawal seizures**

Withdrawal seizures may occur during the initial 72 hours of detoxification although the incidence peaks after approximately 36 hours (Raistrick 2000). All patients should be prescribed PRN 10mg *Diazepam* to be given rectally in the event of a seizure.

7.5 **Treatment of Acute Wernicke-Korsakoff Syndrome.**

Detoxification may take place after symptoms of Wernicke’s encephalopathy (see Box 1). These symptoms must be treated with Pabrinex (Parenteral thiamine) urgently. There is a very small risk of Anaphylaxis with IV (intravenous) vitamin supplementation. This is greatly reduced when administered IM (intramuscular) which is the recommended route for the trust. There is one known case of anaphylaxis solely attributable to IM Pabrinex.

**Box 1**

<table>
<thead>
<tr>
<th>Signs/symptoms of Wernicke-Korsakoff Syndrome evident in service users/patients undergoing an alcohol detoxification.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ataxia</td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Poor short term memory disturbance</td>
</tr>
<tr>
<td>Poor mobility altered walking gait</td>
</tr>
<tr>
<td>Ophthalmoplegia</td>
</tr>
<tr>
<td>Hypotension</td>
</tr>
<tr>
<td>Hypothermia</td>
</tr>
<tr>
<td>Coma</td>
</tr>
<tr>
<td>Nystagmus</td>
</tr>
<tr>
<td>Neuropathy</td>
</tr>
</tbody>
</table>

See Appendix 8 - Protocol for Administration of Thiamine of Pabrinex

7.5.1 **When to Use Pabrinex?**

A history of heavy drinking over a long period is associated with a deficiency in water soluble vitamins, especially the B vitamins, namely pyridoxine, riboflavin, thiamine and nicotinamide. Inadequate food intake and malabsorption caused by irritation of the gut by alcohol, is also common where there is a history of heavy drinking.
Using the recommended graded response depending on risk as follows:

- Low-risk patients without neuropsychiatric complications who appear and state that they have a reasonable diet – minimum treatment thiamine 300mg daily split doses 100mg tds. This regime is also recommended during alcohol detoxification or periods of high alcohol intake.

- Oral thiamine absorption is limited and evidence suggests that outcome is dramatically improved if parenteral thiamine is given in the form of Pabrinex®. For service users with severe deficiency, ie.
  - Wernicke-Korsakoff’s Syndrome (nystagmus, ophthalmoplegia and ataxia.)
  - DTs
  - Peripheral neuropathy

High-risk patients who present Malnourished Thiamine 250mg daily. One pair of ampoules IM od for 3-5 days.

- Confirmed or strongly suspected diagnosis of Wernicke’s. These patients would be managed within the local acute trust as a medical emergency.

The IM route is preferred and “Pabrinex®” which contains ascorbic acid 500mg, nicotinamide 160mg, pyridoxine hydrochloride 50mg, riboflavin 4mg and thiamine hydrochloride 250mg, is the preferred preparation.

7.5.2 The administration of Pabrinex® should be in the presence of a doctor with resuscitation equipment available.

See Summary of product characteristics for Pabrinex available at www.medicines.org.uk

This comes in two ampoules
For prevention of the above complications a minimum of one pair should be given daily for 3 to 5 days.
For treatment one pair should be given twice daily for 3-7 days, depending on the severity of the underlying deficiency.
The injections should then be replaced by oral administration of thiamine.

Potentially serious allergic reactions may occur during or immediately after administration of Pabrinex®. The MHRA CHM therefore recommends that:

1. Parenteral administration is restricted to those service users in whom it is essential
2. IV should be administered slowly i.e. over 30 minutes (facilities for giving IV injections are not normally available on mental health wards)
3. Facilities for treating anaphylaxis should be available when it is administered (anaphylactic shock packs and instructions for use are available on all in-patient units)
4. Follow the resuscitation policy for your unit.
7.6  Anaphylaxis

7.6.1  Signs and symptoms of anaphylaxis

- Pallor, limpness.
- Upper airway obstruction - swelling of throat and mouth, difficulty in swallowing, speaking and breathing.
- Lower airway obstruction – feeling of tightness in chest, difficulty in breathing with audible wheeze from bronchospasm.
- Cardiovascular - alteration in heart rate. Drop in BP (hypotension) in association with tachycardia; severe bradycardia.
- Skin - rapid development of urticarial lesions, intensely itchy weals anywhere on the body. Generalised flushing of the skin.

Not everyone would necessarily experience all of these symptoms and may experience only mild forms. It is essential to refer to medical staff for further investigation. If there is marked difficulty in breathing or swallowing, and/or a sudden weakness or floppiness call 999.

7.6.2  First line treatment of anaphylaxis for adults and children over 12

See BNF section 3.4.3 Allergic Emergencies

Secure airway
Restoration of BP – lay service user flat and raise the feet
Administer adrenaline intramuscularly
For adults give 500 micrograms (0.5ml adrenaline injection 1 in 1000) by IM injection
Repeat if necessary at 5 minute intervals according to pulse, BP and respiratory function
Oxygen should be administered.

7.7  Other medication that may be prescribed for service users undergoing alcohol detoxification by Consultant when needed

In case of seizures Stat dose: Diazepam Rectal tubes 10mg.

Nausea and vomiting
Prochlorperazine tablets 5mg up to three times daily.
Diarrhoea
- If severe loperamide - 2-4 mgs (one or two capsules) PRN.
Heartburn
Peptac - 10 mls PRN.
Itching
- Check for signs of significant liver disease
Chlorphenamine (chlorpheniramine) - 4 mgs tds.
Headache
- Paracetamol - 1g (2 x500mg) up to four times a day if not contraindicated by liver disease.
Poor sleep
Offer advice regarding sleep hygiene. Consider PRN Zopiclone 7.5mg at night
7.8 Monitoring parameters

On admission monitor
U+Es, calcium and magnesium
FBC, B12 and folate
LFT, TFT
Clotting factors
Serum amylase if indicated
BP, pulse and temperature
Blood glucose.

Get medical attention urgently if glucose, potassium, calcium or magnesium are below normal range as deficiencies leave service users more at risk of seizures and DTs.

Glucose should not be given without prior parenteral B vitamins.

During treatment pulse, BP and temperature should be measured a minimum of twice a day for the first three days.

7.9 Alcohol withdrawal assessment

The assessment scale and care plan are tools to rate the presence or absence of withdrawal symptoms. Over the initial phase of admission, the scale should be used as a tool to administer chlordiazepoxide until withdrawal symptoms are stable and the person is placed on a reducing regime. An example is included at Appendix (CIWA-AI scale)

7.10 Common problems associated with alcohol withdrawals

Many of these symptoms are normal in withdrawals. Initially re-assure the service user they will improve during detoxification. Avoid unnecessary treatment only treat if severe:-

Sleep
See Trust hypnotic policy
- Try sleep hygiene measures.
- If severe consider increasing the night-time dose of chlordiazepoxide for 1-2 days, or extend detoxification.

Appetite
- Encourage diet.
- If underweight consider food supplements and vitamin. Prophylaxis.

Anxiety
- Very common in withdrawals.
- Often resolves after 3-4 days.
- May persist and reveal pre-existent anxiety.
- Consider a licensed treatment with a SSRI, for persistent anxiety after careful review.
Depression
- Very common.
- Majority of depressive symptoms in withdrawal resolve after 2-4 weeks without treatment (90%)
- Monitor for severe / persistent symptoms / suicidal ideation.
- If using an antidepressant consider an SSRI.

Transient hallucinatory experience
- Common, short lived insight retained.
- May herald the onset of DTs / alcoholic hallucinosis.

Alcoholic hallucinosis
- 2nd person / 3rd person / running commentary.
- 2nd delusional system.
- Acute onset, clear consciousness.
- Usually lasts longer than a month. Consider a short course of an antipsychotic.

7.11 Fitness to drive

From the DVLA's guide for medical professionals to help them with enquiries from the public about driving with various conditions, patients should be advised to notify the DVLA (0300 790 680) they may be advised to cease driving until their alcohol and or drug use has been stabilised for a period of up to 1 year.

Alcohol dependence
“A cluster of behavioural, cognitive and physiological phenomena that develop after repeated alcohol use and which include a strong desire to take alcohol, difficulties in controlling its use, persistence in its use despite harmful consequences, with evidence of increased tolerance and sometimes a physical withdrawal state”

Indicators may include a history of withdrawal symptoms, of tolerance, of detoxification(s) and/or alcohol related fits.

Reference to ICD10 F10.2 – F10.7 inclusive is relevant.

Group 1 entitlement ODL – car, motorcycle
Alcohol dependence, confirmed by medical enquiry, requires licence revocation or refusal until a 1 year period free from alcohol problems has been attained. Abstinence will normally be required, with normalisation of blood parameters, if relevant.

Licence restoration
Will require satisfactory medical reports from own doctor(s) and may require independent medical examination and blood tests, arranged by DVLA. Consultant support/referral may be necessary.

