Sample Drugs Policy
and
Guidance Notes

v1.01 March 2017

Moderate Tolerance Version
for
Lower-Use Environments

homeless link
KFx
Learning of Substance

Copyright and Disclaimer

This document has been prepared by Kevin Flemen at KFx. It is a new version of the Sample Drugs Policy, and is intended for "moderate tolerance" environments working with non-users at minimal risk of lapse by exposure to drug use, experimental and recreational users working to manage their use and other settings where there is a rationale for a flexible approach to managing drug use.

Versions of the Sample Policy for "High Tolerance" and "Low Tolerance" environments are also available. It is essential that organisations base their policy selection on their needs rather than policy preference.

The Sample Drugs Policy was written originally written in 1999 with subsequent revisions in 2001, 2004, 2006, 2011. In 2016 it was significantly revised to reflect the passing of the Psychoactive Substances Act 2016 and the changing drugs landscape relating to NPS use.

Organisations are welcome to use and adapt the contents of this document and may reproduce it for internal use or for onward distribution. Please be aware that significant amendment may make the Policy contradictory and unworkable and so please exercise care when changing wording. We would ask that the authorship of the document is acknowledged and a reference to the KFx website is included so that end-users can track back to the source document.

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.

The development of this resource took place with the support of Homeless Link.

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CONTENTS

1. INTRODUCTION

1.1 BACKGROUND

The *Sample Drugs Policy* was first published in 1999. It was written by Kevin Flemen while working at the drugs charity Release. Following the "Wintercomfort Trial" in Cambridge, organisations were very concerned about producing an effective drugs policy.

The *Sample Drugs Policy* was a response to these concerns and offered a model which on the one hand sought to increase access to services to homeless drug users, who are all too frequently excluded from services. Simultaneously, the policy ensured that agencies work within the law.

1.2 REVISIONS TO THE ORIGINAL VERSION

The original document has been revised a number of times, and was last revised in 2011 with the help of Homeless Link.

The emphasis of the Policy has shifted somewhat over time. It adopts a "safety first" approach which prioritises, in the first instant, the safe management of incidents. Irrespective of an organisation's stance on drugs, the first responses in the procedures are broadly similar as they work to make the situation safe. Later responses will vary according to the organisation's stance on drugs.

In the intervening five years, there have been some changes in drugs trends with the advent of Novel Psychoactive Substances (NPS) and the increased use of Naloxone to manage opiate overdoses. In addition to this shift in emphasis, various wordings have been revised to ensure the Policy remains up-to-date and relevant.

1.3 WHO SHOULD USE THIS SAMPLE POLICY?

This version of the *Sample Drugs Policy* is a **Moderate Tolerance Model.** It is designed for use in organisations or projects who intend to work with some ongoing drug use, including experimental and on-going recreational use. It extends to environments where use may be problematic.

It is for environments where service users are:

- Non-users, but who do not need to be in abstinent housing to avoid lapse
- Recreational and controlled users who experience few or no problems with their use
- Recreational users who may be at risk of developing problems or who are trying to manage their use better.

The policy is especially suitable for housing aimed at 18-25 year olds where a significant proportion of the cohort will have some recreational use, and where a Low Tolerance Policy would result in a high exclusion rate. It allows for repeat episodes of use and provides scope for such on-going work.

The policy is not suitable where the organisation anticipates working with people with significant levels of problematic drug use, regular on-going use and drug dependency, especially where injecting is a feature. In such situations the **High Tolerance Model** will be more suitable. This is in the Resource Section of the KFx Website. [http://www.kfx.org.uk/resources.php] The two policies are very similar, and the key differences are found in the aims, and the sections on injecting and paraphernalia.

In Part 1 of this document, there is a simple exercise that can help an organisation establish which type of policy model will meet their needs: The Organisational Drug Aims Identification Tool [p13.] If an organisation is uncertain what type of policy they will need, they should read the first section of this document and complete this exercise.

It cannot be stressed enough that an organisation should base its policy on its aims, NOT choose a policy because they like that particular policy.

1.4 PURPOSE OF THIS GUIDANCE

The document cannot, of course, offer a panacea to all service providers working with drug users. Each organisation needs to look at its own specific situation, and adapt a policy accordingly. Hopefully, this document will provide a useful framework to assist this process.

The *Sample Drugs Policy* is intended to be read alongside several other documents on the KFx website, including the Drugs Legislation document, and additional essential resources; these are listed in the Reading List on page 58 of this document.

Please note that this is a working document. It is produced for discussion, guidance and consultation, and will be updated and improved in response to feedback.

Agencies are welcome to use, adapt and incorporate ideas or wording from this document in their own policies. If you wish to use some or all of the document for internal use, we would ask that the following wording is included:

> "This policy draws on the '*Sample Drugs Policy* developed by Kevin Flemen/KFx.
> This is located at www.kfx.org.uk"

Agencies are also welcome to reproduce and distribute this document, provided that it is not altered without consent and that Kevin Flemen/KFx are credited and that these caveats are included in the document.

1.5 ACKNOWLEDGEMENTS

This document and the work that has stemmed from it owe a huge debt to many workers and individuals who have supported this work and taken it forward. I would like to express my deepest appreciation to those people for their support, encouragement and input, and for implementing so much of this work practically.

The development of this version of the Sample Policy and previous revisions was undertaken with the financial support of Homeless Link, whose assistance is gratefully acknowledged.

Kevin Flemen: March 2017.

2. GETTING IT RIGHT: HOW TO WRITE A DRUGS POLICY

2.1 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?

The second half of this document is the "Sample Policy." But that doesn't mean that this 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 this pack, 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 this pack 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.

2.2 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.

