Tees, Esk and Wear Valleys
NHS Foundation Trust

Protocol for Management of Substance Misuse in Inpatient Settings

Ref CLIN-0029-002-v1

Status: Approved
Document type: Protocol

Contents

1 Purpose

The aim of this protocol is to give guidance about:

- optimising management of drug and alcohol use in inpatient settings,
- detecting drug or alcohol use on the ward,
- dealing with situations in which patients use drugs or alcohol on the ward; and
- learning after such incidents have happened.
- Support and embed the standards for discharge of dual diagnosis.

2 How to optimise management of drug and alcohol use on the ward

2.1 CLIP Dual Diagnosis

The trust has developed a Clinical Link Pathway 'Mental Disorder and coexisting Substance Misuse (Dual Diagnosis)' that aims to develop a clinical pathway that is compliant with national guidance by NICE and the UK guidelines on clinical management of drug misuse and dependence (Orange Book).

2.2 Methadone and buprenorphine prescribing

If patients with opioid misuse or dependence are admitted to psychiatric wards it is important to optimise the patients medication programme. Insufficient management of opioid withdrawal can trigger increased craving for opioids, which can lead to drug use on the ward.

Before prescribing methadone or buprenorphine clinicians should check for objective symptoms of opioid withdrawal. If methadone or buprenorphine is initiated on a psychiatric ward with the aim of alleviating withdrawal symptoms, clinicians should also be aware that the opoid reduction programme will need to be completed in hospital. It is often impossible to hand over incomplete methadone or buprenorphine detoxification into the community. As a rule of thumb opioids should only be initiated on the ward if patients are on a confirmed community prescribing programme with opioids. Otherwise it is recommended that, prior to prescribing opioids, a consultant with experience in treatment of opioid dependence is consulted.

Methadone Buprenorphine In-Patient Prescribing Guideline

2.3 Naloxone

2.3.1 Prevention of overdose after discharge

Naloxone is a safe and effective antidote to opioid overdose. Naloxone blocks this effect and reverses the breathing difficulties associated with opioid overdose.

It is possible to dispense naloxone to patients with high risk of heroin overdose. Every inpatient unit should participate in these discussions by active contribution to local dual diagnosis networks. Inpatient units will be informed if agreements have been found for dispensing of naloxone on discharge. Such agreements might vary from locality to locality.

2.3.2 Management of overdose

Naloxone is also available on inpatient units to treat patients with suspected opioid overdose. Guidance can be found on InTouch Naloxone Hydrochloride In-Patient Guidance

All inpatient facilities have to make sure that naloxone is stocked as an emergency medication.

2.4 Alcohol

Psychiatric inpatient units often admit alcohol dependent patients, many of these patients develop withdrawal symptoms that need to be managed pharmacologically.

In light of recently published NICE guidance, a new alcohol detoxification process was developed that incorporates symptoms triggered elements. Alcohol detoxification - inpatient clinical algorithm

3 How to detect drug or alcohol use on the ward

3.1 Drug testing

The tables on the following pages give guidance about recognition of drug use and drug testing.

It is important that clinicians do not only rely on drug tests. Drug use is usually detected by clinical judgement and supporting information. Drug tests are only one piece of evidence in making a clinical judgement.

The following abbrevations are used in the tables:

- opiates (OPI)
- cocaine (COC)
- cannabis (THC)
- amphetamines (AMP)
- methadone (MTD)
- buprenorphine (BUP)
- benzodiazepines (BZO)