Alcohol misuse
There is no single definition which embraces all the variables in this condition but the following is offered as a guide:
“a state which, because of consumption of alcohol, causes disturbance of behaviour, related disease or other consequences, likely to cause the patient, his/her family or society harm now, or in the future, and which may or may not be associated with dependence”

Reference to ICD10 F10.1 is relevant.

Group 1 entitlement ODL – car, motorcycle
Persistent alcohol misuse, confirmed by medical enquiry and/or by evidence of otherwise unexplained abnormal blood markers, requires licence revocation or refusal until a minimum 6 month period of controlled drinking or abstinence has been attained, with normalisation of blood parameters.

Patient to seek advice from medical or other sources during the period off the road.

Ecstasy
NB: Multiple substance misuse and/or dependence – including misuse with alcohol – is incompatible with licensing fitness.

Reference to ICD10 F10.1-F10.7 inclusive is relevant.

Group 1 entitlement ODL – car, motorcycle
Persistent use of or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum 6 month period free of such use has been attained.

Amphetamines
NB: Multiple substance misuse and/or dependence – including misuse with alcohol – is incompatible with licensing fitness.

Reference to ICD10 F10.1-F10.7 inclusive is relevant.

Group 1 entitlement ODL – car, motorcycle
Persistent use of or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum 6 month period free of such use has been attained.

Cannabis
NB: Multiple substance misuse and/or dependence – including misuse with alcohol – is incompatible with licensing fitness.

Reference to ICD10 F10.1-F10.7 inclusive is relevant.

Group 1 entitlement ODL – car, motorcycle
Persistent use of or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum 6 month period free of such use has been attained.

Heroin
NB: Multiple substance misuse and/or dependence – including misuse with alcohol – is incompatible with licensing fitness.
Reference to ICD10 F10.1-F10.7 inclusive is relevant.

Group 1 entitlement ODL – car, motorcycle
Persistent use of, or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum one year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required. In addition favourable consultant or specialist report may be required on reapplication.

**Cocaine**
NB: Multiple substance misuse and/or dependence – including misuse with alcohol – is incompatible with licensing fitness.

Reference to ICD10 F10.1-F10.7 inclusive is relevant.

Group 1 entitlement ODL – car, motorcycle
Persistent use of, or dependence on these substances, confirmed by medical enquiry, will lead to licence refusal or revocation until a minimum 1 year period free of such use has been attained. Independent medical assessment and urine screen arranged by DVLA, may be required. In addition favourable consultant or specialist report may be required on reapplication.

A new offence, to make it easier for the police to arrest drivers who drive after taking illegal drugs or abuse medicinal drugs, came into force in England and Wales on 2 March 2015. (Please refer to, ‘Drugs and Driving: Update’)

http://nww.swyt.nhs.uk/docs/Documents/1079.doc

8. **Staff training**

The diversity of agencies and disciplines working with dual diagnosis service users is considerable and a comprehensive training plan will be required. A list of the primary agencies working with substance misuse is available in Appendix 4.

8.1 **Core skills**

- Staff should be provided with skills in detection of mental illness and substance misuse.
- The majority of staff should be provided with skills in assessment and treatment of mental illness and substance misuse.
- Professional inpatient staff will undertake training in search, identification and disposal of substances.
- An understanding of legal issues (drug legislation and Mental Health Act) and issues of consent and capacity will be required.
- An agreed substance misuse assessment and a dual diagnosis treatment model should be identified to promote a common understanding and language across agencies and disciplines.
- An understanding of risk assessment and risk management will be required. This will include social exclusion, criminality, violence, suicidality and physical health (E.g. Hepatitis B & C and HIV infection).
8.2 Specialist Skills

Staff from each working age adult and medium / low secure inpatient ward should receive specialist skills training in order to provide additional support, supervision and coaching to colleagues (Appendix 4). Specialist skills will include the following:

- Identification and response to any emergency or acute problem.
- Assessment of patterns of substance misuse and degree of dependence/withdrawal problems.
- Assessment of physical, social and mental health problems.
- Consideration of the relationship between substance misuse and mental health problems.
- Development of specialist skills will be overseen by the Drug & Therapeutic trust action group including the dual diagnosis nurse practitioners.
- Consideration of any likely interaction between medication and other substances.
- Assessment of carer involvement and need.
- Assessment of knowledge of harm minimisation in relation to substance misuse.
- Assessment of treatment history
- Determination of individual’s expectation of treatment and their degree of motivation for change.
- The need for, and understanding of, pharmacotherapy for substance misuse
- Use of the Chirus data express reader with Accusign test.
- The use of CPR and identification and treatment of anaphylaxis

All staff should be competent and confident in challenging and negotiating and managing difficult situations.
All staff should be familiar with substance misuse policy and procedure and be aware of sources of support during and following substance misuse incidents.

9. Search, identification and disposal

Please refer to Trustwide Disclosure and Search Policy

Disclosure & Search (Incorporating the searching of service users and their belongings, and banned items)

The internet link is:-
http://www.southwestyorkshire.nhs.uk/content/about/docstore/details.asp?docid=171

The intranet link is:-
http://nww.swyt.nhs.uk/Policies/documents/171.doc

10. Accountable officer for controlled drugs, police liaison and support

Police involvement in the management of risk should be sought when there is suspicion of drug trafficking.
The supply of information to the police by health care staff is a statutory duty where illegal activity has been detected. There is not a legal requirement by staff to assist police investigations however. Issues relating to higher offences such as drugs trafficking must be disclosed directly to the police. Decisions to inform the police should be made after senior management and the multidisciplinary team discussions.

Disclosure of information to the police or any other agency may breach Trust confidentiality. The multidisciplinary team and senior management have a responsibility to decide whether police disclosure is appropriate. **The general manager must be informed if disclosure does not occur.**

HSG (96)18, the NMC Guidelines for Professional Practice, the General Medical Council Guidance on Confidentiality and the Guidance of the Medical Defence Union on Confidentiality support non disclosure where public interest is absent.

Managers have professional responsibility to inform the police if they believe that service users are committing offences on hospital premises under the Misuse of Drugs Act 1971. Managers may be liable to prosecution under Section 8 of the Act if they allow these activities to take place on hospital premises.

**11. Evaluation**

This will be carried out by the Dual Diagnosis Practitioner Group and will include

- Case note audit of dually diagnosed service users regarding assessment and interventions relating to substance misuse.
- Audit of handling and disposal of substances.

**12. References**


Bazire S. The Psychotropic Drug Directory 2014

Crawford V. Co-Existing Problems of Mental Health and Substance Misuse (Dual Diagnosis) A Review of the Relevant Literature. 2001

Department of Health. Dual Diagnosis Good Practice Guide. 2002

Department of Health. Dual diagnosis in mental health in-patient and day hospital settings. 2006

Department of Health Drug Misuse and Dependence – Guidelines on Clinical Management. 1999

Manchester Mental Health and Social Care Trust Policy for Substance Misuse on Psychiatric In-patient wards.
Rethink Dual Diagnosis Toolkit – A practical guide for professionals and practitioners
Turning Point, 2004

Royal College of Psychiatrists. Co-Existing Problems of Mental Health and Substance Misuse (Dual Diagnosis) An information manual. 2002

'The detection of alcohol misusers attending hospital and the management of alcohol withdrawal syndrome and Wernicke's encephalopathy. An evidence based protocol'. Produced by Link Pharmaceuticals and endorsed by the Nursing Council on Alcohol. March 2004

Appendix 1

CALCULATING DAILY UNIT CONSUMPTION

By knowing that 1 unit = 10 ml of absolute alcohol, a patient’s daily alcohol consumption can be worked out easily if the alcohol concentration of the drink consumed is known (patients often know this so ask them):

- e.g. strong cider (8.5% alc/vol) = 8.5 units per litre
- super-strength lager (9% alc/vol) = 9 units per litre = 4 units per 440ml can
- wine (12% alc/vol) = 12 units per litre = 9 units per 750ml bottle

Units of alcohol consumed = alcohol concentration (% alc/vol) x volume consumed (litres)

WHEN TO CONSIDER ALCOHOL DETOXIFICATION

The AUDIT (Alcohol Use Disorders Identification Test) now on RiO should be completed on admission by nursing staff. If considered appropriate a further detailed alcohol history should be taken by the admitting doctor. If the patient is alcohol dependent, alcohol detoxification should be initiated. If this is unclear, Chlordiazepoxide (Librium) 10-20mg PRN should be prescribed alongside regular monitoring for withdrawal symptoms. If withdrawal symptoms become evident, a Chlordiazepoxide (Librium) reducing regime should be commenced.

CIWA-AR (Clinical Institute Withdrawal Assessment for Alcohol) scale should be repeated daily to monitor withdrawal symptoms during alcohol detoxification. A score of 15 or more indicates that the patient may be at increased risk of seizures/confusion unless the patient is elderly in which case the threshold for concern is lower (i.e. a score of 10 or more).