2.3 CORE PRINCIPALS 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.

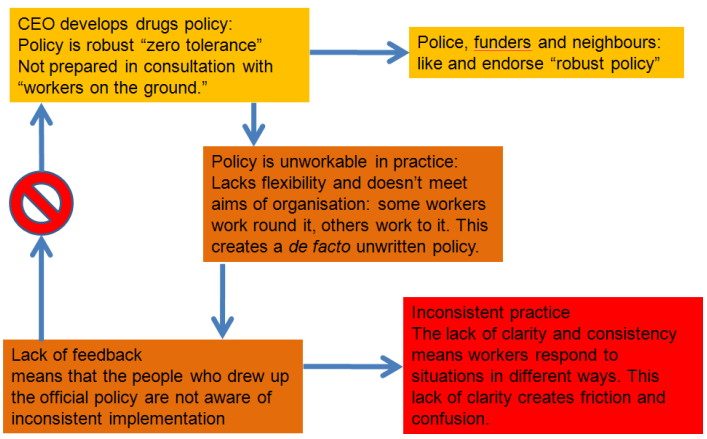
- **Ensure that it does not require workers to follow a course of action that is illegal or could put them at risk of harm.**
  Example: It would be illegal for staff to store confiscated controlled drugs in an office drawer until they could be collected by the police later in the week. It would be unsafe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

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 policy needs to be flexible enough to cope with a wide range of different situations. 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 often useful to 'stress test' a policy by running a range of 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.

2.4 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 several 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) Do you plan to work with injecting drug users?		
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 low to moderate levels of use		
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.

2.5 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:
To work with ongoing users including current injectors

Policy:
We allow the possession of injecting equipment provided that it does not create a risk to others

Procedures:
- 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:
To work with ongoing users including current injectors

Policy:
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.

Procedures:
- 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.

2.6 PRODUCING A USABLE DOCUMENT

The policy that follows will look overly long. However, it is 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 flow-charts 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.

3. SAMPLE DRUGS POLICY [MODERATE TOLERANCE MODEL]

3.1 USING THE SAMPLE POLICY

To make the document as useful as possible, there are several different types of information, which are laid out as follows:

POLICY AREA: THE SECTION OF THE POLICY UNDER CONSIDERATION

SUB-SECTION OF AREA: THE SPECIFIC SECTION OF THE POLICY AREA UNDER CONSIDERATION

EXAMPLES

Examples of the type of incident under consideration

SAMPLE WORDINGS

These are examples of how organisations could choose to word sections of the policy. They are intended to inform staff, clients or others about the implications of the policy.

These sections could be extracted and would inform the basis of a simplified policy for distribution to residents and staff.

LAW

Legal points provide an interpretation of law, and are important in ensuring that policies are legal. Where the law creates a COMPULSORY legal step, it will be marked with the following symbol:

These don't need to be included in a summary of a policy, but should be included in a comprehensive reference document for senior staff and managers, and for everyone else to refer to.

PROCEDURES

These are a suggested set of responses to each section of the policy. They include steps that can be taken in response to breaches or suspected breaches of the policy.

These steps are not definitive. They could be adapted by organisations to their own situations as appropriate.

NOTES

Additional information is provided about the issues and rationale for each area of the policy. This section looks at the policy area in question and provides further information, discussion of alternatives, or highlights issues raised by the section.

Frequently, there will be a range of alternatives to a given policy area, and some of these will be explored here.

Where relevant the rationale for specific policy wordings will be explained here.

3.2 INDEX OF POLICY AREAS

PURPOSE, AIMS AND ETHOS

SAMPLE WORDING

"The aim of this organisation is to work with people in housing need. This project supports people who may or may not use drugs, and do not currently have significant levels of drug use. This includes:

- those who do not currently use any substances;
- Those whose use of substances is largely under control and so can comply with all project policies in relation to use;
- People who use and sometimes struggle to manage their use, but do not have a high level of dependency and do not inject drugs.

Our aim is to provide an environment where substance-related activity is managed at a low level and that wherever possible people who use are supported to reduce and control their use so that it does not have a negative effect on them or other people in the project.

The organisation also recognises that it has other duties and obligations including:

- An obligation to work within the law
- A duty to provide a safe arena for all workers and volunteers
- A duty to provide a safe arena for all clients, including non-users,
- A duty to work with and be sensitive to the local community

T
he organisation does not condone the possession or use of illicit drugs or Novel Psychoactive Substances (NPS) on site and will always act to address the use of such substances, or intoxication resulting from use.

The organisation also has rules governing the use of other substances including alcohol and medicines.

The organisation cannot and will not tolerate the supply of Controlled Drugs on site and will always take action to prevent such activities on site. Action will also be taken if other substances are being supplied on site.

NOTES

It is useful to include an overarching statement that outlines the purpose and scope of the drugs policy.

In the present example, the purpose of the policy is to create an environment where substance related activity is managed at a low level, which offers a more flexible alternative to a low tolerance model.

Other agencies may need to adopt a policy that creates a less restrictive environment when seeking to work with ongoing users.

STAFF AND THE DRUGS POLICY

SAMPLE WORDING

"Staff are expected to work to the drugs policy. Where staff are unhappy with an aspect of the policy, or are unclear how to deal with a situation, they should always discuss it with a senior worker.

Failure to adhere to this policy will be treated as a serious disciplinary matter."

PROCEDURES

- All staff should, as part of their induction, have the drugs policy explained to them. They should be given a copy of the drugs policy.
- As part of the induction process, staff should "sign off" to confirm that they have had the drugs policy explained to them.
- Locum staff and agency staff should have the policy available to them while on shift. Wherever possible, locum and agency staff should receive an induction that familiarises them with the drugs policy.
- As soon as practical after starting staff should attend a drugs training course. Regular training courses should be held in-house to refresh staff knowledge and ensure consistency in responding to situations. Such training should also develop the skills necessary to deliver the drugs policy such as increasing drugs awareness and dealing with difficult and challenging behaviour.
- All staff should receive regular supervision; implementation of the drugs policy should be discussed in supervision and difficulties in delivering the drugs policy addressed. Where necessary, further training or skills development should be made available.
- In some circumstances, it may be necessary to take disciplinary action such as when there has been a serious failure to follow the drugs policy and related procedures.