SUBSTANCE	SYMPTOMS	DRUG TESTING	MANAGEMENT	INFORMATION
Amphetamine **Cocaine** **Methamphetamine** **Methylphenidate** Synthetic Cathinones (**NPS**) : • Khat (Bath Salts) • Mephedrone	PHYSICAL: • Racing heartbeat and breathing • Dilated Pupils • Clenched jaws • Sweating, nausea, dehydration MENTAL & BEHAVIOURAL • Confidence, sense of well-being, euphoria & energy • Lowered appetite, • Paranoia, mood swings, anxiety • Visual or auditory hallucinations • Sexual arousal, sexual impotence • High-risk sexual behaviour • Depression & violence when comedown	Amphetamine : 48 h (+ AMP) Cocaine: 48h-72h (+ COC) Methamphetamine: 48 h (+ AMP) Methylphenidate : 48h (+ AMP) Synthetic Cathinones (NPS) : (TEST NOT AVAILABLE)	INTOXICATION = SYMPTOMATIC TREATMENT - Anxiety & agitation: Diazepam and/or lorazepam, Promethazine - Psychotic symptoms: Haloperidol or any other SGA. ECG required. RESIDUAL SYMPTOMS; - Affective disorders; It may require antidepressant medication. Caution re Serotonin Syndrome for those continue using stimulants. ADDICTION: To be referred to local addiction services for pharmacological & relapse prevention therapies.	Cocaine Methamphetamine Synthetic Cathinones
MDMA (ECSTASY)	SHORT TERM • Lowered inhibition; enhanced sensory perception; increased heart rate and blood pressure; muscle tension; nausea; faintness; chills or sweating; sharp rise in body temperature leading to kidney failure or death. • In Combination with Alcohol MDMA decreases some of alcohol's effects. Alcohol can increase plasma concentrations of MDMA, which may increase the risk of neurotoxic effects. LONG TERM • Long-term Long-lasting confusion, depression, problems with attention, memory, and sleep; increased anxiety, impulsiveness; less interest in sex. WITHDRAWALS SYMPTOMS Fatigue, loss of appetite, depression, trouble concentrating.	Not available		MDMA

SUBSTANCE	SYMPTOMS		DRUG TESTING	MANAGEMENT
HEROIN (Diamorphine) **METHADONE** **BUPRENORPHINE** **CODEINE** **TRAMADOL** **FENTANYL** **MORPHINE**	INTOXICATION: • Pupil constriction • Slurred speech • Unsteady gait • Conjunctival injection • Disinhibition • Drooling • Dizziness • Itching/scratching TOXICITY • Drowsiness • Shallow breathing • Poor circulation • Slow pulse • Lowered temperature • Nausea and vomiting • Headache • Confusion	ACUTE WITHDRAWAL • Objective and subjective withdrawal symptoms • 6-12 hours (heroin,morphine) vs 36-48h (methadone) • Reach peak intensity (H: 2 to 4 days, obvious physical withdrawal signs no longer observable after 7 days) vs Methadone: 5 to 21 days • Rarely life threatening OBJECTIVE SYMPTOMS • Yawning/10 min • Rhinorrhoea • Goosebumps • Sweating • Dilated pupils • Pulse rate • Shivering • Vomiting • Agitation • Watering eyes SUBJECTIVE SYMPTOMS • Lack of appetite & Abdominal cramps • Tremor • Insomnia and restlessness • Generalised aches & pains	Methadone : 3 days. Longer if patient on maintenance (+ MTD) Buprenorphine : 3 days . Longer if on maintenance (+ BUP) HEROIN: 2-4 days (+ MORPHINE) MORPHINE: 2-3 days CODEINE: 48 h FENTANYL: Test NOT available	Follow trust guidelines **INFORMATION** Heroin Fentanyl

