Getting it right:

How to write a drugs policy

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This is an extract of a document prepared by Kevin Flemen at KFx. It is part of a document originally written in 1999, revised in 2001, 2004 and 2006, which was reviewed and substantial revisions made in 2011. It was further amended in August 2016 to reflect the passing of the Psychoactive Substances Act 2016 and the changing drugs landscape relating to NPS use.

In Spring 2017 Homeless Link funded the development of moderate and low tolerance versions and some amendments were made to this document as these new documents were developed.

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Drugs legislation and practice is frequently changing and so we would urge organisations to check for updates on the KFx website and elsewhere.

We would also strongly encourage organisations to seek legal advice and consult with stakeholders before implementing such protocols.

No liability will be accepted from criminal or civil action or any other claims that may arise in the course of implementing the content of this briefing.

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POLICY DEVELOPMENT – FOUNDATIONS

What is a drugs policy?

In its most basic form, a drugs policy is a simple statement of an organisation's stance on drugs and drug use. In practice, most organisations will need to develop something that is more than this simple statement and produce a document that serves the following purposes:

- A statement of the organisation's stance on drugs
- A series of rules governing different drug-related scenarios
- Guidance for staff on how to proceed when encountering drug-related situations.

In effect, a drugs policy becomes policy and procedures for dealing with drug-related incidents. The POLICY defines the stance that the organisation takes and the PROCEDURES the steps the organisation will take when the policy is breached.

Who needs a drugs policy?

All housing services should have a drugs policy. The scope of the policy will depend, to an extent, on the nature of the client group with whom you engage. But a drugs policy should not only cover situations that you have encountered or currently encounter but also potential situations that you may encounter.

Why have a drugs policy?

A good, well thought out drugs policy is not only essential, but can also be hugely beneficial:

- It can reduce the risks of prosecution by ensuring staff are aware of the correct, legal procedures within which they should work;
- It can increase safety for staff and clients by ensuring that policy and procedures that conform to best practice are both in place and adhered to;
- Clear policy and procedures can avoid setting residents up for a fail, ensuring that residents are housed within an environment with an appropriate policy;
- Policy and procedures can reduce avoidable evictions and exclusions;
- A properly-formulated policy can ensure that an organisation has clarified its aims and in turn develops a policy commensurate with those aims;
- Policy and procedures, with associated training, ensure staff are clear what they need to do in any given situation increasing both their competence and confidence to respond effectively;
- A clear policy which is explained to residents and clients can help reduce friction within organisations, ensures services users are aware of their rights and responsibilities, and understand consequences of breaking rules;
- Policy can help reduce discrimination by ensuring that people are treated equitably within the policy;
- A policy ensures that workers know how they are expected to work, and by doing so will be protected by the principal of vicarious liability should things go wrong;
- A clear policy is an asset to external agencies, and can improve quality of referrals;
- Police may want to be sure that organisations are working in a legal manner;
- Neighbours will be keen to ensure that the presence of a service working with drug users does not have a negative impact on their own quality of life and will want to know that there is an effective drugs policy in place.

Given all the above, it is astonishing that so many housing organisations still do not have a drugs policy, and many the remaining policies are not fit for purpose!

Where do we get a policy?

This document is published alongside three sample drugs policy templates. But that doesn't mean that one of them is the "right" policy for you. You may need to revise and adapt it to make sure that it meets your needs. All too often organisations just pick an "off the peg" policy, by looking on the Internet, finding a policy, cutting and pasting it and then using it as their own. They risk incorporating poor policy wording from the plagiarised policy along with the good bits. Worse, the policy hasn't been developed with specific reference to what you want to do and how you want to work. An off the peg policy may be fit for one organisation; it may not be suitable for you.

So how do we develop a policy?
You use the sections of the policy templates, methodically, starting at the front and working your way to the back. That way you end up with a policy that reflects your needs. There are some sample policy wordings in the templates but you need to understand how those wordings have been arrived at and how they may need to be adapted – and that means reading the early parts of the pack first.

POLICY DEVELOPMENT – KEY PLAYERS

Who should write a drugs policy?
All too often, one worker is given or takes on the task of writing a drugs policy. This is not the best way to undertake such a task. It may be useful for a single worker to take a lead, but the policy needs to be the result of genuine consultation involving a range of parties.

The most effective strategy for organisations is to convene a working group that consults internally and externally on developing the policy.

Who should be involved in developing a drugs policy?
For a drugs policy to be effective, consultation is essential. The following parties will usually need to be consulted, though this will vary according to individual circumstances.