NOTES

It is important that managers ensure that staff understand and implement the drugs policy. It is not enough solely to draw up a policy. Steps, as outlined above, need to be taken to ensure compliance with the policy.

Many organisations are increasingly reliant on agency staff to cover staff shortages. It remains essential, nonetheless, that such workers work within the law and follow the drugs policy.

It is important that workers feel that the policy allows them to work effectively. Often, policies are written in a way that does not reflect actual working practices.

Ideally, a process of staff training, consultation and policy development will result in a policy that is both legal and that staff are happy to work within.

CLIENTS AND THE DRUGS POLICY

SAMPLE WORDING

"There is a drugs policy to protect the rights and safety of all clients. If you have significant support needs in relation to drugs, it is important that you discuss this with staff. Your accommodation may be at risk if you are unable to work with the Project's drug policy. This may be difficult for you if have problems controlling your drug use. We will work with you to address your support needs and where possible identify the most appropriate housing for you.
If you are not sure what the rules mean to you, please discuss them with the staff."

PROCEDURES

- All clients will have the organisation's drug rules explained to them when they start using the service. It is important that this is done in a clear way and that the client understands the rules. Some clients may have restricted reading ability, and so may not read the written policy. In residential settings clients, will also be given a written copy of the rules as part of their induction pack.
- Clients may be asked to sign an agreement that confirms that they have had the drugs policy explained to them and that they are prepared to work within the terms of the policy.
- In addition to this, notices outlining key points from the policy will be displayed on posters around the building. For a sample poster see page 68.
- Clients will be able to give feedback about the drugs policy via anonymous comment forms and through regular client meetings.

NOTES

Clients need to know what the rules are and that the rules will be implemented. It is important that clients not only understand what rules are there but also why those rules exist.
As this is a moderate tolerance policy it is only fair to stress that it will not create an appropriate environment for those struggle to control their use, have a high level of dependency and/or are current injectors who are not able to stop at this time.
User consultation can represent a useful way of agreeing rules and sanctions that clients think are fair.

DRUGS COVERED BY THE POLICY

SAMPLE WORDING

"The drugs policy covers many drugs, including:

- Controlled Drugs, whether prescribed or not: e.g cannabis, methadone, diazepam
- Prescription-only medicines, Pharmacy Medicines and medicines on the General Sales List, e.g. Prozac, Night Nurse, Paracetamol, other medicines,
- Alcohol and Tobacco
- Novel Psychoactive Compounds (sometimes known as Legal Highs)
- Misuse of energy drinks
- Culturally specific substances e.g. khat and betel"

LAW

Drug law is complex, and is covered by numerous pieces of legislation, especially: *Misuse of Drug Act (1971), Misuse of Drugs Regulations (1985)*, *Drugs Act (2005), Psychoactive Substances Act (2016). The Medicines Act (1968)* governs the manufacture and supply of medicines. Other legislation, such as the *Criminal Justice and Public Order Act*, *Roads Traffic Act (1988)*, the *Drug Trafficking Offences Act (1986)*, the *Crime and Disorder Act (1998)*, the *Antisocial Behaviour Act (2003)*, and licensing laws all have an impact on drugs offences.

PROCEDURES

- The policy is primarily concerned with Controlled Drugs illicitly held. The term Controlled Drugs (CDs) refers specifically to drugs listed under the Misuse of Drugs Act 1971. This includes, but is not limited to, heroin, ecstasy, cocaine, LSD, cannabis, and amphetamines. It also includes prescribed Controlled Drugs such as methadone or benzodiazepines when held without prescription.
- The policy also addresses prescribed controlled drugs licitly held, prescription-only medicines (POMs) and over-the-counter medicines (OTCs) where applicable.
- The policy also looks at other drugs not covered under the *Misuse of Drugs Act* including, but not limited to Novel Psychoactive Compounds (NPS), volatile substances (solvents), amyl and butyl nitrites (poppers), tobacco and alcohol.

NOTES

In a broad scientific sense, a drug is a substance, natural or artificial, that by its chemical nature alters structure or function in a living organism. It therefore includes alcohol, nicotine, volatile substances such as glue and gas, medicines and controlled drugs such as cannabis and LSD.

Different drugs occupy different legal and social positions and it is important to be clear what we mean when we talk about drugs. This will frequently mean dividing the term "drug" into different groups. The drugs policy and responses will, in turn, need to respond differently to these different groups.

Further information about controlled drugs and medicines is included in the appendices and on the KFx website.

PREMISES

SAMPLE WORDING

"We will take action under the drugs policy when we have concerns about drug-related activity both on and near the premises. This includes the entire building, and the area around it.

Drug-related activity in the neighbourhood around the building threatens the future of the organisation, and we will always take action when we become aware of such activity."

[*add the clause below if you support people living independently in the community where you provide floating support*]

"The property for which you have a tenancy is considered 'premises.' As the landlord/landlord's agent, we will take action when we have concerns about drug-related activity in, or near the premises. Such activity may jeopardise your tenancy."

LAW

Section 8 of the *Misuse of Drugs Act (1971)* places obligations on managers of premises to prevent certain activities on those premises.

"Premises" refer to hostels and night shelters, day centres and other settings such as drop-ins. Any building within the project grounds would be defined as premises, as would any yards, gardens, front steps, adjoining alleys or out-buildings. For landlords, the properties that they rent are premises and will need to be the subject of a drugs policy.

All areas within buildings, including individual residents' rooms should be treated as part of the premises. Other settings such as mobile outreach services operating from a bus may also constitute premises.