SUBSTANCE	SYMPTOMS	DRUG TESTING	MANAGEMENT/INFORMATION
Diazepam **Lorazepam** **Temazepam** **Chlordiazepoxide** **Zopiclone** **Gabapentin** **Pregabalin** **Rohypnol (Flunitrazepam)**	PHYSICAL: • Slurred speech • Reduced reaction times • Sweating • Nausea, Vomiting & Dehydration • Respiratory Depression • Unconsciousness, coma, death • Seizures in withdrawal MENTAL & BEHAVIOURAL : • Euphoria, confidence, risk-taking • Disinhibited behaviours, Crime, • Addiction, • Aggression, • Blackouts • Confusion, withdrawal • Depression and mood swings, • High-risk sexual behaviours • Fatigue, accidents	Benzodiazepine test (+ BZO) - Short acting (lorazepam) : 24 h - Intermediate –acting (Temazepam/ Chlordiazepoxide) 40-80 h - Long-acting (Diazepam, Flunitrazepam) : 7 days (up to 30 days) Zopiclone (TEST NOT AVAILABLE) Gabapentin (TEST NOT AVAILABLE) Pregabalin (TEST NOT AVAILABLE)	INTOXICATION: - Observation. Contact with medical team if rpm <12 - WITHDRAWALS: - Use attached Benzodiazepine Withdrawal Scale. Use long acting (Diazepam) within BNF limits . Short acting if severe Liver impairment . - Aim for the lowest dose that will prevent withdrawal. - Avoid maintenance prescribing whilst inpatient - ADDICTION: - To be referred to local addiction services for long term pharmacological management & relapse prevention therapies.
GHB, GBL	WITHDRAWAL: Insomnia, anxiety, tremors, sweating, increased heart rate and blood pressure, psychotic thoughts, seizures,delirium	Test not available	GBH, KT, Rohypnol
SOLVENTS, INHALANTS	WITHDRAWAL: Nausea, tremors, irritability, problems sleeping, and mood changes.	Test not available (Solvents are very short acting and disappear rapidly from the body)	

SUBSTANCE	SYMPTOMS	DRUG TESTING	MANAGEMENT	INFORMATION
KETAMINE	SHORT TERM: • Problems with attention, learning, and memory; • Confusion; loss of memory; • Dreamlike states, hallucinations; sedation; • Raised blood pressure; • Dangerously slowed breathing. • Unconsciousnes LONG TERM: • Ulcers and pain in the bladder; • kidney problems; • stomach pain; • Depression & poor memory. NO SPECIFIC WITHDRAWALS	Not available	SYMPTOMATIC TREATMENT Anxiety & agitation: Diazepam and/or lorazepam, Promethazine Psychotic symptoms: Haloperidol or any other SGA. ECG required.	Club Drugs and Ketamine
SALVIA	SHORT TERM • Short-lived but intense hallucinations • Altered visual perception, mood, body sensations; • Mood swings, • Sweating • Feelings of detachment from one's body			Salvia
PCP	SHORT TERM Delusions, hallucinations, paranoia, problems thinking, a sense of distance from one's environment, anxiety. • Low doses: slight increase in breathing rate; increased blood pressure and heart rate; shallow breathing; face redness and sweating; numbness of the hands or feet; problems with movement. • High doses: nausea; vomiting; flicking up and down of the eyes; drooling; loss of balance; dizziness; violence; seizures, coma, and death. LONG TERM • Long-term Memory loss, problems with speech and thinking, loss of appetite, anxiety. WITHDRAWAL SYMPTOMS Headaches, increased appetite, sleepiness, depression			

SUBSTANCE	SYMPTOMS	DRUG TESTING	MANAGEMENT	INFORMATION
LSD	SHORT TERM: Rapid emotional swings; distortion of a person's ability to recognize reality, think rationally, or communicate with others; raised blood pressure, heart rate, body temperature; dizziness; loss of appetite; tremors; enlarged pupils. LONG TERM Frightening flashbacks (called Hallucinogen Persisting Perception Disorder [HPPD]); ongoing visual disturbances, disorganized thinking, paranoia, and mood swings. WITHDRAWAL SYMPTOMS Unknown.	Not available	INTOXICATION = SYMPTOMATIC TREATMENT Anxiety & agitation: Diazepam and/or lorazepam, Promethazine Psychotic symptoms: Haloperidol or any other SGA. ECG required. ADDICTION: To be referred to local addiction services for pharmacological & relapse prevention therapies.	Hallucinogens
Psilocybin (MAGIC MUSHROOMS)	SHORT TERM: Hallucinations, altered perception of time, inability to tell fantasy from reality, panic, muscle relaxation or weakness, problems with movement, enlarged pupils, nausea, vomiting, drowsiness. LONG TERM Risk of flashbacks and memory problems. WITHDRAWAL SYMPTOMS Unknown.			