If a patient is inebriated on admission, detoxification should only begin once the signs and symptoms of withdrawal ensue.
Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale

This clinical tool assesses 10 common withdrawal signs. A score of 15 + points means the patient may be at increased risk of alcohol withdrawal effects such as confusion or seizures. Clinicians working with older adults note that a lower cutoff is advisable for older adults, as a score of more than 15 may mean a potential health crisis.

Older adults do not always show withdrawal signs in the same way that younger adults do. For example, older adults may not demonstrate signs of anxiety, shakes, or sweating. Alternatively, the signs may be confused with other medical conditions that the older adult has, such as Parkinson's disease. In other cases, the person may have some degree of cognitive impairment and may not be able to accurately tell you how she or he is feeling. For that reason, monitoring vital signs before withdrawal (and having a baseline of what is normal for this person) and during withdrawal can provide very important information.

Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale

Patient_________________________ Date ___/___/___ Time _____ : _____

y m d (24-hour clock, midnight = 00:00)

Pulse or heart rate, taken for 1 minute:___________ Blood pressure:___________/

______
NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.

0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient’s arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.

0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
ANXIETY — Ask "Do you feel nervous?" Observation.

0 no anxiety, at ease
1 mildly anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.

0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, burning sensations, numbness or do you feel bugs crawling on or under your skin?" Observation.

0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

**AUDITORY DISTURBANCES —** Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"

Observation.

0 not present

1 very mild harshness or ability to frighten

2 mild harshness or ability to frighten

3 moderate harshness or ability to frighten

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

**VISUAL DISTURBANCES —** Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"

Observation.

0 not present

1 very mild sensitivity

2 mild sensitivity

3 moderate sensitivity

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations
HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel as if there is a band around your head?" Do not rate for dizziness or light-headedness. Otherwise, rate severity.

0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"

0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

Total CIWA-Ar score: ________
Rater’s initials: ________
Maximum possible score: 67

This scale is not copyrighted and may be used freely.
Appendix 2

South West Yorkshire Partnership NHS Foundation Trust

Procedure for dealing with suspected illicit substances handed in by or found on a service user on an in-patient unit

Philosophy
Service users with mental health problems co-morbid with substance misuse form a substantial and significant proportion of in-patients. The principle underlying this procedure is to engage the service user in treatment and harm reduction rather than into the criminal justice system. Illicit substances handed in by / found on a service user will be disposed of in accordance with Trust policy.

Procedure
If a substance handed in by / found on a service user is thought to be a suspected illicit substance it should be dealt with by two members of staff as follows:

1. Wear disposal gloves.
2. Retain the substance – exceptions are syringes which must be disposed of in the sharps bin immediately.
3. Place item in a self sealing bag labelled with the following details
   Found by:
   Found in possession of:
   Ward:
   Date ……… Time………
4. Inform the nurse in charge of the ward.
5. Nurse in charge to complete Suspected Illicit Drug Confiscation Form.

6. For small quantities
   a) Place substance in CD cupboard.
   b) In the CDs register designate a page for suspected illicit substances and enter the details as in 3 above.
   c) Inform the ward pharmacist within 24 hours or on the next working day in the case of weekends and bank holidays.

7. Inform bleep holder who will inform the police if necessary (e.g. large quantities / class A drugs).
8. **For larger quantities**
   a) Seal in a designated container and hand to the Police for storage or disposal.
   b) Police and Bleep holder to sign confiscation form.
   c) The police will take possession of suspected illicit substance.

9) The balance between treatment and the pursuit of criminal prosecution should be clear in the care plan. It may be necessary to convene a CPA meeting to determine the course of action.

10) Inform the Consultant at the earliest opportunity.

11) Copies of the confiscation form will be handed to the police (where informed) or Ward Pharmacist and the ward will retain a copy.

12) Complete Health and Safety incident / SUI form.

**Destruction**

☼ Small quantities of suspected illicit substances should be destroyed or disposed of by the ward pharmacist together with the senior nurse on duty. Use the pharmacy department approved de-naturing kit.

☼ The destruction must be recorded and signed by the ward pharmacist. The senior nurse on duty must witness and countersign using the CD register and the confiscation form.

☼ The Senior Manager (on call manager if necessary) must be informed immediately (that working day).
Appendix 3 –

South West Yorkshire Partnership NHS Foundation Trust

Suspected Illicit Drug Confiscation Form

Date:                                                                 Time Found:

Name of Service user or Visitor:                                    Service user’s Hospital Number:

Ward / Department:

Details of suspected illicit substance and circumstances surrounding incident:

Signature of Staff Member (1)…………………………………. Print Name:

Signature of Staff Member (2)…………………………………..Print Name:

Details of disposal:

Signature of pharmacist destroying the substance

Witnessed by                                                   (Senior Nurse on duty)

To be completed by Bleep Holder
Date and time police contacted (if applicable):

Handed to police by (signature / print name):

Receiving police officer (signature / print name):

Copy: (please circle) Ward / Team / Chief Pharmacist / Audit
Appendix 4 – Service User and Visitor Information Leaflet (copy)
Appendix 5 South West Yorkshire Partnership NHS Foundation Trust

Wakefield BDU

Sean McDaid
Nurse Consultant Dual Diagnosis
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP
01924 328666
sean.mcdaid@swyt.nhs.uk

Calderdale BDU

Kevin Parkes
Community Psychiatric Nurse
Lower Valley CMHT
kevin.parkes@swyt.nhs.uk

Sarah Peel
Community Psychiatric Nurse
Calder Valley CMHT
sarah.peel@swyt.nhs.uk

Forensic BDU

Emma Kennedy
Dual Diagnosis Practitioner
Low Secure,
Bretton Centre
Fieldhead
Wakefield
WF1 3SP
emma.kennedy@swyt.nhs.uk

Tom Butler
Community Psychiatric Nurse
Assertive Outreach Team
Thomas.butler@swyt.nhs.uk

Rebecca Gledhill
Community Psychiatric Nurse
Early Intervention Team
Rebecca.gledhill@swyt.nhs.uk

Alexandra Foster and Matt Gilligan
Dual Diagnosis Practitioners
Medium Secure
Newton Lodge
Fieldhead
Wakefield
WF1 3SP
Matt.gilligan@swyt.nhs.uk
Alexandra.foster@swyt.nhs.uk

Kirklees BDU

Adam Barrett
Advanced Practitioner Dual Diagnosis
Adam.barrett@swyt.nhs.uk

Barnsley BDU

Alison Hill
Lead Nurse for Community Mental Health
Alison.hill@swyt.nhs.uk
Pharmacological Advice

<table>
<thead>
<tr>
<th>Barnsley BDU</th>
<th>Senior Clinical Pharmacist, Mental Health, Barnsley</th>
<th>01226 435801</th>
<th><a href="mailto:Mohammad.fazlee3@swyt.nhs.uk">Mohammad.fazlee3@swyt.nhs.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mohammad Fazlee</td>
<td>Seni</td>
<td>01226 435801</td>
<td><a href="mailto:Mohammad.fazlee3@swyt.nhs.uk">Mohammad.fazlee3@swyt.nhs.uk</a></td>
</tr>
<tr>
<td>Ruth Lister</td>
<td>Senior Clinical Pharmacist, Community/Hospice Care, Barnsley</td>
<td>01226 435801</td>
<td><a href="mailto:Ruth.lister@swyt.nhs.uk">Ruth.lister@swyt.nhs.uk</a></td>
</tr>
<tr>
<td>Service Manager: Sarah Hudson, Lead Pharmacist, Barnsley</td>
<td></td>
<td><a href="mailto:sarah.hudson@swyt.nhs.uk">sarah.hudson@swyt.nhs.uk</a></td>
<td>01226 434649</td>
</tr>
<tr>
<td>Calderdale and Kirklees BDU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bash Fazlee</td>
<td>Senior Clinical Pharmacist, The Dales</td>
<td>01422 222933</td>
<td><a href="mailto:Mubashhir.fazlee@swyt.nhs.uk">Mubashhir.fazlee@swyt.nhs.uk</a></td>
</tr>
<tr>
<td>Ian Grace</td>
<td>Senior Clinical Pharmacist, South North Kirklees</td>
<td>08448 118110</td>
<td><a href="mailto:Ian.grace@swyt.nhs.uk">Ian.grace@swyt.nhs.uk</a></td>
</tr>
<tr>
<td>Sharon Oliver</td>
<td>Senior Clinical Pharmacist, South Kirklees</td>
<td>01484 434602</td>
<td><a href="mailto:Sharon.oliver@swyt.nhs.uk">Sharon.oliver@swyt.nhs.uk</a></td>
</tr>
<tr>
<td>Service Manager: Diane McGowan, Principal Pharmacist, Calderdale &amp; Kirklees</td>
<td></td>
<td><a href="mailto:diane.mcgowan@swyt.nhs.uk">diane.mcgowan@swyt.nhs.uk</a></td>
<td>01484 434602</td>
</tr>
<tr>
<td>Forensic and Wakefield BDU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katie Crowe</td>
<td>Senior Clinical Pharmacist, Forensics</td>
<td>01924 328691</td>
<td><a href="mailto:Katie.crowe@swyt.nhs.uk">Katie.crowe@swyt.nhs.uk</a></td>
</tr>
<tr>
<td>Mark Payne</td>
<td>Senior Clinical Pharmacist, Wakefield</td>
<td>01924 328691</td>
<td><a href="mailto:Mark.payne@swyt.nhs.uk">Mark.payne@swyt.nhs.uk</a></td>
</tr>
<tr>
<td>Service Manager: Paul Hardy, Principal Pharmacist, Wakefield &amp; Forensics</td>
<td></td>
<td><a href="mailto:paul.hardy@swyt.nhs.uk">paul.hardy@swyt.nhs.uk</a></td>
<td>01924 328691</td>
</tr>
<tr>
<td>Specialist Services BDU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please contact the senior clinical pharmacist within the geographical area that your service sits.</td>
<td></td>
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</tr>
</tbody>
</table>
Local Services Kirklees and Calderdale