Staff: The people who will work within and deliver the drugs policy should be consulted. If staff are not actively involved in the development of the policy, they are unlikely to have any sense of ownership of it. In turn, this may mean that they are less likely to adhere to the drugs policy. Ultimately this creates an unsafe environment for both staff and clients.

Clients: As with staff, a policy that has been developed in conjunction with clients is likely to be more readily accepted than one that is simply imposed. The process of discussing and agreeing what rules and sanctions should be in place with clients can be empowering for both staff and clients. Some organisations have found that, where this process has taken place, clients are much more willing to self-regulate and self-police because, in part, the Policy reflects 'their' rules.

Trustees and management committees: Where organisations have a management committee, it is important that they play an active part in developing the policy. For some organisations, this proves problematic.

There may be a gulf between face-to-face workers and management committees. Management committees may impose impractical policies on workers with little or no consultation. Conversely, management committees may be expected to agree to a drugs policy, having had no induction, training or input into the process.

It may be advantageous to provide a seminar for management committees and trustees so that they have the opportunity to explore drug-related issues and the law in a constructive and facilitated environment.

External agencies: External bodies can offer useful advice and information and should be consulted as part of the policy development process. The following bodies at least should be involved in the consultation process:

- Funders and commissioners
- Drug Action Teams
- Local drugs services

The police:
The police need to be involved in the development and implementation of a drugs policy. In many areas, this has been a fruitful and productive process. Occasionally this is not the case, typically where the Police seek to impose onerous drug policy requirements.

It is essential that both police and provider agencies recognise the important role that each has to play. Intransigence on either part is unhelpful and will obstruct the development of policy and practice.

Just as some agencies are confused or unclear about the nuances of drug-related legislation, it is also possible that police officers liaising on policy development may not have specialist knowledge around drugs legislation.

Joint workshops or training for service providers and the police can prove highly useful to address these and related issues. They can offer insight into the operational difficulties that all parties encounter and can reassure participants that joint working is not only possible but also highly beneficial.

When striving to agree a policy with the police it is important to distinguish between factors that are legal obligations and those that are not. The following example is intended to illustrate this.

EXAMPLE: NEWTOWN NIGHT SHELTER

The night shelter has drafted a drugs policy. The policy says that, where a worker is aware that supply has taken place on site, the organisation should decide if police involvement is warranted. The police are insisting that all episodes of supply are reported to them. The night shelter feels obliged to agree to this, even though they are unhappy with this approach.

The night shelter is working legally. They have a choice and are not obliged to report each episode of supply to the Police. However, they should strive to work through the disagreement and hopefully reach some consensus acceptable to both parties.

Region-wide drug strategies

Some areas have sought to develop overarching drug strategies. These may be drawn up on a city-wide, county or regional basis.

This approach ensures local agencies all work to minimum agreed standards and all work within a legal framework. Such region-wide policies may be drawn up under the auspices of the DAT, by a locally-constituted working group or as appropriate.

It is important that locally agreed policies to do not create or impose additional restrictions on agencies above and beyond those required under the law. The policy should be limited to establishing agreed minimum standards, and leave scope for organisations to then develop their own in-house policies as appropriate to each organisation. A separate briefing document *Management of Drugs on Premises: Regional Protocols for Accommodation Providers* provides a more detailed consideration of this subject.

Group-organisational strategies

Larger organisations may have, or be in the process of developing, an organisation-wide drugs policy. As with city- or region-wide strategies, it may be beneficial if such strategies restrict themselves to minimum legal and good practice standards and allow local agencies to develop their own locally applicable policy. A housing provider may be working with drug users across the spectrum of use from chaotic and dependent use through to abstinence. A “one size fits all” policy is clearly not appropriate. Projects could use the high, mid or low tolerance policy as appropriate, within an umbrella of an overarching minimum standards policy.

EXAMPLE: NATIONAL DRUG AND MENTAL HEALTH CHARITY

A large national drug and mental health charity operates a range of different provision. This included residential rehabilitation provision, supported accommodation for people with mental health issues, street-level drug projects and outreach services.

The organisational drugs strategy established the minimum standards across the organisation. Each local service developed a drug strategy that reflected their own provision, and these also tied in with area drug strategies where applicable.

CORE PRINCIPLES OF POLICY DEVELOPMENT

Different organisations will end up with different stances relating to drugs. Some will be much more liberal and seek to work with ongoing use. Others will be less tolerant of substance use. Irrespective of these differences, there are some core principals which must be features of any drugs policy. These are not stance-dependent.

Legal

A drugs policy needs to be legal. While this may sound like an obvious point, it is fundamental to developing a good drugs policy. The policy should:

- **Ensure that the organisation is aware of and addresses its legal obligations.**
  Example: An organisation is legally obliged to stop the supply of controlled drugs taking place on its premises. The drugs policy reflects this and ensures that such activities are prohibited.