The powers to close premises included in the *Antisocial Behaviour Act (2003)* can be triggered by antisocial behaviour associated with a property even if the activity is not taking place in the property. Hence it is important that the policy has regard for activity taking place near as well as on the premises.

PROCEDURES

- While staff are on the premises, they will ensure that the building and the surrounding area is supervised effectively.
- Where there are insufficient staff to monitor the whole building, access to non-essential areas should be restricted.
- "Hot spots" where supply or other activities could take place clandestinely should be checked regularly.
- All complaints from the public regarding drug-related activity in the vicinity of the building should be logged, and the complaint should be looked in to. If this investigation supports the complaint, appropriate action should be taken.

NOTES

Where it is unclear where the boundary of a particular set of premises lies, organisations should consult the land registry entry for the building.

There is a lack of clarity as to how this piece of legislation should be applied to certain settings, especially in supported housing projects where staff are not constantly present, and tenants have Assured Shorthold Tenancies. While the tenant may be solely liable for what takes place in their flat, this is by no means certain. Liability may rest as well (or instead) with the organisation.

Erring on the side of caution, the policy should assume that the organisation could be held responsible for prohibited activities taking place in the tenant's flat.

The policy should address both what takes place on premises but also what takes place off premises, but in the vicinity of the premises, and incidents that take place away from premises. While organisations may not be legally liable under *MDA* s.8 for these incidents, organisations need a policy that allows them to respond to local incidents.

POSSESSION

ILLEGALLY-HELD DRUGS

EXAMPLES: *CANNABIS, NON-PRESCRIBED METHADONE, ECSTASY*

SAMPLE WORDING

"We do not condone people bringing prohibited substances into the building. Where we know or suspect that this is happening we will discuss the matter with you and may take further action, especially if you are putting other staff or clients at risk or distress."

LAW

The client is committing an offence by being in unlawful possession of a controlled drug. The organisation concerned, however, is not committing an offence even if they know or suspect that the client is in possession of a controlled drug.

Although the organisation is not in breach of legislation, bringing drugs on site is prohibited under a Low Tolerance policy.

PROCEDURES

Immediate:

These stages only apply if the drugs are found at a time when the user is present. If substances are found when the owner is absent, workers should proceed using the Finding Drugs section on [p33.]

- The worker will assess the situation from a risk perspective and act based on this assessment. The worker should challenge possession if it is safe and appropriate to do so.
- If a client is known or believed to be in illegal possession of controlled drugs they will be reminded that this means that they are committing an offence under the *Misuse of Drugs Act (1971)*, and workers will highlight the legal risks that this carries for the service user.
- The resident should be given the opportunity to surrender or dispose of the drugs should they wish to, or to remove them from the building. Workers should not impose this last option if it would encourage the person to use in a more hazardous location.
- Workers will ensure that information about drugs and relevant support agencies is available to the client, in order that they have the opportunity to look at reducing their drug use or reducing the risk of drug-related harm as appropriate.
- In exceptional circumstances, such as when a person is dangerously intoxicated and still has drugs in their possession workers could consider removing drugs in order to protect life.
- Where the quantity of the drug or other factors suggest that the client may be supplying drugs, the worker should proceed as described in supply [p38.]
- Where factors indicate that the drug is being used on the premises, the worker should proceed as described in use [p41.]
- All actions should be recorded.

Later Responses:

- Review of incident and appropriateness of accommodation
- Agreed behaviour policy or move-on as agreed
- Workers will ensure that information about drugs and relevant support agencies is available to the client, so they can explore reducing use or reducing risk as appropriate.

NOTES

This is a difficult area and one that involves no small amount of controversy. But, as the law stands, there is no obligation to prevent a person being in possession of a controlled drug. Many drugs policies do impose restrictions, such as saying "*no drugs on the premises.*"

It is not usually feasible to enforce such policies rigidly, as it will not normally be acceptable to search people, their property or rooms for drugs. More frequently, agencies will only take action when they become explicitly aware that a person has drugs on them.

In an environment working with some ongoing use, the aim is not to prevent drugs coming on site. However this doesn't mean "no action." All possession episodes should be addressed. The procedures above allow for a range of responses including the ongoing management of possession, whilst offering the resident the choice of removing, surrendering or disposing of drugs.

PRESCRIBED CONTROLLED DRUGS AND MEDICATION

EXAMPLES: PRESCRIBED CONTROLLED DRUGS: METHADONE, SUBUTEX, DIAZEPAM
PRESCRIBED MEDICATION (NON-CONTROLLED DRUGS): FLUOXETINE, ANTIBIOTICS

SAMPLE WORDING

"You must discuss bringing any prescribed Controlled Drugs or other Prescribed Medicines with staff in advance. You should only bring such medicines on site with staff approval. This is for your wellbeing, the safety of staff and other customers.
Always keep such approved medicines either on your own person, or store them somewhere securely. Please keep them in their original packaging and with labels intact, so we know that they are yours. Do not give them to other people to take or to look after."

LAW

Where clients are in possession of Controlled Drugs that has been prescribed to them, no offences are being committed.

PROCEDURES

- In keeping with a moderate tolerance environment, there may be restrictions placed on some commonly misused medications such as opiates or benzodiazepines. It may be that the need for such medication, although prescribed, indicates a higher level of support need than is appropriate for a medium tolerance environment.
- Clients are therefore required to inform staff what drugs they have been prescribed.
- With the client's consent, workers should seek to work with prescribers and pharmacies to ensure clients are not prescribed large quantities of drugs at one time.
- Prescribed drugs should be kept in their original packaging, with labels left intact. Such medication should not be openly displayed, left unattended or given to others for safe- keeping.