SUBSTANCE	SYMPTOMS	DRUG TESTING	MANAGEMENT	INFORMATION
CANNABIS	SHORT TERM A 'high' - a sense of relaxation, happiness and sleepiness, colours and music sounds appear more intense. Increasing anxiety, confusion, paranoia (pending on mood and circumstances), psychotic symptoms with hallucinations and delusions lasting a few hours. LONG TERM Depressant effect and reduce motivation. Long-term use can lead to (??) irreversible, but minor cognitive deficits. WITHDRAWALS: Onset is within 24-48 hours post cessation of use, Peak effects are seen from day 2 to day 4 Resolve in 1-3 weeks (Budney et al., 2003) Common Symptoms: Anger or aggression, decreased appetite or weight loss, irritability, nervousness or anxiety, restlessness, sleep difficulties including strange dreams	CANNABIS (THC) Single use: 3 days Moderate use: 4 days Heavy use (daily): 10 days Chronic Heavy use	INTOXICATION = SYMPTOMATIC TREATMENT Anxiety & agitation: Diazepam and/or lorazepam, Promethazine Psychotic symptoms: Haloperidol or any other SGA. ECG required. ADDICTION: To be referred to local addiction services for pharmacological & relapse prevention therapies.	marijuana (cannabis)
Synthetic cannabinoids (k2, spice)	30 -500 times more potent than THC (read attached leaflet) WITHDRAWALS: Similar to cannabis but more intrusive and intense becoming withdrawn and aggressive often resorting to crime to pay for it. Diaphoresis (extreme sweating) and insomnia/sleep disturbance are the most common and noticeable withdrawal symptoms, with some often waking with bed sheets soaked.	SYNTHETIC CANNABINOIDS (Drug tests are not able to detect all varieties spice)		Spice

3.2 Searching of patients, property, environment and visitors

It can be a challenging situation if patients or their visitors are suspected that they are bringing or have brought drugs or alcohol onto the ward. Staff often feel unsure if they are allowed to search patients, visitors or their property. The following policy on inTouch gives guidance how to deal with such a situation:

Searching of Patients their Property environment and visitors

4 What to do if patients use drugs or alcohol on the ward

4.1 Patient 'compact'

For treatment interventions to be successful it is usually necessary that patients engage with the treatment process, especially if they have capacity to consenting to hospital treatment. Drug or alcohol use whilst in hospital is almost invariably detrimental to successful recovery. Drug and alcohol use also puts vulnerable patients at risk of misusing substances. Drug and alcohol use can also lead to aggressive and disruptive behaviour that makes it impossible for staff to maintain a therapeutic environment on the ward and put staff and other patients at risk of harm.

Patients who misuse drugs or alcohol while an inpatient will need to be reminded about these facts. It is advisable that staff and patients who are at risk of using drugs have such a conversation as soon as practicable. Service users should be informed that use of drugs or alcohol during their stay in hospital makes it difficult to impossible to maintain a therapeutic environment and a discharge from hospital will be considered. The content of such a conversation needs to to be documented.

4.2 Involving dual diagnosis workers, peers and specialist staff

The trust has a variety of staff members with enhanced knowledge and skills in managing patients with mental health and comorbid substance misuse. In order to achieve and maintain specialist status regular attendance and contribution to local dual diagnosis networks is required. Wards should make sure that an appropriate number of staff members have specialist dual diagnosis skills. These staff members are the first point of access to get advice in managing patients with substance misuse problems on the ward.

In some hospitals specialist dual diagnosis workers are employed or peers can provide inreach sessions. Wards should actively establish links to substance misuse services and be open to be developing processes to involving peers on an inreach basis.