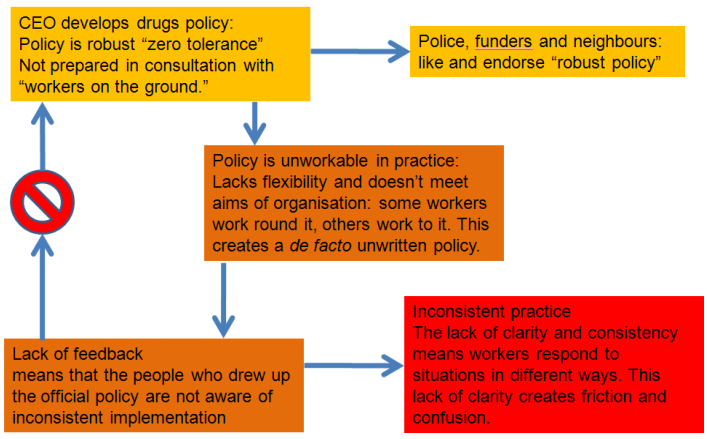
- **Ensure that it does not require workers to follow a course of action that is illegal or could put them at risk of harm.**
  Example: It would be illegal for staff to store confiscated controlled drugs in an office drawer until they could be collected by the police later in the week. It would be unsafe for a policy to mandate that staff must confiscate drugs from people known to be in possession of controlled drugs.

- **Ensure that it does not prohibit a course of action that may be legally required at some point, or be necessary as a matter of good practice.**
  Example: Under some circumstances, it will be essential to pass information on to third parties such as the police without a client's consent. The drugs policy should not preclude such a course of action.

Agreed between key parties

The policy should be agreed between key parties - managers and trustees, frontline staff, client, external parties such as the police and the local community. All too frequently, organisations end up with a written policy which reflects the needs and opinions of one interest group but doesn't reflect the situation on the ground. This can lead to the following situations:

- While there may be a single written policy, in practice this is rarely followed or implemented. It may well be agreed with funders, neighbours and the police but is, in reality, for public consumption rather than in use as a practical working document.
- In practice, staff work to a different policy – often an unwritten one. Such an arrangement leaves all parties – staff, managers, clients and external parties at risk. Staff cannot or do not work to the drugs policy and interpret situations as they think appropriate. This creates confusion for clients who will receive markedly different treatment from different staff. This fosters resentment and is more likely to result in conflict.
- Managers are left believing that an effective drugs policy is in place, and may be unaware that staff cannot and do not actually deliver it. In their liaison with external agencies such as the police, managers, in good faith, continue to spread the message that the organisation has and is working to the agreed drugs policy.



EXAMPLE: SENIOR MANAGEMENT ENFORCING A POLICY

The senior management of a housing charity has developed a rigorous anti-drugs policy. It includes a clause that says: "***The use of illegal drugs will not be tolerated. Anyone found using illegal drugs will be asked to leave immediately***."

The managers have consulted with the police who have supported the agency's tough stance on drugs.

In practice, workers frequently encounter people who may be using drugs, especially smoking cannabis. They do not think that it would be appropriate to evict people each time they find out they are smoking cannabis, and do not do so.

Some staff do nothing, and turn a blind eye to it; others warn residents what could happen. However, staff rarely enforce the sanctions as outlined in the drugs policy.

The managers are unaware that the policy is not being informed and in good report to trustees, the police and funders that the policy is working.

The aim of an effective policy and consultation process should be to produce a single workable policy that reflects the requirements of all the relevant parties. The outcome is that each party involved in the policy has a clear insight into what is really going on. Staff have a clear policy that they were instrumental in developing. In turn, managers are kept informed of breaches of the drugs policy, and actions that have been taken. Finally, external bodies can be kept informed of how the drugs policy is being implemented.

Reflects the aim and nature of the organisation

Different organisations have very different aims and objectives. Each organisation's policy will need to reflect those aims and objectives, within existing legal constraints. The drugs policy should not conflict with the organisations stated aims and its raison d'être. For example, a residential rehab would want to adopt a policy that worked to create a drug-free environment, and so may well want to exclude people who were intoxicated or in possession of various drugs. They would need to use a Low Tolerance policy. On the other hand, such a policy may not be appropriate for a night shelter seeking to house current drug users, in which case a higher tolerance model should be implemented.

The physical environment, the staffing levels and the skills of staff will also have an impact on policy development. The issues facing a day centre are very different to those in a residential setting. Night shelters with dormitory-style facilities will need to adopt different policies to those that have individual rooms.