Please see
A directory of services for Drugs and Alcohol in Kirklees 2004/5

On the units in Dewsbury and Huddersfield you will see a leaflet from Kirklees DAT
A directory of services for Drugs and Alcohol in Kirklees

**Lifeline Adult Drug Services**

<table>
<thead>
<tr>
<th>Address</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 Station Street</td>
<td>3 Wellington Street</td>
</tr>
<tr>
<td>Huddersfield</td>
<td>Dewsbury</td>
</tr>
<tr>
<td>HD1 1LZ</td>
<td>WF13 1LY</td>
</tr>
<tr>
<td>Tel 01484 35333</td>
<td>Tel 01924 438383</td>
</tr>
</tbody>
</table>

**Alcohol Services**

<table>
<thead>
<tr>
<th>Address</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 St Peters Street</td>
<td>15 Union Street</td>
</tr>
<tr>
<td>Huddersfield</td>
<td>Dewsbury</td>
</tr>
<tr>
<td>HD1 1RA</td>
<td>WF13 1BG</td>
</tr>
<tr>
<td>Tel 01484 437907</td>
<td>Tel 01924 486170</td>
</tr>
</tbody>
</table>

**Young people drug and alcohol services**

- The Base
- 2 Spring Bank
- New North Road
- Huddersfield
- HD1 5NB
- Tel 01484 541589.

**Kirklees Drug Action Team**

NHS Kirklees
Kirkgate Building
Byram Street
Huddersfield
West Yorkshire
HD1 1BY
01484 221671

**Calderdale**

Developing Initiatives for Support in the Community (DISC)

Calderdale Recovery Steps
St. Johns House
2 St. Johns Lane, Halifax
HX1 2JD
Tel: 01422 415550
Local Services Wakefield

From 1st April 2015 the new Integrated Substance Misuse Service for Wakefield is called Inspiring Recovery. The general switchboard is contacted through 03001231912; Option 3 and then

Option 1;

- **Inspiring Recovery Wakefield**
  Grosvenor House 8-20
  Union Street Wakefield
  WF1 3AE

Option 3;

- **Inspiring Recovery South Kirkby**
  Former Staff Houses 1 & 2 Rear of Langthwaite House Langthwaite
  Business Park South Kirkby
  WF9 3AE

Option 2;

- **Turning Point Castleford** 4-6
  Wesley Street Castleford
  WF10 1AE

Barnsley Substance Misuse Services

**Barnsley Drug and Alcohol Action Team (DAAT)**
Joint Commissioning Adults and Communities
PO Box 679
S70 9JE
01226 774956

**Phoenix Futures**
9-10 Burleigh Court,
Burleigh St.,
Barnsley.
S70 1XY
Tel. 01226 779066/ 08454 561 079
Take all professional referrals

**Phoenix Futures – Widening Horizons**
Henry Windsor House,
13 Pitt St.,
Barnsley.
S70 1AL.
Tel. 01226 329688
Run a structured day programme.
Addaction
John St.,
Barnsley.
S70 1LL
Tel. 01226289058
Take self referrals, harm reduction and advice.

Young Addaction
1-3 Regent St.,
Barnsley.
S70 2EG
Tel. 01226 705980
Referrals for under 18 years

Specialist Prescribing Services, SWYFT
1, Burleigh Court,
Burleigh St.,
Barnsley.
S70 1XY
Tel. 01226 7787316
Community drug and alcohol teams, including staff from the Shared care scheme.

Swanswell Carer’s Support
Henry Windsor House,
13, Pitt St.,
Barnsley.
S70 1AL.
Tel. 01226 329686
Appendix 6

Intoxication and Capacity Test in Mental Health Assessment

(This test is to help secure the patient’s safety, even if they are intoxicated.)

1. Does the person appear intoxicated? Yes/No
   Evidence – slurred speech / smell of alcohol / unsteady gait / other /(no smell of alcohol=no intoxication with alcohol)
   ………………………………………………………………………………………………………………………………………………………………

2. What does the person say they have taken?
   ………………………………………………………………………………………………………………………………………………………………
   ………………………………………………………………………………………………………………………………………………………………

3. Consent to provide Alcohol Breathalyser Test? Yes/No
   If yes, result indicates score …………………………………………………………………………………………………………………
   Drink drive limit / stupor / refused (Please circle) / other: ………………………………

4. Consent to illicit urine drug test? Yes / No
   If Yes, Positive Results (Please circle) / Cannabis / Amphetamine / Cocaine

5. Can the person maintain a 3 to 4 minute conversation without repetition? Yes / No

6. Spacial awareness – Can the person complete a three order command?
   (for example, print / write on a piece of paper – ‘fold this paper in half and place it on the floor’) Yes / No

7. Can the person retain information? Yes / No
   Provide (non-complex) information and ask the person to repeat after a few / five minutes, for example a made up name and address

8. Can the person understand information after a few minutes? Yes / No

   Check the understanding after ‘a few’ minutes (MCA,2005)
   The person should be able to retain and communicate / give a rough explanation of the information and weigh up the information that was explained
   (Use open questions to avoid yes / no responses)

9. Can the person give a rough explanation (Communication) of the information given? Yes / No

   Only one of the four elements required (understand, retain, weigh-up or communicate) needs to be absent for the person to lack capacity.

Assessor ……………………………………………………………………………………………………………………………………………………..

Witness ……………………………………………………………………………………………………………………………………………………..

Best Interest – if there is a chance that the person will regain capacity to make a decision, then it may be possible to put off the decision until later, if it is not urgent and an estimation of the timescale when capacity is likely to be regained. (In an emergency this decision would have to be taken immediately)
10. Can a later time to be seen be given because of intoxication? Yes / No

11. What arrangements have been made to secure the patient’s safety between now and reassessment?

12. Later appointment time given was - ..................................................

Outcome .............................................................................................................

Notes

- Serious physical illness (e.g. sub-dural haemorrhage) can mimic or accompany intoxication
- People intoxicated with alcohol present with a lot of alcohol in their stomach and that they often get a lot drunker before they sober up, increasing the risk of respiratory depression
- Pinpoint / dilated pupils may be an indicator of intoxication, but they must be the same size, a difference suggesting a brain injury
- On the spot urine testing kits may vary in their sensitivity and cross reactions may take place (check euromed website). History is much more reliable.
- Ketamine is widely used and can induce a strange dissociated hallucinosis with excitement, but this is almost always accompanied by peripheral numbness, especially of the face

Mental Capacity Act (2005)

Mental Capacity – ‘a person who lack capacity’ is defined as a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. (MCA, 2005)

This may be because they have an illness or condition that means their capacity changes, for example, their ability to make a decision may be affected by the influence of alcohol or drugs. Presumption of capacity involves two stage test stating that

- Does the person have an impairment of the mind or brain or is there some sort of disturbance affecting the way their mind or brain works? (for example, the symptoms of drug or alcohol use)
- If so, does the impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

A person is unable to make a decision if they cannot:

- Understand information about the decision to be taken.
- Retain that information in their mind.
- Use or weigh up that information as part of the decision making process or
- Communicate their decision.
Drug Induced Psychosis Criteria

What is causing the problem? Is it the chemicals in the system or the mental health problem?

Substance induced paranoid or schizophrenic type psychoses have been characterised by paranoid delusions and hallucinations in a person with little clouding of consciousness.

Literature on drug-induced psychosis is extensive, BUT mainly case reports and short controlled studies. A possible classification system has been proposed –

- Intoxication mimicking functional psychosis, for example, substance induced and persists for several days until the substance has cleared the system.
- Psychoactive substances altering the clinical presentation of an existing psychosis, for example, cannabis or amphetamine creating a more aggressive and disturbed person with existing diagnosis of a psychosis / schizophrenia.
- Chronic hallucinations induced by substance abuse, for example, where insight is usually present, no clouding of consciousness, and the hallucination continue despite long-term abstinence, for example, alcoholic hallucinosis, LSD or cannabis flashbacks.
- Substance induced relapse of functional psychosis, for example, schizophrenia being affected by small amounts of substance use (super-sensitivity in certain individuals).
- Withdrawal states, for example, delirium tremens in alcohol withdrawal, benzodiazepine or barbiturate withdrawal.
- Others, for example acute intoxication / confusion with clouding of consciousness, post-intoxication depression, for example, post-amphetamine crash, panic / anxiety from hallucinogens such as cannabis or LSD.