OTHER SUBSTANCES (NON-MEDICINAL, NON-CONTROLLED)

EXAMPLES: *NOVEL PSYCHOACTIVE SUBSTANCES, POPPERS, SOLVENTS*

SAMPLE WORDING

"Most drugs that used to be legal are now covered by the Psychoactive Substances Act, unless specifically exempt by law. These Novel Psychoactive Compounds (NPS) used to be called "Legal Highs." It is an offence to import, export, produce and supply these substances. It is also an offence to possess them in some circumstances (such as in prisons and if you intend to supply them.)
Although possession of NPS is not an offence, we do not permit the possession or use of such substances. As with other drugs we will always take some action if we become aware that you are in possession NPS. This could include enforcement action and a review of your ongoing accommodation.

LAW

Supply of such substances, unless exempt, became an offence under the Psychoactive Substances Act 2016. This legislation does not however make them Controlled Drugs under the Misuse of Drugs Act 1971.

Possession of these substances does not become an offence under the Psychoactive Substances Act except in Custodial settings or if there is an intent to supply.

Some substances are exempt, such as alcohol, nicotine, caffeine, medicines, even if being misused and legitimate foods. The Home Office provided interpretation in relation to specific substances, but these are not legally binding. It has held that Poppers (alkyl nitrites) are not covered as it does not consider them psychoactive. It considers that nitrous oxide (laughing gas, Nos) being supplied for recreational use would be covered.

NOTES

The Psychoactive Substances Act (PSA) came in to force in May 2016 to address the supply of newer unregulated drugs, which have been supplied on-line and via 'head-shops.'

The PSA doesn't add drugs to the list of Controlled Drugs, which is a function of the Misuse of Drugs Act 1971. They would have to be added to the Misuse of Drugs Act for this to happen. It

doesn't create the same sort of obligations for the managers of buildings that the Misuse of Drugs Act does.

Instead the PSA makes it an offence to produce or supply any psychoactive substances (except for specific exempt compounds) where it is known or could reasonably be known that the substance is to be used for intoxication – or the supplier is reckless in this regard.

The Act creates Criminal prosecution, and Civil powers, allowing for orders to be made against individuals and premises where there are reasonable grounds to believe activities restricted by the Act are taking place. This could include power to close premises where activities prohibited under the PSA are taking place. Organisations will therefore need to be proactive in addressing supply of NPS on site.

There is no offence of possession drugs covered by the PSA, except in Custodial settings.

GENERAL ADDITIONAL PROCEDURES FOR POSSESSION OF ALL SUBSTANCES

- The possession of any substance unless specifically permitted will trigger some action under this moderate tolerance policy.
- The guiding principal should be one of managing the situation safely in the first instance.
- It could also include situations where the drug is hazardous, such as where it is flammable.
- In such situations staff should act to ensure their own safety, the safety of other staff and customers, and the safety of the person in possession of drugs.
- Other steps to get the substances off site or destroyed can then be addressed.
- Where there is suspicion of supply, staff should refer to the Supply guidelines [p38.]
- Where substances are being openly displayed, the client should be warned that their behaviour is unacceptable, as it poses a risk to other clients. They should be asked to change the way that they are behaving to reduce the risk to others.
- Should the behaviour continue, further steps must be taken. This could include warnings or other sanctions.
- All actions should be documented.

Where drugs have been found unattended or abandoned refer to finding drugs [p33.]

STORAGE OF DRUGS

PRESCRIBED CONTROLLED DRUGS

EXAMPLES: *A CLIENT WANTS STAFF TO LOOK AFTER SOME METHADONE OR DIAZEPAM*

SAMPLE WORDING

"We cannot store your prescribed Controlled Drugs on your behalf. You should ensure that such drugs prescribed to you are safely and securely stored. If you are prescribed other medication, please discuss this with staff. "*

LAW

If workers were to take possession of methadone or another controlled drug to store it for a client, it is likely that they would be committing an offence. The *MDA* makes it an offence to be in possession of a controlled drug unless you have legal authority to be in possession of it. Doctors, pharmacists and the police could legitimately be in possession of certain controlled drug, as of course can the person to whom it was prescribed.

Workers in a hostel or a day centre however do not enjoy this legal authority to possess controlled drugs except in the following circumstances:
that the worker takes possession of the drug:
"for the purpose of delivering it into the custody of a person lawfully entitled to take custody of it and that as soon as possible after taking possession of it he took all such steps as were reasonably open to him to deliver it into the custody of such a person." [MDA 1971 s. 5(4)(b)] or "a person engaged in conveying the drug to a person authorised by these regulations to have it in his possession." [Misuse of Drugs Regulations 1973 6(f)]

The former would apply where a worker either found a drug or took a drug from someone who was not entitled to have it and, as soon as reasonable afterwards took it to the police or a pharmacist. It would not apply where the drug was taken from someone who was legally entitled to be in possession of it.

The latter would apply where, for example, a worker went to the pharmacy to collect methadone for a client and then brought it to them as soon as practical afterwards. This situation is not applicable here.

While it appears to be contrary to good practice, it seems workers would be committing an offence if they store methadone or other controlled drugs on behalf of clients.

*A key exception to this will be in treatment services with Nursing staff on site. This would include residential drug treatment services who will need their own policy to address the storage and dispensing of prescribed medicines including Controlled Drugs.

PROCEDURES

- Workers require customers to disclose that they are bringing prescribed methadone or other prescribed controlled drugs into the building and this needs to be approved.
- The organisation should work with prescribers and pharmacies to ensure people are prescribed daily rather than receiving large weekly quantities.
- Special provision should be agreed with pharmacies to prevent large quantities being dispensed over holiday periods.
- In residential premises, each resident should have a room with a good quality lockable door.
- In addition, especially where rooms are shared, each resident should be provided with a secure lockable cabinet in which they can safely store prescribed controlled drugs.
- Where such provision is not available (e.g. dormitory-style accommodation) organisations must seek to ensure the safety of all residents by reducing the risk of methadone or other drugs being stolen. Agencies should discuss the situation with local agencies and prescribers, the police and funders and attempt to agree local protocols.