In part this is why it will prove impossible to develop a single strategy for all environments: each agency will need to tailor responses to their own situations. This issue is discussed in greater detail in the template documents.

Workable

It is essential that the written drugs policy is practical and workable. This means that it can reasonably be delivered in practice, and does not create unreasonable or unrealistic expectations of staff or clients. The best way to establish a workable policy is to ensure that staff who deliver it are actively involved in the process.

EXAMPLE: AN UNWORKABLE ELEMENT OF A DRUGS POLICY

A drugs policy says "*Where staff know or suspect that the supply of drugs is taking place they will immediately bar that person and call the police."*

In practice, this would mean that each time staff suspected that a person shared cannabis with another, they would need to be immediately barred and the police would need to be called. While there would be a clear need to act in such a situation, the steps required by the policy are likely to be impractical and unworkable.

Flexible
The drugs policy needs to be flexible enough to cope with the wide range of different situations that workers encounter. The temptation is to write rigorous and inflexible rules. Certainly, these leave little room for confusion and make it clear what staff are expected to do. All too often staff have requested clear 'black and white' policies, disliking the uncertainty that can creep in with a flexible policy.

The risk is that such inflexible rules leave little scope for staff to take account of specific circumstances and do not have the opportunity to make their own decisions.

It is very difficult, if not impossible, to write a policy that takes into account all the possible situations that staff may encounter. It is preferable to adapt the following strategy:

- Develop a policy that is flexible, but ensures that some action is taken in each situation
- Provide training that ensures staff have the skills and confidence to work within a flexible policy
- Ensure that procedures for recording and reporting back are incorporated into the policy to ensure that it is being implemented effectively and equitably.

Whether a rigorous or flexible policy is adopted, it is imperative that once written, the policy is implemented rigorously. If aspects of the policy prove unworkable they should be redrafted.
The golden rule of policy writing that emerges from this is **policy should be written flexibly and followed rigidly, not written rigidly and followed flexibly.**

EXAMPLE: BEING FLEXIBLE WITH YOUR POLICY

An organisation has a policy that reads "*where we know or suspect you of supplying drugs, you will be asked to leave immediately.*"

One night at 3am in January, one of the female residents is seen giving one of her Valium to another resident who is very distressed. The workers feel that the breach of the drugs policy requires some action, but it is not appropriate, safe or helpful to require the person to leave at this point. However, the policy is unequivocal, and allows no other course of action. Following discussion with the managers it is clear that the policy on this occasion is unworkable and needs to be revised.
Subsequently, the policy is revised so that staff can decide on appropriate action in each case. It now reads "*Where we know or suspect that you are supplying drugs we will always take action to stop this. This may include you being temporary or permanently barred, and may result in the police being involved."*

The revised policy goes out for consultation, and is approved by external key agencies.

In training and policy development, it is useful to 'stress test' a policy by running scenarios against it. By using a range of scenarios, from the minor to the extreme, it should be possible to see if the policy and procedures have the flexibility to cope with a broad spectrum of situations.

ORGANISATIONAL AIMS AND POLICY DEVELOPMENT

For an organisation's drugs policy to work, the starting point should be a careful consideration of the organisation's aims and objectives in relation to people who use drugs. Not a single clause of the policy or procedures should be committed to paper unless and until the organisation has ensured that it is clear on its aims. Fundamentally the aims of the organisation shape the ethos and spirit of the policy. All too often, things are set up the other way around: the policy is written first but then conflicts with the organisation's aims.

Factors that shape the organisational aims
The organisation's aims in relation to drugs will be shaped by several factors. These include:

- **Charity/organisational mission statement/objectives**
  While the organisation may not have a specific set of aims in relation to drug use, their wider

aims and objectives are likely to have a bearing on the direction of the drugs policy. For example, an organisation attempting to house single male rough sleepers aged under 30 will invariably be working with significant levels of drug-related need. It would therefore need a drugs policy that would accommodate such need – a higher tolerance model.

- **Local need/client need**
  Hopefully, the development of any project reflects local need and so the project's aims have emerged in part as a response to local needs assessment.
- **Requirement of funders**
  Project aims may need to change, evolve and adapt to reflect the needs and expectations of funders. This could be, for example, a requirement by funders to develop a service which is better able to meet the needs of drug users.
- **Project aim**
  A project may have specific aims, within the wider organisation. This could be to work, for example, with people who are currently abstinent or, conversely, may be aimed at people who experience high levels of drug-related need.
- **Staff and building limitations**
  In the real world, the shape and structure of a building, the number of staff available and the skill-set of staff may determine what can and cannot be done in terms of a drugs policy. Shared houses, shared rooms and dormitories mean that some behaviour cannot be tolerated that would be acceptable in non-shared settings.