“There’s surprisingly little, if any, proof that such a causal link can be made firmly between substance use and later psychosis.”
Appendix 7  **Alcohol Detoxification and Vitamin Supplementation Prescription Chart**

Attach to main drug chart and write in the next free regular drug box of the chart that an alcohol detoxification chart is in use. Indicate that an additional chart is in use in the front of the main chart.

Trust guidelines on the management of alcohol and other substances subject to misuse should be read prior to completing this prescription.

<table>
<thead>
<tr>
<th>Patient’s name:</th>
<th>Ward:</th>
<th>RiO/Hospital no:</th>
</tr>
</thead>
</table>

**Malnourished patients at high risk of Wernicke’s encephalopathy:**

**High potency B-complex vitamins, (Pabrinex®)** – One pair of intra-muscular ampoules, daily for 3-5 days. 

*Administer in presence of doctor*

<table>
<thead>
<tr>
<th>Date</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<tbody>
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</tbody>
</table>

**Oral vitamins should be prescribed on the main Drug Prescription and Administration Chart -**

**Thiamine** 100mg TDS, **Multivitamin Tablet** 1 daily, **Vitamin B Compound Strong** 2 tablets TDS, usually all for 3-6 months.

**Chlordiazepoxide**

Over the initial phase of admission, up to 48 hours, chlordiazepoxide is to be written up on a PRN basis on the main medication chart (10-20mg in divided doses over 24 hours, max 120mg). If higher doses are required, a consultant should authorise. Once stable, a reduction regime can be tailored to usage – see the management of alcohol and other substances subject to misuse for example regimes.

<table>
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<tr>
<th>Day</th>
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</tbody>
</table>

**Duration (days)** | **Doctor’s signature** | **Print** | **Date** |
|---------------------|----------------------|-----------|---------|

**Chlordiazepoxide 10 - 20mg orally for ‘breakthrough’ withdrawal.**

(Maximum total dose in 24 hours not to exceed 250mg).

<table>
<thead>
<tr>
<th>Date</th>
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</tr>
</tbody>
</table>

**Diazepam 10mg per rectum ‘as required’ for seizures.**

<table>
<thead>
<tr>
<th>Date</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
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<td>Time</td>
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<td>Dose</td>
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<tr>
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</table>

**Note:**

- Doses are not absolute and may be increased or decreased according to severity of dependence and/or withdrawal symptoms.
- Patients often tolerate an increased rate of reduction.
- Doses should be omitted if patient unexpectedly drowsy – (consider hepatic encephalopathy).
- Nurses must record omitted doses by entering an “O” in the administration record and document the reason in the patient’s notes.
- PRN doses can be given at 2 hourly intervals if required, but should not usually be given beyond the first 48 hours. Subsequent timing.

Adapted from Sussex Partnership NHS Trust
### Auditory (hearing) Disturbances:
Ask “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?”

**Observation**
- 0 not present
- 1 very mild harshness or ability to frighten
- 2 mild harshness or ability to frighten
- 3 moderate harshness or ability to frighten
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

### Visual (sight) Disturbances:
Ask “Does the light appear to be too bright? Is it’s colour different? Does it hurt your eyes? Are you seeing anything that’s disturbing you? Are you seeing anything that you know is not there?”

**Observation**
- 0 not present
- 1 very mild sensitivity
- 2 mild sensitivity
- 3 moderate sensitivity
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

### Tremor:
Arms extended and fingers spread wide apart.

**Observation**
- 0 no tremor
- 1 not visible, but can be felt fingertip to fingertip
- 4 moderate, with patient’s arms extended
- 7 severe, even with arms not extended

### Nausea and Vomiting:
Ask “Do you feel sick to your stomach? Have you vomited?”

**Observation**
- 0 no nausea with no vomiting
- 1 mild nausea with no vomiting
- 4 intermittent nausea with dry heaves
- 7 constant nausea, frequent dry heaves and vomiting

### Paroxysmal Sweats:

**Observation**
- 0 no sweat visible
- 1 barely perceptible sweating, palms moist
- 4 beads of sweat obvious on forehead
- 7 drenching sweats

### Anxiety:
Ask “Do you feel nervous?”

**Observation**
- 0 no anxiety, at ease
- 1 mildly anxious
- 4 moderately anxious or guarded, so anxiety is suggested
- 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic states

### Agitation:

**Observation**
- 0 normal activity
- 1 somewhat more than normal activity
- 4 moderately fidgety and restless
- 7 pacing back and forth during interview, or constantly thrashes about

### Headache, Fullness in Head:
Ask “Does your head feel different? Does it feel like there is a band around your head? Do not rate for dizziness or light-headedness.

**Otherwise, rate severity.**
- 0 not present
- 1 very mild
- 2 mild
- 3 moderate
- 4 moderately severe
- 5 severe
- 6 very severe
- 7 extremely severe

### Tactile (touch) Disturbances:
Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?”

**Observation**
- 0 none
- 1 very mild itching, pins and needles, burning or numbness
- 2 mild itching, pins and needles, burning or numbness
- 3 moderate itching, pins and needles, burning or numbness
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

### Date:

**Time:** 24 hour clock (Hrs)

**Respiratory Rate:** breaths per minute. If <10 inform medical team

**Auditory disturbances (0-7)**

**Visual Disturbances (0-7)**

**Tremor (0-7)**

**Nausea / Vomiting (0-7)**

**Sweats (0-7)**

**Orientation (0-4)**

**Anxiety (0-7)**

**Agitation (0-7)**

**Headache (0-7)**

**Tactile disturbances (0-7)**

**TOTAL SCORE (MAX 67)**

**Rater’s Initial**

---

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised – to be repeated daily to monitor withdrawal symptoms during alcohol detoxification. A score of 15 or more indicates that the patient may be at increased risk of seizures/confusion unless the patient is elderly in which case the threshold for concern is lower (i.e. a score of 10 or more).
Appendix 8
Protocol for Administration of Thiamine or Pabrinex (Parenteral thiamine) to clients undergoing alcohol treatment

1. **Purpose of Guidance**
   This protocol is to provide guidance for use of vitamins in alcohol dependent clients. It applies to the Community Alcohol Team and the Specialist Inpatient Unit, Barnsley NHS. For staff working within primary care settings it is recommended to follow the guidance on oral thiamine only, if Parenteral thiamine is indicated this should be discussed with the alcohol team prior to commencing treatment.

2. **Context**
   Clients, particularly heavy drinkers, who have a high daily intake of alcohol often have a poor diet plus gastric irritation. This can lead to significant vitamin deficiency, in particular thiamine. It is usual to consider vitamin supplements at the point of detoxification regardless of the setting in which the detoxification will take place i.e. community or as an in-patient.

3. **Background**
   Due to the lack of high quality studies surrounding this area, it is inevitable that practices vary across the country, but for the purpose of the protocol the following guidelines have been used.
   
   I. National Treatment Agency;
   II. British Association for Psychopharmacology;
   III. Scottish Intercollegiate Guidelines Network (SIGN)

4. **Evidence**
   Severe vitamin deficiencies may lead to a variety of conditions, Wernicke’s encephalopathy is the most critical.

   Wernicke’s encephalopathy is caused by a deficiency of Thiamine. This condition is commonly seen in heavy drinkers due to poor diet, poor intake of vitamins, poor gastro-intestinal absorption due to gastritis and high demand because the metabolism of alcohol depends upon Thiamine as a co-enzyme. On average 80% of cases are sub-clinical and only 10% present with the classic triad of confusion, ataxia and ophthalmoplegia. It is important to know that Wernicke’s is reversible with high doses of Thiamine, but lack of Thiamine and without immediate and adequate treatment can result in irreversible brain damage known as Korsakoff’s syndrome.

4.1 **Treatment of Acute Wernicke-Korsakoff Syndrome.**
   Detoxification may take place after symptoms of Wernicke’s encephalopathy (see Box 1). These symptoms must be treated with Pabrinex (Parenteral thiamine) urgently. There is a very small risk of Anaphylaxis with IV (intravenous) vitamin supplementation. This is greatly reduced when administered IM (intramuscular). There is one known case of anaphylaxis solely attributable to IM Pabrinex.
Box 1

<table>
<thead>
<tr>
<th>Signs/symptoms of Wernicke-Korsakoff Syndrome evident in service users/patients undergoing an alcohol detoxification.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ataxia</td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Poor short term memory disturbance</td>
</tr>
<tr>
<td>Poor mobility altered walking gait</td>
</tr>
<tr>
<td>Ophthalmoplegia</td>
</tr>
<tr>
<td>Hypotension</td>
</tr>
<tr>
<td>Hypothermia</td>
</tr>
<tr>
<td>Coma</td>
</tr>
<tr>
<td>Nystagmus</td>
</tr>
<tr>
<td>Neuropathy</td>
</tr>
</tbody>
</table>

4.2 **Oral Suspension**

No studies have been found to support oral Thiamine’s effect on memory either in the recovery period of an alcohol dependant patient or patients who continued to drink alcohol on a daily basis. Absorption was lowered when patients continued to drink. The BNF recommended does is 300mg daily.

