

FORENSIC DIRECTORATE

Drug and Alcohol Service Operational Policy

Document Control Summary

Date of Publication:	25 th April 2022
Author:	Dr Matt Charles (Head of Drug and Alcohol Service)
Document Version:	1.0
Review date:	N/A
Next Review Date	25 th April 2025
Target audience:	All staff in ELFT Forensic Directorate
Department:	Drug and Alcohol Service
Accountable Director:	Lawford Clough (ACD for Therapies and Recovery)

Version Control Summary

Version	Date	Status	Comment/Changes
1.0	25 th April 2022	Final	Policy created to replace the Forensic Dual Diagnosis Service Operational Policy.

CONTENTS

1. INTRODUCTION	4
2. DEFINITIONS, BACKGROUND AND REMIT	4
3. ETHOS.....	5
4. FUNCTIONS OF THE DRUG AND ALCOHOL SERVICE.....	5
4.1. Detailed Functions – Direct Care – Inpatient Service.....	6
4.2. Detailed Functions – Indirect Care	7
5. SERVICE EVALUATION	8
6. HOURS OF OPERATION AND TEAM STRUCTURE.....	8
7. COMMUNICATION AND RECORD KEEPING.....	8
7. REFERENCES	9
8. Appendix A: Overview of Drug and Alcohol Service provision.....	10
9. Appendix B: Group Interventions Available	12

1. INTRODUCTION

The Drug and Alcohol Service is a specialist multidisciplinary team within East London NHS Foundation Trust's (ELFT) Forensic Directorate. It exists to provide specialist intervention to forensic service users with co-occurring mental disorder and substance misuse problems. It also offers support to the wider service by a variety of means to improve the care and outcomes of this group of service users.

This policy replaces the earlier Forensic Substance Use Support Service Operational Policy, which is now void.

2. DEFINITIONS, BACKGROUND AND REMIT

Services of the type like the Drug and Alcohol Service have historically been referred to as providing care to people with 'dual diagnosis'. Indeed, this service was once had 'dual diagnosis' within its name.

'Dual diagnosis' was a term developed to describe a group of individuals who experience co-occurring mental disorder and substance misuse problems. Its definitions have varied, but early national policy was focused on those with both mental disorder and substance misuse problems of high severity (Department of Health, 2002). This would typically encompass people who would attract diagnoses of psychotic disorders and whose substance misuse was at least problematic, but often reaching levels of very harmful use and dependence. More recent national guidance, however, avoids the term 'dual diagnosis', and its scope is broader, including those with less severe forms of mental disorder and less harmful substance use (Public Health England (PHE), 2017). The terminology within this more recent guidance is 'co-occurring mental health and alcohol/drug use conditions', or 'co-occurring conditions' for short.

Previously, provision of treatment for people with dual diagnosis was provided by specialist teams that sat separate to mental health and drug and alcohol services. That model has since fallen out of favour, as the evidence did not support it. Now, the aim is for providers of mental health and drug and alcohol services to work closely together to meet the needs of this group. Inherent in this approach, is the need to provide training and supervision to staff in both services about the particular needs of this service user population that spans both. Two overarching principles to the provision of services in the community are that it is 'everyone's job' (i.e. there is shared responsibility), and there is 'no wrong door' (i.e. mental health and drug and alcohol services should have open doors to people with co-occurring conditions) (PHE, 2017). For how this works in ELFT community services, see the ELFT Dual Diagnosis Policy.

The forensic context provides a particular challenge here, however, as community drug and alcohol services do not provide in-reach to our service users. This means access to specialist drug and alcohol intervention would be limited. One of the core functions of the Drug and Alcohol Service is to meet this need, i.e. provide such specialist interventions to forensic inpatients. Its second core function, however, is to support the wider service, particularly ward-based MDTs, through training, consultation and close working relationships, so that this group of our service users can be provided the most effective care possible in an integrated way.

For the purposes of this policy, service users falling within the Drug and Alcohol Service remit are any forensic service user that has ever used any substance (defined as including alcohol, other legal, as well as illegal substances). (However, only a subset of those with at least problematic use of substances are likely to be offered intervention from our service. More detail on this is provided below).

An offshoot of this definition and core functions is that our service does not provide any sort of alternative care pathway for service users in the forensic directorate. Rather, we offer additional support to this group of service users that is integrated within their broader care plans developed with their MDT.