4.3 Proactive approach to dual diagnosis

The person centred behaviour support policy provides a consistent framework of actions to support staff involved in managing patients with challenging behaviours. The policy recognises that

effective and respectful positive communication is central in supporting patients and staff. This includes working with patient's behaviours that challenge formalising a Patient Behavioural Support plan and providing formal warning as required utilising TEWV Local Security Management Specialist who can also support team in management

Positive working relationships are promoted with local police, who can help support ward staff in managing patient's behaviours by meeting with patient and discussing misuse/supply of drugs/alcohol within in patient setting, including behaviours that often coincide nonverbal/verbal aggression, impact on other patients, and legal actions that may be taken as a consequence of continued behaviours.

4.4 Formulation, stop the line or MDT meeting

If patients have a history of misusing drugs or alcohol during hospital admission or if their history indicates that they are at risk of doing so, the formulation meeting should involve everybody who can help to assess and reduce this risk. This can include family members, friends or substance misuse workers, as appropriate. The patient's **care plan** and the **safety summary** will need to be updated. An individual **response plan** should be co-produced with the service user.

A rationale should be provided if service user involvement is not possible or the service user declined to participate or did not attend. If the service user is not involved in the development of the plan, then it should be documented how the plan has been shared or will be shared with the service user.

4.5 Response plan

For patients who have misused drugs or alcohol while an inpatient or are at risk of doing so a risk management plan should be agreed. When balancing different alternative strategies it is important to include short and long term risks as well as the impact of substance misuse on other, potentially vulnerable, patients.

The following strategies should be considered:

- Increased level of support for the patient (eg. involvement of peer worker or motivational work)
- Increased levels of restriction (eg. use of the Mental Health Act, restriction of leave or visits)

Only if both these strategies have been exhausted or deemed inappropriate the discharge of the patient should be considered. The following discharge standards below should be considered.

4.6 Standards for discharge of dual diagnosis patients.

NICE guideline NG58 gives standards that need to be considered when patients with dual diagnosis problems move between services. These standards still apply when patients are discharged from the ward after misusing drugs or alcohol:

- All practitioners who have been, or who will be, involved are invited to the multiagency and multidisciplinary meetings and the discharge or transfer meeting.

- There is support to meet the person's housing needs.
- The discharge plan includes strategies for ongoing safety or risk management and details of how they can get back in contact with services.
- There are crisis and contingency plans in place if the person's mental or physical health deteriorates (including for risk of suicide or unintentional overdose).
- Providers share information on how to manage challenging or risky situations.

Patient confidentiality should be respected and information sharing protocols should be followed: Confidentiality and sharing information policy. There are however limits to this, especially if there are risks to the service user themselves, other patients or other people such as family members and children.

The following document can be used for the documentation of response plan discussions with patients who misuse drugs and alcohol.

Multiagency plan draft.docx

4.7 Support for the staff team

At all stages of the process staff team members should be offered supervision/debriefs and support to challenge and manage the patient within the ward in a consistent and coordinated way, including individual support as required

There is range of timely support that can be offered to staff based upon their individual need or preference

Following incidents on the ward post incident procedures should be followed including incident reporting and investigating policy which describes incident response and management process.

4.8 Criminal incident reporting

Criminal incident reporting procedure supports staff in reporting criminal incidents to the police. The relationship with local police is essential to support safeguarding of other patients, staff and others, promoting timely management of incidents

5 How this procedure will be implemented

• This procedure will be published on the Trust's intranet and external website.
• Line managers will disseminate this procedure to all Trust employees through a line management briefing.
• Dual diagnosis networks and staff with specialist knowledge will support the implementation of this protocol

5.1 Training needs analysis

Staff group	Dual diagnosis related responsibilities	Training requirements
Service managers	Determine number of dual diagnosis leads as well as their training, development and support needs	
Specialist level	Supervise and advise dual diagnosis leads	To be recognised by local dual diagnosis network.
Dual diagnosis leads	Advise frontline staff in managing patients with dual diagnosis	Staff that have • completed new e-learning module • Attended 2 network meetings per year • presented 2 cases to DD network
High need teams	As per job description	To be achieved by completing new dual diagnosis essential e-learning package
Awareness level (all staff)	As per job description	Completing dual diagnosis basic awareness in other (eg. lifestyle orientated) training module