5. **When to Use Pabrinex?**

Using the recommended graded response depending on risk as follows:

* Low-risk patients without neuropsychiatric complications who appear and state that they have a reasonable diet – minimum treatment thiamine 300mg daily split doses 100mg tds. This regime is also recommended during alcohol detoxification or periods of high alcohol intake.

* High-risk patients who present Malnourished Thiamine 250mg daily. One pair of ampoules IM od for 3-5 days.

* Confirmed or strongly suspected diagnosis of Wernicke’s. These patients would be managed within the local acute trust as a medical emergency.

6. **Route of Administration**

The IM route is preferred due to a lower risk of anaphylaxis. IM route should only be considered if the patient’s INR is within normal range. To minimise the risk of anaphylaxis the following is recommended:

I. Ensure the patient has not previously had any adverse drug reactions.
II. Ensure an anaphylaxis resuscitation pack is available.
7. **Intramuscular Route**
Both ampoules are drawn up together (ampoule marked 1 and 2) total 7mls. Mixture should be carried out just before use. The high potency mixture should be injected slowly high into the gluteal muscle.

Ampoule 1 contains:

- Thiamine Hydrochloride BP | 250mg
- Riboflavin | 4mg
- Pyridoxine Hydrochloride BP | 50mg

Ampoule 2 contains:

- Ascorbic Acid BP | 500mg
- Nicotinamide BO | 160mg

8. **Post Alcohol Detoxifications**
Vitamin B supplements should be considered if there is evidence of cognitive impairment 300mg daily = 100mg tds, vitamin B co strong tds. This is recommended for 3 – 6 months. It is important to consider compliance.

9. **References**


### Clinical Opiate Withdrawal Scale

**RiO:**  
**Date:** / / 

For each item, mark the choice that best describes the patient’s signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase would not add to the score.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Scores</th>
</tr>
</thead>
</table>
| 1. Resting pulse rate | **Pulse rate**  
   - Measured after patient is sitting or lying for 1 minute **bpm** |        |
| 2. GI upset           | Over last ½ hour **No GI symptoms**  
   - Stomach cramps  
   - Nausea or loose stool  
   - Vomiting or diarrhea  
   - Multiple episodes of diarrhea or vomiting |        |
| 3. Sweating           | Over past ½ hour not accounted for by room temperature or patient activity  
   **No report of chills or flushing**  
   **Subject report of chills or flushing**  
   **Flushed or observable moistness on face**  
   **Beads of sweat on brow or face**  
   **Sweat streaming off face** |        |
| 4. Tremor             | Observation of outstretched hands  
   **No tremor**  
   **Tremor can be felt, but not observed**  
   **Slight tremor observable**  
   **Gross tremor or muscle twitching** |        |
| 5. Restlessness       | Observation during assessment  
   **Able to sit still**  
   **Reports difficulty sitting still, but is able to do so**  
   **Frequent shifting or extraneous movements of legs/arms**  
   **Unable to sit still for more than a few seconds** |        |
| 6. Yawning            | Observation during assessment  
   **No yawning**  
   **Yawning once or twice during assessment**  
   **Yawning three or more times during assessment**  
   **Yawning several times per minute** |        |
7. Pupil size
   Pupils pinned or normal size for room light □ 0
   Pupils possibly larger than normal for room light □ 1
   Pupils moderately dilated □ 2
   Pupils so dilated that only the rim of the iris is visible □ 5

8. Anxiety or irritability
   None □ 0
   Patient reports increasing irritability or anxiousness □ 1
   Patient obviously irritable or anxious □ 2
   Patient so irritable or anxious that participation in the assessment is difficult □ 4

9. Bone or joint aches:
   If patient was having pain previously, only the additional components attributed to opiate withdrawal is scored
   Not present □ 0
   Mild diffuse discomfort □ 1
   Patient reports severe diffuse aching of joints/muscles □ 2
   Patient is rubbing joints or muscles and is unable to sit still because of discomfort □ 4

10. Gooseflesh skin
    Skin is smooth □ 0
    Piloerection of skin can be felt or hairs standing on arms □ 3
    Prominent piloerection □ 5

11. Runny nose or tearing:
    Not accounted for by cold symptoms or allergies
    Not present □ 0
    Nasal stuffiness or unusually moist eyes □ 1
    Nose constantly running or tears streaming down cheeks □ 4

The total score is the sum of all 11 items.

**SCORE:**

5-12 = mild
13-24 = moderate
25-36 = moderately severe
more than 36 = severe withdrawal

# Appendix B - Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

**DECEMBER 2015**

**Date of Assessment: __________________________________________**

<table>
<thead>
<tr>
<th>Equality Impact Assessment Questions:</th>
<th>Evidence based Answers &amp; Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Name of the document that you are Equality Impact Assessing</td>
<td>Policy and Guidance on the management of alcohol and other substances subject to misuse.</td>
</tr>
<tr>
<td><strong>2</strong> Describe the overall aim of your document and context?</td>
<td>The Trust has a responsibility to maintain an alcohol and illicit drug free environment for staff, service users and carers.</td>
</tr>
<tr>
<td></td>
<td>This policy provides a framework to assist staff in:</td>
</tr>
<tr>
<td></td>
<td>1) Preventing and reducing substance misuse on in-patient wards</td>
</tr>
<tr>
<td></td>
<td>2) Implementing measures that are safe and effective for the service user, fellow service users, carers and other visitors should substance misuse occur</td>
</tr>
<tr>
<td></td>
<td>3) To provide effective care and management of service users who misuse substances, in a safe and therapeutic manner.</td>
</tr>
<tr>
<td></td>
<td>All staff</td>
</tr>
<tr>
<td><strong>3</strong> Who is the overall lead for this assessment?</td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>4</strong> Who else was involved in conducting this assessment?</td>
<td>Nurse Consultant Dual Diagnosis</td>
</tr>
<tr>
<td><strong>5</strong> Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?</td>
<td>The Policy and Guidance on the management of alcohol and other substances subject to misuse has been produced in partnership with key SWYPFT staff. In addition external members of staff working for partner agencies and a service user volunteer who attend the Trust Wide Drug and Therapeutics Committee have offered additional comments and accuracy checking.</td>
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<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>6</strong> What equality data have you used to inform this equality impact assessment?</td>
<td>As this is a trust wide policy we have included demographics’ for the four areas covered by the trust. People with ‘dual diagnosis’ (severe mental illness combined with misuse of substances) are some of</td>
</tr>
</tbody>
</table>
Equality Impact Assessment Questions: | Evidence based Answers & Actions:
---|---

|  | the most vulnerable in our society. The extent and nature of ‘dual diagnosis’ is poorly understood and may vary according to characteristics protected by the Equality Act 2010: age and race as well as other factors. |

7 What does this data say? | There is a potential for equality issues to be important for particular groups, such as:

- adults or young people who are: homeless or in insecure accommodation, from a low-income family or on a low income, socially isolated, lesbian, gay, bisexual, transsexual or transgender, have been young or former offenders, sex workers, travellers, asylum seekers or refugees, from a minority ethnic group;
- adults or young people who have a learning disability; or
- adults who have a history of being ‘looked after’ or adopted; have a history of experiencing, or witnessing or perpetrating violence or abuse
- young people who: have experienced abuse or witnessed domestic violence and abuse, are ‘looked after’ or adopted, are excluded from school, are teenage parents, have been excluded from school or whose parents have mental health or substance misuse problems.

Prevalence, access to services and outcomes may also vary by geographical location

8 Taking into account the information gathered above, could this policy/procedure/strategy affect any of the following equality group unfavourably: Yes/No Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact.