3. ETHOS

The Drug and Alcohol Service explicitly does *not* adopt the position of “drugs are bad”. Rather, that substances can be bad for some people, some times.

Associated with this is that we do not assume an ‘abstinence only’ approach to our therapeutic work. This approach actively harms people who continue to use substances by not providing them with information that keeps them safe, and by limiting access to services. Instead, goals of intervention are developed collaboratively with service users, incorporating their views, and are informed by the evidence base and clinical best-practice guidelines. In practice, this means that for some service users abstinence is recommended and/or pursued, while for others it might be that controlled use or harm reduction approaches are recommended and/or pursued.

Of course, there are often legal restrictions on forensic service users. For example, the rules of the inpatient setting, or the many restricted inpatients that will be discharged with conditions to abstain from drug and/or alcohol use. Where such restrictions are in place, the Drug and Alcohol Service holds open and honest conversations with service users about such restrictions, how they may be incompatible with their own goals, and the possible implications of breaching these conditions. So while the restrictions may shape the conversation that is had about goals, in themselves they do not dictate the therapeutic approach taken.

4. FUNCTIONS OF THE DRUG AND ALCOHOL SERVICE

The Drug and Alcohol Service provides the following:

1. Specialist assessment of forensic service users who are using, or have used substances.
2. To develop formulations around service users’ substance use that speak to its function, and its links with their mental health and offending behaviours, if any.
3. Based on this formulation, to deliver psychosocial treatments to address substance use, where needed.
4. Where indicated, to recommend other Therapies or – in discussion with Responsible Clinicians – pharmacological interventions as part of service users’ broader care.
5. To provide consultation to MDTs on the above, including providing input into risk assessments where substance use is associated with offending behaviour.

6. To deliver to staff of all disciplines training on substances, substance use, screening for substance use, and working with people who use or have used substances.
7. Provide consultation and support to the Security Department regarding the management of substances, their movement around the unit, and drug screening and detection procedures.
8. To periodically attend Clinical Improvement Groups, Community Meetings and other key ward meetings, to provide input and support to decision-making around care of service users as it relates to substances.

The Drug and Alcohol Service provides the above to both the inpatient and community parts of the forensic directorate.

4.1. Detailed Functions – Direct Care – Inpatient Service

An overview of what the Drug and Alcohol Service provides is available in Appendix A. All practice of the Drug and Alcohol Service is NICE compliant.

Engagement and Assessment

In the inpatient service, members of the team spend time on wards speaking with service users. Comprehensive assessments are offered to those who express an interest in discussing things further with the team. So that no service users are omitted from this approach, new admissions' psychiatric and nursing admission assessment reports and other available records to that date are screened by members of the team so that individuals who are likely to need input from our team are actively identified. This allows those individuals to be specifically approached by members of the team, and efforts made to engage them.

In the community, service users require referrals from their clinical teams. For service users who wish to receive one, a comprehensive assessment is offered. Referrals are to be sent to elft.fx-DrugAndAlcoholService-ELCFS@nhs.net.

Formulation and Intervention

Following a comprehensive assessment, a formulation is developed of the service user's substance use, and its links – if any – to their mental health and offending. Recommendations for treatment are then made and treatment goals are set.

Treatment will typically involve either individual therapy or a therapy group, but may sometimes involve referrals for other specialist interventions (for example, family therapy). Motivational interviewing and cognitive behaviour therapy underpin the core interventions of the team. Where service users do not wish to engage with us but are actively using substances, by working closely with the MDT, consideration can also be given to contingency management approaches. Further details of the groups offered by the Drug and Alcohol Service can be found in Appendix B.

The Drug and Alcohol Service will generally offer intervention to people whenever they require it, at any point in their care pathway. For most service users needing our support, this involves some therapeutic work early in their inpatient admission, followed by some follow-up support, particularly at major transitions in their care pathway, which are known to be higher-risk times for

lapses in substance use. Such times of transition include the beginning of unescorted community leave, step-downs in security, or discharge from inpatient services. For the latter, the community practitioners in the team offer specialist in-reach work to support service users throughout the discharge process.

For those service users with ongoing and/or severe substance use problems, a member of the team will act as a 'key worker', who has periodic contact with them throughout their care pathway. In these cases, regular attendance at CPAs will be provided.