6 Document control

Date of approval:	24 January 2019	
Next review date:	31 October 2023	
This document replaces:	N/A	
Lead:	Name	Title
	Belinda Boam	Associate Nurse Consultant in Dual Diagnosis
Members of working party:	Name	Title
	Dr Wolfgang Kuster,	Consultant Psychiatrist, Trust Lead for Dual diagnosis, Clinical Director Adult Mental Health, Durham and Darlington
	Belinda Boam,	Associate Nurse Consultant in Dual Diagnosis
	Karen Atkinson	Head of Nursing Teesside
	Andrea Card,	Ward Manager, Stockdale Unit, Roseberry Park Hospital, Middlesbrough
	Denise Colmer	Service Development Manager, Adult Mental Health
	Dr Hany El-Sayeh,	Consultant Psychiatrist, Clinical Director Adult Mental Health, North Yorkshire
	Helen Embleton	Trust Lead for Acute Care Services
	Dr Raul Perez	Consultant Psychiatrist
	Chris Williams	Chief Pharmacist
This document has been agreed and accepted by: (Director)	Name	Title
	Ruth Hill	Chief Operating Officer
This document was approved by:	Name of committee/group	Date
	Drugs and Therapeutics Committee	24 January 2019
An equality analysis was completed on this document on:	26 June 2019	

Change record

Version	Date	Amendment details	Status
1	18 Jul 2019	New Protocol	Published
1	30 Mar 2021	Review date extended to 24 July 2022	Published
1	May 2023	Review date extened to 31 Oct 2023	Published

Appendix 1 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Adult Mental Health Dual Diagnosis					
Name of responsible person and job title	Dr Wolfgang Kuster, Consultant Psychiatrist, Trust Lead for Dual diagnosis, Clinical Director Adult Mental Health, Durham and Darlington Belinda Boam, Associate Nurse Consultant in Dual Diagnosis					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Dr Wolfgang Kuster, Consultant Psychiatrist, Trust Lead for Dual diagnosis, Clinical Director Adult Mental Health, Durham and Darlington Belinda Boam, Associate Nurse Consultant in Dual Diagnosis Karen Atkinson, Head of Nursing Teesside Andrea Card, Ward Manager, Stockdale Unit, Roseberry Park Hospital, Middlesbrough Denise Colmer, Service Development Manager, Adult Mental Health Dr Hany El-Sayeh, Consultant Psychiatrist, Clinical Director Adult Mental Health, North Yorkshire Helen Embleton, Trust Lead for Acute Care Services Dr Raul Perez, Consultant Psychiatrist Chris Williams , Chief Pharmacist					
Policy (document/service) name	PROTOCOL FOR MANAGEMENT OF SUBSTANCE MISUSE IN INPATIENT SETTINGS					
Is the area being assessed a…	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state - Protocol					
Geographical area covered	Trust Wide Adult Mental Health					

Aims and objectives	The aim of this protocol is to give guidance about: • optimising management of drug and alcohol use in inpatient settings, • detecting drug or alcohol use on the ward, • dealing with situations in which patients use drugs or alcohol on the ward; and • learning after such incidents have happened. • Support and embed the standards for discharge of dual diagnosis.
Start date of Equality Analysis Screening	15 April 2019
End date of Equality Analysis Screening	26 June 2019

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
The aim of this policy is to provide additional support to Trust staff who find themselves working with dual diagnosis within an inpatient setting and promoting a positive approach to care and management, reducing stigma and negativity, aimed at improving practices and service delivery in working with dual diagnosis					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	Yes	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	Yes	**Sex** (Men, women and gender neutral etc.)	Yes
Gender reassignment (Transgender	Yes	**Sexual Orientation** (Lesbian, Gay,	Yes	**Age** (includes, young people, older people – people of all	Yes

and gender identity)		Bisexual and Heterosexual etc.)		ages)	
Religion or Belief (includes faith groups, atheism and philosophical belief's)	Yes	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	Yes	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	Yes

Yes – Please describe anticipated negative impact/s

No – Please describe any positive impacts/s

In patient units receive a wide range of individuals with needs as described above, Dual diagnosis often leads to stigmatisation, not only in general public but also among professionals. Stigmatisation can lead to negative attitudes, poor outcomes and exclusion from getting the same level of care than other people without a comorbid problem.

