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Substance use and misuse in psychiatric wards

A model task for clinical governance?

Substance use has reached endemic proportions. Inevitably, the world of psychiatric wards must reflect issues arising in our society. Given that the populations of psychiatric wards are disproportionately younger, male and socially disadvantaged (quite apart from the impact of patients' problems that prompt admission), one might expect that drug misuse in them would match, if not outstrip, the general trend. Recognition of its impact is a key issue for patients and staff alike.

Apart from the potential for, sometimes, seriously harmful effects of substances for individual patients, use or misuse can have unsettling effects on ward regimes as a whole. This may lead to conflict between staff and patients, as well as between patients. Major concern about the physical safety of patients and staff arises frequently from the deleterious effects of intoxication in combination with psychiatric symptoms and medication. This is sometimes voiced in the press, for example, by the headline 'Drug dealing rife in mental wards' (*Evening Standard*, 1 March 1999).

Mental illness and substance misuse

At the present, there are two terms used to describe the combination of mental illness and substance use – comorbidity and dual diagnosis. Comorbidity is a general term, which delineates the co-occurrence of symptoms or disorders. Dual diagnosis is appropriately used to indicate a closer relationship between the two conditions, perhaps including cause or effect. We prefer the term comorbidity as it avoids a presumption as to whether substances are used or misused or any implication of a causal relationship between the two (or more) conditions. Also, it includes dual diagnosis within it.

Comorbidity arising from the use of substances by psychiatric in-patients includes people who have the following disorders (Cohen *et al*, 1999).

Psychiatric disorder and the effects of substance use

Morbidity may not solely arise directly from the toxicology of substance use. Therefore, this situation includes occurrences in which substance use may compromise the ability of patients, and not necessarily only the index person, to make use of treatment interventions. This group includes people who:

(a) use substances on a more or less controlled basis that is substantially independent of a co-existing psychiatric disorder;
(b) use substances on a more or less controlled basis, but their substance use complicates substantially the way in which they are cared for and treated or compromises the ability of services to offer effective care;
(c) do not use or misuse substances, but have relatives or other visitors who use or misuse substances, that is, the drug culture is introduced to in-patient units through visits.

Comorbid disorders

These people have a definable psychiatric disorder and a health problem arising from substance misuse. Crome (1999*a*) provides a summary of 10 mechanisms whereby these two are related. Sub-groups include people who have a psychiatric disorder and a substance misuse disorder that are:

(a) substantially unrelated;
(b) related by one being either symptomatic of, or a consequence of the other;
(c) related by both appearing to stem from the same risk factors or core pathology;
(d) related by the treatments for each being intertwined such that the care of the person overall requires both disorders to be considered together if any headway with either condition is to occur (the latter three are dual diagnoses).

What is apparent from the literature, anecdotal reports and the observations of the Mental Health Act Commission (MHAC) (1995, 1997, 1999) is that people who present these mixtures of problems are now commonplace in mental health services. The risk of relapse and the rate of non-adherence with treatment increases greatly when patients with a primary psychiatric disorder use illicit drugs and alcohol (NHS Health Advisory

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Service, 1996; Gourney *et al*, 1997) and particularly so when the two are combined with a personality disorder.

The significant and, apparently, increasingly frequent effects of substance misuse on the impact of psychiatric disorders, especially schizophrenia, is now established. One survey in an inner London district, where 36% of patients with psychosis misused drugs or alcohol, found that comorbid patients spent twice as many days in hospital in the previous year than those with schizophrenia alone (Menezes *et al*, 1996). There is also an increased risk of aggressive and anti-social behaviour consequent on substance use (Steadman *et al*, 1998). Individuals with comorbidity have been reported as more likely to report offending or recent hostile behaviour than those with psychosis only (Scott *et al*, 1998). A review of reports of inquiries into homicides committed by people with a mental illness showed that substance misuse was a major factor in over half the cases (Ward & Applin, 1998).