Throughout service users' care, the input of the Drug and Alcohol Service constitutes an additional therapeutic activity as part of their broader Therapies care plans. Care is taken to avoid duplication of therapeutic work between Therapies departments.

Not all service users with a history of substance use will require specialist intervention from the Drug and Alcohol Service. This is in keeping with NICE and best-practice guidelines, which indicate that such intervention is not indicated for recreational or non-problematic use. Consequently, some assessments will conclude that no intervention from our service is required.

Additional Features of Direct Care

The Drug and Alcohol Service also provides standalone Recovery College sessions each term on alcohol, crack cocaine, cannabis, synthetic cannabinoids, and nicotine. Sessions on additional substances are considered on a needs basis.

The team also produces a range of literature for staff and service users. It includes information about the team itself and what it offers, as well as individual leaflets about different substances. These are also made available to carers and relatives.

4.2. Detailed Functions – Indirect Care

In addition to direct care, the Drug and Alcohol Service also offers a number of other services.

1. Training for all staff, including co-produced training, where appropriate. Topics include working with people who use substances, approaches to drug screening, and novel psychoactive substances.
2. Consultation and/or supervision to MDT colleagues on aspects of care related to substances. This includes advice on how to support service users (for example, when they lapse in their substance use), drug screening and use of the ion tracker, and specialist input into risk assessments. The team can also support trainees, students, or colleagues with particular interest to undertake work in this specialist area, with clinical supervision provided by the team.
3. Attendance at CPA meetings and ward rounds for service users engaged with the team, where indicated.

4. Attendance at Community Meetings and Clinical Improvement Group meetings for each ward. This will vary in frequency dependent on need, though is likely to average quarterly across the service.
5. Attendance at the service's Friends and Family Open Day and Carer's Forum to raise awareness of the support the team offers service users with the important people in their lives.
6. Chairing of the monthly, directorate-wide, Drugs Intelligence Meeting (DIM). This meeting provides a forum to review audit data related to substance use and facilitate discussion between different parts of the service to:
 - Understand the extent of current substance use within the service
 - Identify emerging trends in substance use
 - Identify possible sources of supply and means of substances being moved around the service
 - Develop plans to restrict the supply and distribution of substances within the service, and to reduce harms associated with substance use
 - Identify service users who may need additional support from the Drug and Alcohol Service, or indeed any other discipline
 - Liaise with the police where the supply of substances is concerned

5. SERVICE EVALUATION

The Drug and Alcohol Service use measures routinely to monitor outcomes. Standardised measures are administered during assessment and before and after every intervention. Routine evaluation of outcomes are performed every two years, with findings made available to the wider service.

6. HOURS OF OPERATION AND TEAM STRUCTURE

The Drug and Alcohol Service operates between 08.30 and 17.30 Monday to Friday.

They can be contacted by phone (0208 510 2463 at John Howard Centre; 0203 222 7176 at Wolfson House) or by email (elft.fx-DrugAndAlcoholService@nhs.net).

The team comprises:

- Lead Clinical Psychologist and Head of Drug and Alcohol Service
- Senior Substance Misuse Practitioner
- Substance Misuse Practitioner
- Community Drug and Alcohol Recovery Worker (x2)
- Assistant Psychologist
- Peer Support Worker (x2)

Service users have access to the contact details of the team, including the work mobile telephone numbers of individual team members supporting them.

7. COMMUNICATION AND RECORD KEEPING

As a team not embedded within each ward MDT, the Drug and Alcohol Service recognise the importance of maintaining effective communication with colleagues. The team aims to provide regular and timely updates to colleagues on the work that they are undertaking with service users.

All Trust policies related to record keeping are followed. At a minimum, formal written reports are produced following assessment and at the end of any individual or group intervention. RiO progress notes are made following every contact. Should updates be required at any other time, for example ahead of a CPA or First Tier Tribunal, MDTs can contact the Drug and Alcohol Service.

Indeed, the Drug and Alcohol Service actively welcomes enquiries from staff and service users.

7. REFERENCES

Department of Health. (2002). *Mental health policy implementation guide: Dual diagnosis good practice guide*. Department of Health.

Public Health England. (2017). *Better care for people with co-occurring conditions: A guide for commissioners and service providers*. PHE Publications.