NOTES

As the law stands, a worker who looks after methadone, or another prescribed controlled drug, would be committing an offence unless they have specific legal authority to possess and supply such drugs.

Thought should be given, therefore, to strategies that reduce the amount of methadone in the building at any given time, and allow clients to store their methadone securely.
There will be circumstances where vulnerable people will be prescribed methadone, and staff feel that the risk of leaving this in their possession is too great, and therefore warrants taking the drug into safe storage on behalf of the client.
Staff should explore all possible options before taking such a step, and accurately record actions taken and the reasons for it. They should also be aware that such an action is illegal.
For further exploration and policy consideration of this vexed issue, please read the KFx Document, *On Storage*, which can be downloaded from the KFx website.

OTHER CONTROLLED DRUGS AND NOVEL PSYCHOACTIVE SUBSTANCES

EXAMPLES: *CANNABIS, ECSTASY, SYNTHETIC CANNABINOIDS*

SAMPLE WORDING

"Staff cannot and will not look after other substances for you, including non-prescribed controlled drugs or Novel Psychoactives ('legal highs.') Should staff come in to possession of your non-prescribed substances for any reason they cannot return them to you and will not do so. Behaviour which is intended to intimidate staff in to returning such substances is a serious breach of the policy and is likely to result in further action."

LAW

Returning non-prescribed Controlled Drugs to a service users could be a Supply offence under the MDA 1971. It could be a defence if it took place under duress.

Supplying other substances covered by the Psychoactive Substances Act would be an offence under this legislation.

PROCEDURES

- Workers will not take possession of any substances that they think may be a non-prescribed controlled drug or an NPS unless it is to destroy it or pass it on to the police.
- Workers will not pass such substances back to the client, unless there are exceptional circumstances such as fears for personal safety.

NOTES

There should be no reason for any workers to take possession of a controlled drug or an NPS unless it is to hand it in for disposal or to destroy it themselves.

Staff may end up in possession of substances where they have found the substances, where they have been surrendered to the worker or where the worker is looking after other items (e.g. bags) which turn out to have substances in them.

If workers are not clear what the substance is they should err on the side of caution, and assume that it is a controlled drug. The same stance should be adopted if the worker has any doubts as to the safety of the substance.

OTHER MEDICINES

EXAMPLES: *PROZAC, ASPIRIN, ANTIBIOTICS*

SAMPLE WORDING

"We will help and support you to take responsibility for your own medication. If you find it difficult to manage your medication talk to staff about this, so they can help you take your medication safely. While we can store some medication for you, this is something that staff will only do as a last resort, in exceptional circumstances."

LAW

Workers can look after other medicines such as prescription-only medicines and over–the-counter medicines for clients.

PROCEDURES

- Ideally, clients should be responsible for storing and taking their own medication.
- Workers should assist this process. To this end, workers will seek to record residents who are prescribed medicines, the prescribing instructions, and contact details for the prescriber.

- Where staff or clients feel unhappy about keeping possession of their own medication, staff can, where appropriate, store it on behalf of the clients.
- Such storage must not take place in premises where there is not 24 hour staff cover.
- Where medicines are being stored, agencies need to ensure that storage facilities are secure and that accurate records are kept of what is being looked after and for whom.
- Medicines should only be taken from and returned to the person to whom they were prescribed, and not returned to other people such as third parties.
- Where medication is stored, and the client ceases to use the service, the medication should be returned to a pharmacy and a record kept of this action.
- Taking custody of drugs for a client is not the same as administering them. While workers can remind and encourage clients to take their medication, workers are not able to insist that clients take the correct amount at the right time. Nor can workers usually withhold any medication from client.
- Where workers have concerns about a client's well-being or safety about their medication, these concerns should be addressed firstly to the client. Their consent should be sought to discuss these concerns with the client's GP and the pharmacist, if appropriate.

NOTES

The storage of medications is another vexed question. One school of thought argues that clients should be encouraged to take responsibility for their own medication, and to that end should be encouraged to look after their own medication. Another school of thought argues that in some settings, especially when working with users with high support needs, workers should be more actively involved in supporting clients with medication. Such a process can assist the client and encourages an interaction between workers and clients. It can also reduce the risk of accidental or deliberate overdose.

It is perhaps best to adopt a policy of adjudging each case on its own merits; some clients may be best served by storing their own medication, others by being assisted in this process. Please consult *On Storage* for further consideration, available on the KFx website.

ALCOHOL

EXAMPLES: *ALCOHOL*

SAMPLE WORDING

"We encourage you to drink responsibly and reduce your use of alcohol wherever possible. We will not normally however store and return alcohol to you. In exceptional circumstances, where we are worried about your safety, we may ask you hand in alcohol. A decision to return this is at discretion of workers."

LAW

There is no legal barrier to storing and returning alcohol to customers. However, it does have civil law implications.

PROCEDURES

- Ideally, clients should be responsible for their own alcohol use.
- Workers should support this process by advising on alcohol management strategies, establishment of drinking plans, and referral to alcohol services.
- Where there is concern about severe intoxication or interaction with other drugs, clients could be encouraged to surrender alcoholic drinks for their own well-being. A decision to return this drink at a later date should be at worker's discretion, in discussion with senior staff. All such incidents should be reviewed and where possible, personal alcohol management strategies put in place.
- the wellbeing of intoxicated clients is a primary concern and so residents who return under the influence of alcohol should be assessed as per the section on Intoxication [p46.]

NOTES

These wordings and approaches are based on a moderate or high tolerance model where use of alcohol is permitted, in specific areas.
Some projects will only allow alcohol use off site. There is also a widespread practice of staff removing and storing alcohol to prevent use on site. These approaches create new policy and civil law issues are not endorsed in this policy.