In an ideal world, service provision would reflect local need alone. In practice, any of the above factors could mean that local need or the needs of clients are not met due to the demands of funders, organisational intransigence or a mismatch between the project's aims and what is really needed.

Drug-specific organisational aims

Drug users are not a homogenous group. They differ in terms of age, gender, ethnicity, sexuality and ability. The drugs used, the nature and level of use, and the extent to which the use is (or is not) problematic will also vary. People who use drugs or have used drugs will also be at different points in their own processes of change. Beyond these personal and drug-specific characteristics, individuals will have a collection of other distinctive characteristics which will influence the type of housing and attached services that will serve them best.

Some of the above factors, such as age group worked with, or gender-specific service provision, may well be linked to organisational or charity aims. A foyer, for example, will be working with under 25s as part of its organisational aims, and a Women's Refuge will, by its nature, be working with women.

But what we then need to consider is what level of drug-related need an organisation aims to work with. There are a number of ways of exploring this. Some commentators, notably Norfolk DAAT[1] approach this from a 'Cycle of Change' model linking preparedness for change to drug-policy models.

Agencies may however find it easier to shape their thinking as to what level of drug use they intend to work with by more drug-specific questions. This means exploring the types and patterns of drug-related behaviour that an agency envisages that they could and should be working with.

Having established the range of drug-related need that the agency plans to work with, this in turn determines the organisational stance/ethos on drugs which best suits that level of need.

Overleaf is a series of questions intended to help identify the drug-specific organisational aims.

[1] Accommodating Substance Misusers: The 'Spectrum of Possibility' - A Guide for Housing Providers Norfolk Drugs and Alcohol Partnership 2007

ORGANISATIONAL DRUG AIMS IDENTIFICATION TOOL (ODAIT)

PLEASE TICK THE <YES> OR <NO> TO THE FOLLOWING QUESTIONS	Yes	No
1: We intend to work with people who were formerly drug dependent and who still have support needs in terms of their recovery. If the answer to this question is <yes> please indicate which of (a) (b) or (c) is closest to your aim. Only choose one.		
a) We expect these people to now be abstinent from all illicit substances, recreational licit substances (e.g. legal highs) and alcohol or		
b) We expect people to be abstinent of all illicit substances but do not expect people to be alcohol free *or*		
c) We expect people to be no longer using the substance on which they were dependent but do not expect them to be drug free (e.g. will work with former heroin users who still use cannabis		
2: We intend to work with people currently actively engaging with structured drug treatment including substitute prescribing. If the answer to this question is <yes> please indicate which of (a) (b) (c) or (d) is closest to your aim. Only choose one.		
a) We expect to be working with people who are using class A drugs on top of their prescribed drugs *or*		
b) We expect people to be exclusively using their prescribed drugs and not using opiates or other class A drugs on top *or*		
c) We expect people to be exclusively using their prescribed drugs and not using any illicit drugs on top *or*		
d) We expect people to be exclusively using their prescribed drugs and not using any substances on top including alcohol		
3: We intend to work with people who have current patterns of problematic and dependent drug use. This will include chaotic patterns of use, polydrug use and long-term use. If the answer to this question is <yes> please indicate which of (a) (b) or (c) is closest to your aim. You can have more than one answer.		
a) We anticipate working with current injectors and other class A drug users		
b) We expect to work with people not currently engaging with structured treatment		
c) While we would always want people to reduce and stop using this is not a condition of housing		
4: We intend to work with people who use drugs. However, we do not anticipate working with very heavy patterns of use. Instead we envisage working with recreational and non-problematic users. If you have answered <yes> to this question, please answer the questions below.		
a) Would you accommodate injecting drug users, even if this was only on an exceptional basis?		
b) Do you plant to work with low levels of problematic use (e.g. binge-drinking, heavy cannabis use) but not dependent use		
c) Do you plan working with significant numbers of young people with moderate levels of use (frequent, recreational)		
d) Do you anticipate working with young people with minimal drug use, and whose use is wholly controlled and currently non-problematic?		
5: We do not intend to work with people who drug-related issues. We primarily work with non-users. If you have answered <yes> to this question, please answer the questions below		
a) We recognise that we may still encounter use either from our own residents or their families, visitors or friends		
b) When we work with former users/ex-users it is at a point where their use is so long in their past that they do not have current support needs in relation to their use recovery.		