8.1 Race | No N/A

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Asian</th>
<th>Black</th>
<th>Mixed</th>
<th>Chinese &amp; Other</th>
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</thead>
<tbody>
<tr>
<td>England % av.</td>
<td>85.5</td>
<td>5.1</td>
<td>3.4</td>
<td>2.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Kirklees % average</td>
<td>79.1</td>
<td>15.7</td>
<td>1.9</td>
<td>2.3</td>
<td>0.7</td>
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<tr>
<td>Barnsley % average</td>
<td>97.9</td>
<td>0.7</td>
<td>0.5</td>
<td>0.7</td>
<td>0.2</td>
</tr>
<tr>
<td>Calderdale % average</td>
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<td>7</td>
<td>0.9</td>
<td>1.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Wakefield % average</td>
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<td>2.6</td>
<td>0.77</td>
<td>0.9</td>
<td>0.29</td>
</tr>
</tbody>
</table>

Taken from Census 2011 for each area

It may be perceived as more difficult to achieve outcomes for non-English speakers. (iii)
Equality Impact Assessment Questions:

Black Caribbean Men are five times more likely to be crack users and therefore the ‘carrot’ of substitute medication cannot be used. (2)

BME men are more likely to come into contact with drug services via the criminal justice route. (2)

<table>
<thead>
<tr>
<th>8.2</th>
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</table>

Day to day activities limited by disability

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>A lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>England % av.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kirklees % average</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Barnsley % average</td>
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<tr>
<td>Calderdale % average</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wakefield % average</td>
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</tr>
</tbody>
</table>

Taken from Census 2011 for each area

Individuals with serious mental & physical health problems may have reduced chances of outcome achievement, while being more expensive to treat. (i)

SWYPFT does not currently monitor disability. However we aim to use the equality monitoring forms for all volunteers and this will give us good qualitative data around the take up/needs of volunteers with a disability.

Across Kirklees, 18.4% of people (almost 37,000) identify as having "limiting long-term illness or disability".

Most Trust Venues have disabled facilities such as toilets and access such as lifts and ramps etc. We also have a loop system for people who have hearing impairments which can be loaned to other services.

<table>
<thead>
<tr>
<th>8.3</th>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
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</thead>
<tbody>
<tr>
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<td>50.8</td>
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<tr>
<td>Kirklees % average</td>
<td>49.4</td>
<td>50.6</td>
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<tr>
<td>Barnsley % average</td>
<td>49.1</td>
<td>50.9</td>
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<tr>
<td>Calderdale % average</td>
<td>48.9</td>
<td>51.1</td>
</tr>
<tr>
<td>Wakefield % average</td>
<td>49</td>
<td>51</td>
</tr>
</tbody>
</table>

Taken from Census 2011 data

There is higher prevalence of problem drug & alcohol use among transgender
Equality Impact Assessment Questions: Evidence based Answers & Actions:

- Communities and there may also be additional problems to address (e.g. stigma). This added complexity may reduce the likelihood of clients in this group to achieve required outcomes. (v)

- Women are more likely than men to engage in treatment and achieve outcomes in drug treatment. (ii)

### 8.4 Age

<table>
<thead>
<tr>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>England % av.</th>
<th>0-15</th>
<th>16-29</th>
<th>30-44</th>
<th>45-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.9</td>
<td>18.6</td>
<td>20.3</td>
<td>22.4</td>
<td>16.9</td>
<td></td>
</tr>
</tbody>
</table>

**Kirklees**

| % average     | 15.8 | 18.5 | 20.3 | 22.2 | 15.8 |

**Barnsley (2011 data)**

| % average     | 18.5 | 10.8 | 26   | 20.9 | 23.8 |

**Calderdale**

| % average     | 19.6 | 16.4 | 20.1 | 24.2 | 16.6 |

**Wakefield**

| % average     | 18.4 | 17.2 | 19.6 | 24.2 | 17.6 |

Taken from Census 2012 data unless specified

It is reasonable to assume that the older the service user, the more likely they are to have been unsuccessfully in treatment previously. Evidence shows that the more treatment episodes an individual has undertaken, the less likely they are to achieve positive outcomes. (iv)

### 8.5 Sexual Orientation

<table>
<thead>
<tr>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>England % av.</th>
<th>Living in a civil partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.01</td>
<td></td>
</tr>
</tbody>
</table>

**Kirklees**

| % average | 0.01 |

**Barnsley (2011 data)**

| % average | 0.2 |

**Calderdale**

| % average (2011 data) | 0.3 |

**Wakefield**

| % average | 0.01 |

Taken from 2012 census data unless specified

There is higher prevalence of problem drug & alcohol use among lesbian, gay and bisexual communities and there may also be additional problems to address (e.g. stigma). This added complexity may reduce the likelihood of clients in this group to achieve required outcomes. (vi)

We need to do some further work around having accurate stats for the Kirklees/Wakefield areas of the trust.
<table>
<thead>
<tr>
<th><strong>Equality Impact Assessment Questions:</strong></th>
<th><strong>Evidence based Answers &amp; Actions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no accurate available data. However, national estimates indicate that 5 to 7% of people are gay, lesbian or bisexual (Stonewall, 2009)</td>
<td></td>
</tr>
<tr>
<td><strong>Kirklees</strong></td>
<td>Based on national data, between approx. ? people are gay, lesbian or bisexual in Kirklees.</td>
</tr>
<tr>
<td><strong>Barnsley</strong></td>
<td>Based on national data, between approx. 11,700 and 16,400 people are gay, lesbian or bisexual in Barnsley.</td>
</tr>
<tr>
<td><strong>Calderdale</strong></td>
<td>Based on national data, between approx. 10,300 and 14,400 people are gay, lesbian or bisexual in Calderdale.</td>
</tr>
<tr>
<td><strong>Wakefield</strong></td>
<td>Based on national data, between approx. ? people are gay, lesbian or bisexual in Wakefield.</td>
</tr>
<tr>
<td>The Trust has been awarded the rainbow tick-Gold Award is aware of the LGBT networks across it areas. The Trust will use the Rainbow tick in its programme to support LGBT and raise awareness within all aspects of volunteering.</td>
<td></td>
</tr>
<tr>
<td>The Trust is developing a guidance document which will include best practice in supporting people from the LGBT community.</td>
<td></td>
</tr>
</tbody>
</table>

### Religion or Belief

<table>
<thead>
<tr>
<th>England % av.</th>
<th>Christian</th>
<th>Buddhist</th>
<th>Hindu</th>
<th>Jewish</th>
<th>Sikh</th>
<th>Muslim</th>
<th>Other</th>
<th>No religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kirklees % average</td>
<td>67.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.1</td>
<td>0.7</td>
<td>10.1</td>
<td>0.2</td>
<td>14</td>
</tr>
<tr>
<td>Barnsley % average</td>
<td>59.4</td>
<td>0.5</td>
<td>1.5</td>
<td>0.5</td>
<td>0.8</td>
<td>5</td>
<td>0.4</td>
<td>24.7</td>
</tr>
<tr>
<td>Calderdale % average</td>
<td>60.6</td>
<td>0.3</td>
<td>0.3</td>
<td>0.1</td>
<td>0.2</td>
<td>7.8</td>
<td>0.4</td>
<td>30.2</td>
</tr>
<tr>
<td>Wakefield % average</td>
<td>66.4</td>
<td>0.16</td>
<td>0.25</td>
<td>0.04</td>
<td>0.12</td>
<td>2.0</td>
<td>0.3</td>
<td>24.4</td>
</tr>
</tbody>
</table>

Taken from 2011 Census data

Religious beliefs may prove a barrier to people discussing substance misuse or accessing treatment. (vii)

We are developing rooms within our main buildings that will have a multi-faith room with access to all. This will be made available via our booking diary to those who wish to pray or have some quiet time as part of their faith or spiritual beliefs.

The Trust has strong links with Bethany Trust and the Urban Retreat at Chickenley regular communication with Chaplains from various faiths.
### Equality Impact Assessment Questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Evidence Based Answers &amp; Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.7 Transgender</td>
<td>No</td>
</tr>
</tbody>
</table>

There is higher prevalence of problem drug & alcohol use among transgender communities and there may also be additional problems to address (e.g. stigma). This added complexity may reduce the likelihood of clients in this group to achieve required outcomes.

National figures estimate that there should be between 17 and 50 Tran’s individuals in each area covered by the trust. The ratio of trans-women (i.e. male to female) to trans-men (female to male) is 4:1 which is consistent with previous studies.

*The trust is currently developing a guide for services with tips on how to be ‘lgbt friendly’ which has been created off the back of the Trust gaining the ‘Rainbow Tick’ award. Also available is a trans-awareness e-learning package and a bank of information on the intranet. Both staff and volunteers are encouraged to access this information.*

### 8.8 Maternity & Pregnancy

Pregnant women may find it easier than others to access services, as they are more likely to achieve positive outcomes.

### 8.9 Marriage & Civil partnerships

<table>
<thead>
<tr>
<th></th>
<th>Married</th>
<th>Single</th>
<th>In a [registered] civil partnership</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Separated</th>
</tr>
</thead>
<tbody>
<tr>
<td>England % av.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kirklees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barnsley</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calderdale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wakefield</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 8.10 Carers*Our Trust requirement*

Three people in every five will be a carer at some point in their life. A carer of any age spends a significant proportion of his or her life providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. Full time caring can lead to breakdown of social networks and isolation. Carers form the mainstay of any preventive approach to community support. As the population ages, effective support for carers to enable them to continue in their caring role will be critical.