FINDING DRUGS

SAMPLE WORDINGS

"Drugs that are left unattended are a risk to others – even if they are prescribed medicines. If staff find any substances unattended in communal or shared areas, they will remove them.

If the drug is an illegal drug it will be destroyed or handed in to the Police. Bringing illegal drugs on site is a serious breach of the drugs policy and if we know who it belongs to we will take further action which could include a review of your ongoing accommodation.

If they are labelled prescribed controlled drugs or other medicines, in their original packaging and with your name on it, we will try and return them to you if it is safe and appropriate to do so. Otherwise they are likely to be handed in to a pharmacy.

If we are uncertain if a substance is a controlled drug or not we will err on the side of caution and assume that it is a controlled drug, and handle it accordingly

Alcohol found unattended in communal spaces is likely to be discarded."

LAW

Workers can take possession of a controlled drug for the purpose of destroying it or to deliver it to someone authorised to possess it (e.g. the police.) Workers would be committing an offence of possession and possibly intent to supply if they took possession of a controlled drug for any reason other than to destroy it or pass it on to someone lawfully entitled to have it.

DRUGS FOUND IN COMMUNAL OR SHARED AREAS: PRESCRIBED CONTROLLED DRUGS

EXAMPLES: *METHADONE, FOUND IN SHARED LOUNGE*

PROCEDURES

- Drugs should be removed from the communal area.
- Where the drugs are clearly labelled, and the identity of the owner is known and is bona fide then the drugs may legally be returned to the owner if it safe and appropriate to do so. They should be reminded of their responsibilities vis a vis storage of medication, and rules around notifying staff of their prescribed medication.
- The possession of such medicines should trigger a review of the resident's support needs and ongoing housing.
- Where the identity of owner is unknown, or where medication is unlabelled, the drugs should be returned to a pharmacy for disposal and a written record kept of this action. The worker should contact the pharmacist prior to setting off.
- Where the identity of the person is not known, all clients should be reminded of drugs policy
- Actions should be documented.

DRUGS FOUND IN COMMUNAL OR SHARED AREAS: ILLICIT DRUGS

EXAMPLES: *CANNABIS, HEROIN FOUND IN SHARED BEDROOM*

PROCEDURES

- These should be removed from the communal area. They should either be destroyed or taken to the police for destruction. See procedures on destruction and disposal, [p35.]
- Client(s) involved should be challenged as described above.

NOTES

Drugs found in communal or shared areas, whether prescribed or otherwise, represent a health hazard to other clients and visitors. The organisation is obliged, under its duty of care to clients, staff and visitors, to address this risk, and so need to remove the drug from the communal area.

In this section “communal” and “shared space” include common areas such as lounges and bathrooms. It also includes shared bedrooms – including those where a parent shares with their child.

DRUGS FOUND IN COMMUNAL OR SHARED AREAS: ALCOHOL

EXAMPLES: *OPEN OR UNOPENED CANS OR BOTTLES*

PROCEDURES

- If open alcohol is found unattended in communal spaces, it should be removed and, in most circumstances will be destroyed.
- In situations where the ownership of the alcohol is clear it should trigger a discussion with the resident, and a decision made with them about removal of drink from premises or disposal.
- Whatever the course of action, a review of the resident’s support needs should take place to prevent reoccurrence and ensure housing remains appropriate.

NOTES

As acute alcohol withdrawal can be dangerous, it may not always be appropriate to remove and destroy unattended alcohol. Where alcohol is found unattended, ownership is clear, and the balance of risk favours returning it to the client, then workers should exercise discretion about returning the alcohol to them.

DRUGS FOUND IN PRIVATE AREAS (E.G. BEDROOMS)

LAW

Law on this is potentially unclear and, as elsewhere, organisations should err on the side of caution.

In residential settings for adults, where residents have exclusive use of their rooms under licences or tenancy agreements, the contents of the residents’ rooms may be treated as their possessions. If residents keep drugs in their rooms, they commit the offence of possession rather than the organisation.

Organisations are under no legal obligation to dispose of substances found in such circumstances.

In a setting such as a residential children’s home, where workers can be considered to be acting *in loco parentis*, workers may potentially be considered to be in possession of controlled drugs if they know that they are in the building, and so should act to ensure their removal and destruction.

If drugs are found in a place where others would be at risk (e.g. a shared bedroom) then there would be an obligation to act under the duty of care that the organisation has to all clients.

PROCEDURES

- Where a client has moved out, workers should act as if the drug were in a communal area, as described above.

If the client is expected to return, the following processes could be used:

- Where quantities of drug or packaging suggest supply may be taking place, the police should be involved immediately.
- The room should be secured, to ensure other clients are not put at risk. On their return, the client should be reminded of policy on bringing drugs in to the building, and the reasons for this policy.
- Once the resident is back in the building, the resident can be treated as described in the section on possession, at [p27.]

Actions should be recorded.

NOTES

Drugs may be found in private areas such as bedrooms by cleaners, in the course of health and safety inspections, or for other reasons, or after a client has moved out.

In some situations, such as on finding a small amount of cannabis, it may be clear to the worker that the person is in illegal possession of a controlled drug. In other situations, this may be less clear cut. A bag of pills could be Valium bought on the street, or could be prescribed drugs, no longer in their original packaging. To remove and dispose of them could constitute theft, and could put the client at risk of harm. Users may experience severe ill effects and, in relation to some controlled drugs such as benzodiazepines or barbiturates, life threatening withdrawal through uncontrolled and unsupervised withdrawal. The removal and disposal of any substances without the client's knowledge and consent should not take place.