ODAIT outcomes

Using the ODAIT tool, organisational aims can be loosely banded, and then matched against broad policy positions. These are described below and linked to the specific ODAIT groups:

POLICY TYPE	DESCRIPTION	ODAIT GROUPS
High Tolerance	This policy position is intended for organisations working with people who have extensive drug-related need and are still using non-prescribed drugs problematically. The policy acknowledges and works with ongoing use and allows for and works with significant levels of drug activity. The policy will work within the existing legislation and has scope to manage injecting on site and potential use of other drugs as far as the law allows. Recognising that the client group includes people who are still in active addiction the policy also works pragmatically with possession and intoxication and also recognises and works with possession on injecting paraphernalia.	2(a) 3(a) 3(b) 3(c) 4(a)
Moderate Tolerance	While clients in this accommodation may have, or have had significant levels of drug-related need, this service is primarily not intended for current Class A drug users or injectors. As such the organisation is going to be less tolerant of episodes of injecting and such other class A drug-use on site and such episodes will be more likely to result in a person's stay being curtailed, with them being moved in to High Support-High Tolerance housing. The policy is intended to be flexible enough so that it can accommodate lapsing drug users, and is especially suitable for young people's housing provision where there is likely to be recurring recreational use but less likely to be dependent and injecting.	1(c) 2(b) 4(b) 4(c)
Low Tolerance (variant A)	The organisation does not primarily have a remit to work with drug use and works with people who have little or no current drug use. Although there is no expectation that people will be abstinent, use of most substances is not permitted on site and so those who do use will be expected to control their use and do so away from the premises. The policy can accommodate and work with minimal levels of drug-related behaviour but doesn't seek to accommodate higher levels of drug use. If the aim is to achieve drug-free housing see Variant B below.	1(b) 2(c) 5(b)
Low Tolerance (Variant B)	Given recent history of substance dependency and high support needs, this population is seeking to live in an effectively drug-free environment. As such the policy will not tolerate ongoing use of substances on site and so any drug-related activity will be met with very low levels of tolerance. It will be inappropriate for people who require this model of housing to be accommodated in High Tolerance housing as the proximity to significant levels of ongoing use may increase chances of lapse.	1(a) 2(d)

Consequences of mismatching aim and policy type
When an organisation's aims and policy type are mismatched, outcomes are invariably negative. These tend to include:

- **Increased evictions and abandonment:**
  residents with high levels of use and high support needs are repeatedly coming in to conflict with rules and policies which set the bar in terms of drugs at an unrealistically high level.
- **Increased secrecy and covert activity:**
  in situations where people with high levels of drug-related need are housed in a low tolerance environment, those that can will keep their drug use hidden so that they don't get punished. While in the short term this means residents are not in breach of the policy, it means that their drug-related need can't be properly addressed.
- **Increased risk of drug deaths:**
  Review of a number of fatalities in housing providers indicates that a mismatch between aim and policy type increases the risk of drug deaths. Where policy actively discourages openness about drug use and increases fears of sanctions for drug use on site, residents are less inclined to involve staff in overdoses, increasing risk of fatality. Furthermore, where policy is mismatched, residents are less likely to be honest about the nature and level of their use and so can't be monitored more closely for risk of overdose.
- **Staff don't comply with policy:**
  If the staff want to retain existing clients but the policy conflicts with this, the odds are high that staff will no longer work to policy, bringing with it inconsistency and conflict.

Mismatching groups
While mixing some of the populations within the Organisational Drug Aims Identification Tool is tolerable this needs to be done with care. Mixing at the extreme ends is not tenable and brings with it risk to some of the parties concerned. Some of these are riskier than others.

- Placing people who should be in high support – high tolerance housing in high support – minimal tolerance housing brings risk to both sides: it can jeopardise the recovery of those who are abstinent, and maximises the chances that the person who is still using will need to be moved again rapidly.
- Similarly placing someone who should be in Low Tolerance (abstinent) settings in High Tolerance settings can jeopardise their recovery.
- Placing people with high levels of use in settings primarily for low-level recreational users (or vice versa) brings with it the risk that use amongst low-level users will escalate. Placing younger, vulnerable low level users in high need – high tolerance settings should be avoided wherever possible.

EXAMPLE: RAINBOW HOUSE AND FIRST STOP

Rainbow House is a hostel housing ex-users in recovery. Their aim is to provide drug-free housing for people who are abstinent and are endeavouring to remain so.

Based on this their policy on possession is that they "*do not tolerate the residents or their guests bringing any substances on site, including medicines, unless approved by hostel staff. This includes caffeine-based products but currently excludes tobacco."*

This is an example of a Low Tolerance Policy clause. Although highly restrictive, the policy is fully in keeping with their aims and is fit for purpose.