8. Appendix A: Overview of Drug and Alcohol Service provision

Clinical Work

1. Engagement – have a regular presence on wards, particularly those that routinely accept admissions
2. Screening – new admissions to the service will be briefly ‘screened’ to determine the level of need they are likely to have.
3. (Points 1 and 2 apply to the inpatient setting; referrals are necessary for community service users).
4. Assessment – includes the use of measures to aid clinical judgment and contribute to outcome monitoring. Measures at assessment are:
 - a. For everyone:
 - i. URICA (motivation)
 - ii. BSCQ (self-efficacy)
 - iii. Change Rulers (motivation)
 - iv. SURPS (personality)
 - v. For community only: MANSA (Quality of Life)
 - b. If an alcohol user:
 - i. AUDIT or LDQ instead if likely dependent
 - c. If a cannabis user:
 - i. CUDIT-R
 - d. If poly/multiple drugs:
 - i. ASSIST Lite

Assessment will end in formulation and recommendations. Communication with clinical teams will be maintained throughout the assessment phase. Consultation, where necessary, will be given, including on the role of substance use in risk formulation.

5. Group treatment:
 - a. Recovery College (standalone sessions each term on key substances, plus a course on smoking)
 - b. Motivation to Change (inpatient)
 - c. SMART (inpatient and community)
6. Individual treatment:
 - a. Where group work not indicated/appropriate
 - b. Perhaps in addition to groups (e.g. severe problems)
 - c. Booster for relapse prevention when approaching discharge
 - d. Where family therapy involvement is needed; scope for joint working
 - e. In-reach work from community Drug and Alcohol provision
 - f. Individual support in community from community Drug and Alcohol provision
7. Other
 - a. Key working for more severe cases



Motivational Interviewing used throughout
Contingency Management available throughout

Teaching and Training

1. Local Induction
2. 1-day training on key issues in substance misuse in forensics
3. Novel Psychoactive Substances
4. Drug Screening
5. Bespoke teaching/training available on request

Consultation/Supervision

1. Supporting clinical teams with psychological support for smoking cessation
2. Drug screening and ion tracker
3. When drugs are on a ward e.g. support at away days/drop-ins/attendance at community meetings
4. Consideration of ward-based interventions in response to acute needs (e.g. ward-based groups)
5. Regular liaison with clinical teams
6. Periodic attendance at community meetings, Clinical Improvement Groups and Away Days; also available on request

Other

1. Presentation at family and friends' open day
2. Attendance at carers' forum on request
3. Provision of literature for families/carers
4. Literature for wards
 - a. For service users; readily available on wards, including information on the team and on individual substances
 - b. For staff in nursing offices, including information on what we offer, contact details etc.

9. **Appendix B: Group Interventions Available**

'Motivation to Change'

Motivation to Change is a 12-week, closed, structured group available to inpatients at John Howard Centre and Wolfson House. It is informed by motivational interviewing and cognitive behaviour therapy. It aims to equip attendees with the skills necessary to manage cravings/urges to use substances, and to reduce their use or abstain. Over the course of the 12 weeks, the following topics are covered:

1. Introduction to motivation and change
2. Goal setting
3. Life events, trauma, and substance use
4. Understanding and identifying cravings, triggers and urges, and how to cope with them
5. Coping with 'high risk situations' (featuring dramatherapy)
6. The links between mental health, offending, and substance use

Self-Management and Recovery Training (SMART)

SMART is an open, semi-structured, peer support intervention available to service users in the community and those approaching discharge from forensic inpatient services. SMART was developed as a secular alternative to Alcoholics/Narcotics Anonymous (AA/NA). The meetings take place in community venues, and are facilitated by a member of the Drug and Alcohol Service and a Peer Support Worker with lived experience of problems with drugs and/or alcohol.

SMART's ethos is one of mutual support. Attendees, assisted by facilitators, support each other with their drug and alcohol use, with an overarching aim of cutting-down or abstaining from use. SMART rests on motivational interviewing and cognitive behaviour therapy (specifically, rational emotive behaviour therapy). There exists several 'tools' that the group uses to support people with whatever stage of their recovery journey they are at. Attendance is encouraged but not mandatory, and there is very much an understanding that individuals will stop attending once they have achieved their goals – the aim is to empower and equip people with the skills to manage their substance use effectively, and not rely on others or a group to do so. (This markedly differs from interventions like AA/NA, which view addictions as 'diseases' that people are personally powerless over).