**Kirklees**

Locally in 2008:

- Over 38,000 adults or 1 in 8 (12%) of the adult population in Kirklees were carers.
Equality Impact Assessment
Questions:

- By 2037 the numbers of carers are set to rise by 60%, to 64,000 locally.
- Carers locally in 2008 were more likely to have poorer health functioning, especially pain and depression.
- They were less likely to have a job, with less than 1 in 3 of those aged under 65 employed and many of those were restricted to part time work.
- Only 1 in 8 received a Carer's Allowance.
- 1 in 6 (17%) of those aged 45-64 were carers, compared with 1 in 8 (13%) of those aged over 65 years and 1 in 12 (8%) of those aged 18-44. This reflects national findings that the peak age for caring is between 50 and 59.
- Women carers are more likely to be younger, i.e. 2 in 3 carers aged 18-44 were more women, whereas aged over 65 carers were more likely to be men, 2 in 3.
- Carers reflected the ethnic diversity of Kirklees with nearly (86%) being white.
- 1 in 3 of 14-year old carers were of south Asian origin compared to 1 in 5 of the overall population.
- 2 in 3 people being cared for were aged over 65 years, 9% aged under 17 years (and tended to be learning disabled).

Barnsley

<table>
<thead>
<tr>
<th>Provides no unpaid care</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides 1 to 19 hours unpaid care a week</td>
<td>15,473</td>
<td>6.7</td>
</tr>
<tr>
<td>Provides 20 to 49 hours unpaid care a week</td>
<td>4,075</td>
<td>1.8</td>
</tr>
<tr>
<td>Provides 50 or more hours unpaid care a week</td>
<td>7,619</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Census 2011 data

Calderdale

In 2001 there were just under 20,000 carers in Calderdale, 10% of the population. Of these, 41% were male and 59% were female. This is broadly in line with national averages. However many do not identify themselves as “carers” – they see themselves simply as supporting family members.

Calderdale Carers Project holds the most comprehensive source of data on carers in Calderdale. They report 1,722 carers and 89 ex-carers on the database. This has increased over previous years. Conditions that led to people needing care included Mental Health (approx a fifth), Learning Disability (approx a fifth), dementia (approx a fifth) and physical disabilities including old age (approx two fifths). Approximately half of their database fell between the ages of 18-64.
<table>
<thead>
<tr>
<th>Equity Impact Assessment Questions:</th>
<th>Evidence based Answers &amp; Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:─</td>
<td>This policy aims to promote best practice and harmonise practices across the Trust. It has been developed in recognition that substance misuse among the severely mentally ill is commonplace and that mainstream psychiatric services are expected to take the lead responsibility for this service user group.</td>
</tr>
<tr>
<td>9a Promotes equality of opportunity for people who share the above protected characteristics;</td>
<td></td>
</tr>
<tr>
<td>9b Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;</td>
<td></td>
</tr>
<tr>
<td>9c Promotes good relations between different equality groups;</td>
<td></td>
</tr>
<tr>
<td>9d Public Sector Equality Duty – “Due Regard”</td>
<td></td>
</tr>
<tr>
<td>10 Have you developed an Action Plan arising from this assessment?</td>
<td>No</td>
</tr>
<tr>
<td>11 Assessment/Action Plan approved by</td>
<td>Signed: Sean McDaid  Date: December 2015  Title: Nurse Consultant Dual Diagnosis</td>
</tr>
<tr>
<td>12 Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Inclusion Team: <a href="mailto:inclusion@swyt.nhs.uk">inclusion@swyt.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please note that the EIA is a public document and will be published on the web. Failing to complete an EIA could expose the Trust to future legal challenge.</td>
</tr>
<tr>
<td></td>
<td>Sources of information used to identify barriers</td>
</tr>
</tbody>
</table>

As this is a trust wide policy we have included demographics’ for the four areas covered by the trust. People with ‘dual diagnosis’ (severe mental illness combined with misuse of substances) are some of the most vulnerable in our society. The extent and nature of ‘dual diagnosis’ is poorly understood and may vary
<table>
<thead>
<tr>
<th>Equality Impact Assessment Questions:</th>
<th>Evidence based Answers &amp; Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>according to characteristics protected by the Equality Act 2010: age and race as well as other factors. There is a potential for equality issues to be important for particular groups, such as: • adults or young people who are: homeless or in insecure accommodation, from a low-income family or on a low income, socially isolated, lesbian, gay, bisexual, transsexual or transgender, have been young or former offenders, sex workers, travellers, asylum seekers or refugees, from a minority ethnic group; • adults or young people who have a learning disability; or • adults who have a history of being ‘looked after’ or adopted; have a history of experiencing, or witnessing or perpetrating violence or abuse • young people who: have experienced abuse or witnessed domestic violence and abuse, are ‘looked after’ or adopted, are excluded from school, are teenage parents, have been excluded from school or whose parents have mental health or substance misuse problems. Prevalence, access to services and outcomes may also vary by geographical location</td>
<td></td>
</tr>
</tbody>
</table>

1 Appleby, The national service framework for mental health – five years on, Department of Health, 2004.
2 Department of Health Black and Minority Ethnic drug misuse needs assessment project 2006
4 The Sainsbury Centre for Mental Health, Substance misuse and mental health co-morbidity (dual diagnosis): standards for mental health services’ health advisory service, 2001.
<table>
<thead>
<tr>
<th>Equality Impact Assessment Questions:</th>
<th>Evidence based Answers &amp; Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Home Office, Updated drugs strategy, 2002.</td>
<td></td>
</tr>
<tr>
<td>10 HM Government, Reaching out: an action plan on social exclusion, 2006; Office of the Deputy Prime Minister, Sustainable communities: settled homes; changing lives. A strategy for tackling homelessness, 2005; Department of Health, Our health, our care, our say: a new direction for commissioning services, 2006.</td>
<td>11 Communities and Local Government, Framework for planning and commissioning of services related to health needs of people who are homeless or living in temporary or insecure accommodation, 2007</td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Head of Involvement and Inclusion together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Corporate Development or Head of Involvement and Inclusion.
## Appendix C - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

<table>
<thead>
<tr>
<th>Title of document being reviewed:</th>
<th>Yes/No/Unsure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the title clear and unambiguous?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Is it clear whether the document is a guideline, policy, protocol or standard?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Is it clear in the introduction whether this document replaces or supersedes a previous document?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>2. Rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are reasons for development of the document stated?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>3. Development Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the method described in brief?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Are people involved in the development identified?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Is there evidence of consultation with stakeholders and users?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>4. Content</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the objective of the document clear?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Is the target population clear and unambiguous?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Are the intended outcomes described?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Are the statements clear and unambiguous?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>5. Evidence Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Are key references cited?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Are the references cited in full?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Are supporting documents referenced?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>6. Approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the document identify which committee/group will approve it?</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>If appropriate have the joint Human Resources/staff side committee (or equivalent)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Title of document being reviewed:</td>
<td>Yes/No/Unsure</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td>approved the document?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. **Dissemination and Implementation**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>YES</td>
</tr>
<tr>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>N/A</td>
</tr>
</tbody>
</table>

8. **Document Control**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the document identify where it will be held?</td>
<td>YES</td>
</tr>
<tr>
<td>Have archiving arrangements for superseded documents been addressed?</td>
<td>YES</td>
</tr>
</tbody>
</table>

9. **Process to Monitor Compliance and Effectiveness**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?</td>
<td>YES</td>
</tr>
<tr>
<td>Is there a plan to review or audit compliance with the document?</td>
<td>YES</td>
</tr>
</tbody>
</table>

10. **Review Date**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the review date identified?</td>
<td>YES</td>
</tr>
<tr>
<td>Is the frequency of review identified? If so is it acceptable?</td>
<td>YES</td>
</tr>
</tbody>
</table>

11. **Overall Responsibility for the Document**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it clear who will be responsible implementation and review of the document?</td>
<td>YES</td>
</tr>
</tbody>
</table>
## Appendix D - Version Control Sheet

*This sheet should provide a history of previous versions of the policy and changes made*

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Status</th>
<th>Comment / changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>October 2008</td>
<td>Sean McDaid</td>
<td>Final</td>
<td>Final version approved by Trust Board</td>
</tr>
<tr>
<td>2</td>
<td>August 2010</td>
<td>Sean McDaid, Dr Fariha Kamal, Syvet Finch, Ros Dellar</td>
<td></td>
<td>Changes made to ensure the policy reflects the changes in service delivery for Dual Diagnosis</td>
</tr>
<tr>
<td>3</td>
<td>July 2012</td>
<td>Dual Diagnosis and Substance Misuse Advisory Group</td>
<td>Final draft</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>October 2012</td>
<td>Dual Diagnosis and Substance Misuse Advisory Group</td>
<td>Final</td>
<td>Changes to ensure the policy reflects practice across all of the organisation including Barnsley</td>
</tr>
<tr>
<td>5</td>
<td>October 2015</td>
<td>Dual Diagnosis and Substance Misuse Advisory Group</td>
<td>Final</td>
<td>Updated following externally commissioned review</td>
</tr>
</tbody>
</table>