First Stop Housing is a direct access hostel providing housing for men over 25 with long histories of rough sleeping. This includes men who are currently using controlled drugs or alcohol problematically, including current injectors.

However, their current policy on intoxication states "*residents who are or appear to be under the influence of any substances will not be admitted to the hostel, or will be asked to leave the hostel until they are no longer intoxicated."*
Here the policy and the aim are in conflict and one of the two needs to be revised.

POLICY AND PROCEDURES

A 'drugs policy' is, in truth something of a misnomer. The document an organisation is really trying to produce is a drugs policy and procedures document. To understand why this distinction is important we need to explore the difference between the policy and the procedures.

Drugs policy

The policy outlines the organisation's stance and ethos in relation to drugs and specific drug-related behaviours. The policy directly derives from the organisation's aims. As such the policies should reflect and be supportive of the organisation's aims. The policy is where the statements of what the organisation will and will not tolerate should be located. Statements of activities that are prohibited are included here.

Procedures

The drug procedures are the set of actions that an organisation will take on encountering a drug-related situation. The procedures will be the practical way that the organisation meets its aims and policy position. Obviously the procedures must be in keeping with the policy, which in turn is in keeping with the aims.

EXAMPLES OF AIMS

Our **aim** is to work with ex-users in recovery so ***we will not tolerate possession*** on site;
Our **aim** is to work within the law so ***we will not tolerate supply on site***
Our **aim** is to work with on-going injectors and so ***while we do not condone injecting we will tolerate this behaviour***.

EXAMPLES: AIMS – POLICY – PROCEDURES

In the example below, the organisational aim is clear, and the Policy (in relation to injecting equipment) is also clear. The Procedures are in line with the Policy and Aim.

Aim:	Policy:	Procedures:
To work with ongoing users including current injectors	We allow the possession of injecting equipment provided that it does not create a risk to others	•We will provide sharps boxes for residents •We will encourage injectors to use needle exchange •We will not apply sanctions to any residents storing sterile needles and syringes in their rooms •We will require residents to remove used equipment stored unsafely, or it will be removed by staff; such behaviour will result in action being taken and could ultimately result in eviction.

In the second example below, while the aim and policy are correctly framed and in agreement, the procedures are not. The procedures would be more akin to a low support – low tolerance model and so are not suitable for a project with these aims.

Aim:	Policy:	Procedures:
To work with ongoing users including current injectors	We do not condone possession or use on site, and will not tolerate this behaviour where it causes risk or distress to staff or service users.	•Where we know or suspect use is taking place users will get a Notice to Quit •A further episode of use within this notice period will result in eviction •Suspicion of use will include intoxication on site or possession of used equipment

Procedures should provide enough detail to ensure workers know how to respond to incidents in the short and medium term. It should be explicit as to which steps are mandatory, and which steps should be considered. The procedures should be sufficiently flexible so that workers can use their own initiative based on specific situations to decide how to proceed in the circumstances.

Structuring procedures – A "Safety-First" Approach
When responding to any incidents, it is helpful to group procedures in to immediate responses and later responses.

- **Immediate responses:** these are the steps that will need to be taken as soon as workers become aware of the incident in question and in the hours thereafter.
- **Later responses:** one the immediate situation is dealt with, subsequent responses could include review of the incident, imposing sanctions if required, moving the person out if required, staff or client support and referral.

Immediate responses – why they tend to cut across aims
Earlier, we have looked at why the organisation's policy and procedures need to be related to the organisation's aims. However, the initial procedures that an organisation will need to adopt to most drug situations will be similar **irrespective of the organisation's broader aim** or policy. This is because the organisation's responses to any given situation should be driven by the following priorities:

- The safety of staff and other clients
- The safety of the person or people directly involved in the issue
- The safety of the wider public.

The aim of the initial procedures should be to **make the situation safe and stable**.

At a later point, any sanctions, educative interventions and referrals can be implemented. But they are not the immediate priority.

As these initial interventions are safety-driven, they will be implemented by all front-line staff and the decisions that need to be made here are **not moral decisions but practical ones**. It is important that staff have been given the authority and equipped with the skills to make these decisions as this is not a time to be referring matters up the management hierarchy.

Later responses
Having dealt with the immediate situation, and hopefully stabilised it, there is now time and space to reflect on what has happened and what needs to happen next. This is an opportune time for other colleagues and senior workers to contribute to determining what responses are required. Decisions at this stage could include:

- warnings and sanctions that could be applied
- educative and harm reduction interventions
- referral to other agencies
- required changes to behaviour to sustain housing
- decisions to evict.

These later decisions will vary much more widely from organisation to organisation. The decision, for example, to evict will be heavily influenced by the organisation's aims and intended client group.