Thus, there is steadily accumulating evidence that use and misuse of drugs and alcohol is a growing problem for all mental health services, which poses difficult clinical and managerial problems particularly when presented in the confined environment of in-patient services. Moreover, limited availability of specialist substance misuse services for mentally ill patients is frequently and consistently reported (MHAC, 1995, 1997, 1999) and there is a shortage of training for staff both in substance misuse generally and about its effects on mental health in particular (NHS Health Advisory Service, 1996; Weaver *et al*, 1999). Paradoxically, this non-availability appears to be even greater for mentally ill people who are in the care of the generic mental health services.

The staff of many mental illness in-patient units crave access for their patients to substance misuse services and consultation for themselves. They request support in understanding the clinical risks and handling the challenges when integrating, in in-patient units, patients who pose problems which arise from their use or misuse of substances with other mentally ill patients. Where these problems are combined within the same patients, the demand appears even greater. Furthermore, the challenges relate to consuming both drugs and alcohol.

What measures are hospital managers and clinicians entitled to take to control substance use and misuse on their premises?

A hospital is entitled to prohibit patients from misusing drugs or alcohol on the wards. But what it is entitled to do to enforce this requirement is more difficult. This is especially so with regard to detained patients. Informal patients can undertake to abide by the rules or, ultimately, they can be asked to leave. Discharge in similar circumstances is not an option with patients who have been detained.

While the Mental Health Act 1983 confers the power to detain and treat for mental disorder, nowhere does it explicitly refer to controlling patients. For example, it contains no provision that allows staff to search detained patients and, in the absence of lawful authority, searching a patient or his or her possessions (including urine screening) without consent constitutes a trespass to the person.

However, Richard Jones (1996), submits that, "A search would be lawful if there are reasonable grounds for suspicion that the patient is in possession of a substance or articles that could be used to harm himself or other people or was in possession of a controlled drug in contravention of the Misuse of Drugs Act 1971". By extension, the authors' opinion is that, where it is suspected that a patient may be under the influence of illicit drugs, the evident dangers, such as the possibility of these substances interacting with prescribed medication or other deleterious consequences of drug use, would justify the responsible medical officer acting under a common law duty of care to the patient by carrying out an investigation, such as urine sampling.

This analysis, and the 1993 edition of the Code of Practice to the Mental Health Act, contributed to a widely held assumption that there is no authority to carry out searches without cause. This was the argument presented by three patients (R. *v.* Broadmoor, Court of Appeal, 5 February 1998), who challenged the policy of Broadmoor Hospital to introduce routine or random searches. The Court of Appeal held that:

> ". . . in the interests of all, in particular the need to ensure a safe therapeutic environment for patients and staff, that the express power of detention must carry with it a power of control and discipline, including where necessary of search with or without cause and despite individual medical objection. It was plain common sense that, on occasion, an individual patient's treatment might have to give way to the wider interest."

The significance of this judgment is that the hospital's justification for exercising its power of control and discipline arose not from its responsibilities for the patient's treatment, as had been considered the case previously, but from the need to maintain order for the safety of all. However, since 1998, the judgment has been interpreted narrowly. As stated in the 1999 edition of the Code of Practice (Paragraph 25.3), the general policy now is that routine and random searching without cause should only be applied in exceptional circumstances. An example of such a circumstance is where dangerous or violent criminal propensities of patients create a self-evident and pressing need for additional security.

Introduction of contracts is an imaginative approach that has been adopted in some units to tackle the consumption of alcohol and illegal drugs by patients. Each patient is asked to sign a treatment contract or declaration, thereby giving an undertaking not to use alcohol or illegal drugs on the ward; consenting to staff searching possessions on suspicion that the patient has brought alcohol or drugs onto the ward; and agreeing to provide blood, urine and breath samples when asked by staff.

Successful implementation requires a range of options for consideration if there is evidence of substance misuse. These include an increase in observation levels, restrictions on leave, more frequent property searches, limits on visits and discharge or, for detained patients, transfer to higher security wards.

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Where a treatment contract has been introduced, patients are reported to accept the policy as part of the admission process and tend to adhere to it during their hospital stay. But success depends on the patients' cooperation, which may not always be forthcoming and staff willingness to implement the policies.

Need for procedures

A survey of mental health nurses conducted by the Royal College of Nursing found that 68% of respondents (n=187) reported illicit drug use in their mental illness unit and, of these, almost half had no policy guidelines to assist them in dealing with the problem (Sandford, 1995).