Dual diagnosis often comes with multiple disadvantages (substance misuse, homelessness and criminal justice involvement), over half (55%) had a diagnosed mental health condition

It is recognised that some groups with diverse needs have problems with certain addictions and can experience difficulties in accessing services. Over recent years access to services has been greatly improved e.g. by women only clinics or initiatives that work with Black and Minority Ethnic (BME) or lesbian, gay, bisexual, and transgender community (LGBT) communities, gypsy and traveller groups, we must be aware of the differing needs of these client groups

The ageing cohort of heroin users is one of the factors identified as a cause of the rise in drug related deaths, due to deteriorating general health and increased susceptibility to overdose (Non-fatal overdose among people who inject drugs in England: 2017 report) and reduced life expectancy.

Those aged over 65 are particularly vulnerable to the effects of drugs and alcohol due to presence of coexisting medical disorders and greater likelihood of drug-drug interactions. Comorbidity can be a key factor, with increased risk with age of suffering from chronic pain, insomnia, bereavement, loneliness and mood. There is a cohort of older people presenting with alcohol dependency and opiate dependency.

Those described as 'late onset users' may have begun using substances regularly only later in life, sometimes following stressful life events or lifestyle changes that typically occur later in life (such as retirement, marital breakdown, social isolation, increasing morbidity or bereavement). The latter group tends to be a larger but less visible population of older drug users typically using prescription or over-the-counter medicines)

.

Although pregnancy is not considered a disorder or even a problem in itself there is often a lot of fear and anxiety of service users accessing support for dual diagnosis due to stigma and concerns identified regarding safeguarding of baby or any children within the home during their inpatient admission

There is a high prevalence among prison populations with the 2009 Bradley report recognising that co-existing alcohol and drug misuse and mental health issues are the norm rather than the exception among most offenders. Prisoners are also at increased risk of self-harm and suicide

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?** This policy has been reviewed in line with national guidelines, including: • NICE guideline [NG58] - Coexisting severe mental illness and substance misuse: community health and social care services • Drug misuse and dependence - UK guidelines on clinical management Including supporting trust guidance and CLIP dual diagnosis	**Yes** **x**		**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership
Yes – Please describe the engagement and involvement that has taken place
Focus group with service users and staff, inpatient wards.
No – Please describe future plans that you may have to engage and involve people from different groups
Utilise community support groups and recovery college/recovery community to support the development/review of protocols

5. As part of this equality analysis have any training needs/service needs been identified?	
Yes	Please describe the identified training needs/service needs below Service managers - to determine number of dual diagnosis leads as well as their training, development and support needs Specialist level Supervise and advise dual diagnosis leads To be recognised by local dual diagnosis network. Dual diagnosis leads Advise frontline staff in managing patients with dual diagnosis Staff that have - completed new e-learning module - Care and Management of Dual Diagnosis - Attended 2 network meetings per year - presented 2 cases to DD network (all staff) As per job description to complete new e-learning module - Care and Management of Dual Diagnosis and be aware of dual diagnosis CLIP and new protocol - Adult Mental Health Dual Diagnosis

A training need has been identified for;

Trust staff	Yes	Service users	No	Contractors or other outside agencies	No

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so	
The completed EA has been signed off by: You the Policy owner/manager: Type name: Belinda Boam	Date: 17 July 2019
Your reporting (line) manager: Type name: Wolfgang Kuster	Date: 17 July 2019
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046	