However, as a guiding principal, organisations should seek to look at each case on its own merits and look at the **context, gravity and history** of each episode when determining the required later responses.

Context: this looks at the immediate factors surrounding the episode. These could be aggravating or mitigating factors. For example supply of methadone is a serious breach of most policies. But if the context was that a vulnerable resident was being bullied in to giving it to other residents, then the context would suggest that support rather than sanctions would be the most appropriate response.

Gravity: The organisations should assess how serious the episode was. This should look at the people involved, the scale of the episode, the substances involved and the level of risk. Possession of a single cannabis plant may warrant a different level of response to someone

growing fifty plants. Likewise, someone found to be giving someone else their prescribed diazepam may warrant a different level of intervention to someone selling crack.

History: This will involve looking at the person's previous behaviour – have there been other incidents and warnings. Has this been the first instance ever, or in a long while? Has the person been engaging well with other services and with supportive interventions?
The team or designated workers should weigh up all these factors and decide on an appropriate course of action.

A collegiate response
Many workers will have different and strongly held views in relation to drugs. Some will be over tolerant; others will be overly prohibitive. To level out some of this personal bias it is preferable to adopt a collegiate or team response where different key workers can be involved in deciding later responses. This could, for example, include the whole team, or specific workers with an interest in the case. A good simple model in many organisations is representatives from housing management, staff from support services and a manager to oversee the process.

Actions – record – review
Taking prompt and appropriate action is essential. But documenting the actions taken is just as important. Records should be kept which detail:

- what happened – making sure that suspicion is recorded as suspicion, and facts are recorded as such. Workers should not make unwarranted or un-evidenced assertions as facts
- what workers initially did to make the situation safe – and the outcomes of this
- what subsequent actions were taken.

There are potentially two reviews that could now take place. One is a review of the incident – what happened and why, and did the procedures and initial interventions work.

Following any serious incident, a review of the incident should take place to see if the incident could have been better anticipated or prevented.

If the procedures or policy were found to be wanting, they should be reviewed and amended in light of the incident; if the incident highlights deficiency in staff knowledge or confidence in dealing with the episode this should be addressed and rectified.

Having finalised later responses (such as warnings or sanctions) a review of the incident should take place to ensure that the measures identified have been put in place and have been effective. If they have not been effective, further action may be required.

Equality of process NOT equality of outcome
It will be very apparent that using the approach described in this section different people who, on the face of it are potentially breaching the same "rule" will end up with different sanctions being applied within the same organisation.

This can lead to accusations that this is not "fair" and what happens to person A should happen to person B if they have both committed the same infraction. There is therefore an argument to be made for a system where there is equality of outcome – that each person receives the same sanction for the same offence, irrespective of the context or gravity or history.

This approach is fundamentally flawed in practice and ends up being much more unfair. Using a previously-cited example, if a resident is being harassed in to sharing his methadone, then under an equality-of-outcome model, they should receive the same sanction as someone who is selling heroin.

When organisations adopt such an inflexible approach, it tends to result in staff having to work round the policy to avoid manifestly unfair application of the policy.

In most situations, it will be better to adopt an "**equality of process"** approach in which everyone's case is handled the same way, but the outcome may vary from case to case. The outcome will then be able to take on board factors such as the **context, gravity** and **history** surrounding each incident and ensure that responses are proportionate.

The downside of an equality of process approach is that it can allow bias and favouritism to influence decisions. To guard against this, it will be better to adopt a team or collegiate approach to deciding on the outcome of incidents, so as to reduce the chance of bias or preferential treatment.

Appeal
In order to make the whole policy and procedure as transparent and fair as possible there should be scope within the policy and procedure for people to appeal against decisions with which they disagree. Any review should take place within a reasonable time and should include people not involved in the original episode.

PRODUCING A USABLE DOCUMENT

The policy templates published alongside this document will look overly long. However, they are intended to cover a range of situations. The team drafting the policy will be able to remove irrelevant clauses. There should be three final versions:

- a comprehensive version for Senior Staff, including project managers and team leaders. It should be the "reference" version which includes most situations, common and uncommon.
- An edited version which includes policy and procedures but doesn't include legal sections and the notes. It would include the flowcharts in the Appendix. This is the working version and is for front-line staff.
- A summary of the key policy sections, in an accessible form, which is available to residents.

While editing the document for different audiences, agencies should of course personalise it to reflect their own organisation. They should however be cautious about changing the wording where to do so would change the intent of the section. The wordings have been carefully chosen to produce a coherent policy and apparently innocent change to a wording can introduce conflict or inconsistency.