The authors' opinion is that all mental health services should draw up and enact a policy with well-defined rules governing conduct relating to substance misuse. This is evidently easier said than done. Where policies and guidelines do exist, they may be unclear, not adhered to consistently and patients or even staff may be unaware of their existence. For example, one nurse, working on an in-patient unit, when asked how he handled drug misuse when he found it replied, "By hoping I don't, as I haven't got a clue".

Where policies have been drawn up, the following are examples of common failings:

(a) it is not clear whether the policy applies equally to alcohol, the hidden use of which can pose as many risks to patients with mental disorder as illicit drugs;
(b) it is not clear how patients (and visitors) will be informed of the policy of not allowing illegal drugs on the premises and the position with regard to alcohol use;
(c) no advice is given to staff on what action they should take in the event of refusal by a patient to be searched or to provide a urine sample;
(d) there has been no consultation with the local police. The issue of how far can and should confidentiality be protected is subject to wide variations in practice;
(e) there is widespread confusion about the Misuse of Drugs Act legislation and especially about the rights of staff to seize, hold and destroy substances. It is understood that Section 5 of the Misuse of Drugs Act provides protection in law for nurses, pharmacists and those responsible for the destruction of drugs to handle the substances;
(f) the differences in the application of the policy to informal and detained patients are not addressed. In particular, advice on whether treatment contracts can be used for detained patients for whom discharge, the ultimate sanction for breach of the rules, is not available.

Therapeutic approach

Clear procedures to control substance misuse are necessary to safeguard the dignity of individual patients and for the legal protection of staff. To be effective they should be combined with other therapeutic approaches. Liebling & McKeown (1995) maintain that attempts to restrict the supply of illicit drugs, in the absence of any other strategy, are almost certainly doomed to failure. They conclude that the most productive strategies would appear to be those geared towards support and therapy, with attention paid to interventions likely to alleviate or minimise demand.

Barker (1998) calls for services to be developed that:

(a) bridge the division between the clinical responsibilities of community mental health and substance misuse services;
(b) build on multi-disciplinary, multi-focal treatment programmes for patients with psychosis with cognitive–behavioural approaches to substance misuse.

However, for these bridging services to be effective, it is necessary to recognise and work to minimise or constructively utilise the differing ethos of mental health and addiction services.

However, despite some evaluations of limited success in developing models for dealing with comorbidity in the USA, there has been little development in the UK (Gournay *et al*, 1997). Crome (1999*b*) has identified inadequacies in both the quality and quantity of medical undergraduate training and considers that this may partially explain why most doctors are ill-equipped to deal with substance problems. Lack of training and skills may also lead to unhelpful responses in which personal attitudes and stereotypes may prevail, either by staff adopting negative, heavy-handed approaches or over-identifying with drug users. It should be noted that 13% of the Royal College of Nursing respondents suggested that medical and/or nursing staff were involved in taking illicit substances outside work.

Nonetheless, Crome (1999*a*) provides a summary of contemporary, pragmatic approaches to providing the services required by people with comorbid conditions. What is also clear is the need to overcome the obstacles to effective inter-agency work and communication (Tickell, 1999). However, even optimal use of resources may necessitate new funding.

Comment

Many units are grappling with the same difficulties yet policies are being developed in a fragmented way. We consider that there is an urgent need for central policy guidance – a view that we believe to be shared by the Royal College of Psychiatrists.

We highlight a challenge to corporate governance and clinical care. So, could a way forward lie within clinical governance? This concept is concerned with "creating an environment in which excellence in clinical care will flourish" (Department of Health, 1998*b*). While, at first sight, this environment intended for staff might appear distinct from that provided for patients, closer examination shows that such a conclusion would be to ignore the central core of clinical governance. Ultimately, its intention is to raise the quality of patient care. Therefore, to separate consideration of ward environments for patients from the culture of life-long learning for staff is to

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misunderstand current policy in which mental health services are required to be safe, sound and supportive (Department of Health, 1998*a*). An early target for clinical governance programmes could be further study of and work to improve the milieu of psychiatric units. This, inevitably, means tackling the thorny issues raised in this paper.

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