Even when workers find a bag of something that they think may be heroin or similar, the ramifications of taking the drug and disposing of it can be very damaging. Such action will require the user to go out and get more money to buy more drugs, and may put them at increased risk. It may cause conflict between clients and lead to accusations of theft. And it will almost certainly damage the relationship between workers and clients, and make drug-related education work more difficult.

In some settings such as residential children's homes, organisations should err on the side of caution and assume that they, potentially, be considered to be in possession.

DESTRUCTION AND DISPOSAL

SAMPLE WORDING

"Staff may take possession of controlled drugs and other substances for the purpose of handing them in or destroying them"

LAW

A controlled drug may be considered destroyed for the purposes of regulation 26 of the *Misuse of Drugs Regulations (1985)* if it has been:

"dissipated or denatured to the extent that it is incapable of being retrieved, reconstituted and used and it is the responsibility of the person carrying out the destruction to ensure this criteria is met."

PROCEDURES

Large quantities: Where the quantity of drugs found suggests supply may be taking place, the police should be involved immediately. If possible the drugs should not be touched or moved, and the police called to the premises.

Handing drugs in to the police or pharmacist:

- If the substance is, or appears to be, a medicine it should be handed in to a pharmacist and a written record of this kept.
- Where a decision is made to take drugs to the police for destruction rather than destroying 'in-house' the police should be informed that a worker is coming to the police station prior to setting off.
- Police liaison should be agreed allowing the delivery of controlled drugs to the police on a "no questions asked" basis.

Destroying drugs:

Destroying is not wholly straightforward. Flushing small quantities of powders away does cause pollution but is a practical way of dealing with the situation. Alternatively, vacuum cleaning the drugs away may provide a solution. However, substances such as cannabis resin or herbal cannabis may not so easy to dispose of in this way, and it may be more practical to take them to the police for disposal.

- The person finding the drug should not pass it on to another worker, but should either destroy it or hand it in themselves.
- On finding substances, a written description of what has been found should be made, and ideally witnessed if possible by another member of staff.
- If the drug is to be destroyed, destruction should take place in the presence of a senior worker, who witnesses the process.
- A record should be kept of the incident.

NOTES

Once decision has been made to take possession of a suspected controlled drug, it is important that the safety of workers is protected, both from prosecution and from accusations of wrongdoing.

A key area of concern is for workers finding drugs during a solo night-shift. Their options are to dispose of it themselves, without witnesses, or to wait until colleagues arrive in the morning. However, the law requires that destruction takes place as soon as reasonably practical, and the law does not require a witness to be present.

In such a situation, the best course of action would be for the worker to phone the local police station on finding the drug, and inform them that they will be coming in the following morning with the substance. It should be noted that the worker finding the drug should be the person who conveys the drug to the police, even if they are coming off a twenty-hour shift!

However, in the interests of common sense it may be more practical for this task to be passed over to other staff – provided that the Police are willing to endorse such an approach.

Storing drugs awaiting police collection
This approach is not robustly lawful and increases risk to the organisation and is not endorsed within this policy.

PRODUCTION OF CONTROLLED DRUGS

EXAMPLES: *GROWING CANNABIS*

SAMPLE WORDING

"We cannot tolerate the production (growing or making) of any Controlled Drugs on site and if we know or suspect this is happening we will always need to take action to make sure it stops. This could include police involvement or eviction."

LAW

Under Section 8(a) of the Misuse of Drugs Act, tolerating supply would be a serious criminal offence and so organisations are legally obliged to take steps to address and stop it.

PROCEDURES

Procedures

- If workers become aware that production is taking place they will need to address it when it is safe and appropriate to do so.

Actions should take it in to account the scale of production. A resident who is found to have a single, small cannabis plant may need to have a different level of response to someone who has fifty plants growing in the spare room.

- Larger episodes of production will warrant police involvement. Lower levels may be dealt with through a warning system.
- All episodes and actions will need to be recorded.

SUPPLY OF CONTROLLED DRUGS, NPS, MEDICINES AND OTHER SUBSTANCES

ACTUAL SUPPLY

EXAMPLES: *CLIENT GIVING SOMEONE SOME METHADONE, ONE CLIENT IS INJECTING ANOTHER WITH HEROIN, TWO PEOPLE SHARING A SPLIFF, A CLIENT SELLING ECSTASY. SUPPLY OF NPS; SHARING MEDICINES*

SAMPLE WORDINGS

"We will not tolerate the supply of Controlled Drugs or Novel Psychoactives on the premises.

Supply of drugs on site creates a serious risk for residents and staff and is something that we must take action to stop.

We will always act where we know or suspect that supply is taking place.

We may take a range of different actions depending on the severity of the incident. We could end up seeking to evict, or involving the police.

We will also take action if the supply of other substances including alcohol, medicines or other intoxicating substances (other than those specifically exempt by this policy) takes place."

LAW

The supply of controlled drugs taking place on the premises can have serious ramifications for both the clients concerned and for the organisation.

The client is committing an offence of supply, which could carry heavy penalties on conviction.

Where workers are aware that supply of controlled drugs is taking place they are obliged to take reasonable steps readily available to them to stop this supply taking place. If they fail to do so, they may be committing an offence under S.8 of the *MDA*.

Supply of NPS doesn't create the same legal risks for organisations as these substances may not be covered by the MDA. However, in order to address risk and reduce chances of supply going unchallenged, workers should treat NPS supply in the same way they would CD supply.

PROCEDURES

- When workers know that supply is taking place, they should take steps to prevent it there and then if it is safe to do so at that moment.
- If it is not safe to do so, a record of the incident should be made, and an intervention made when it is safe to do so.
- Depending on the context, gravity and history an initial response may be to instruct the person to stop, reminding them of the drugs policy and the legal risks that they are taking.
- Such a step, if successful, would discharge your responsibility under Section 8. However, workers should be vigilant to ensure that the measure taken has been effective and that there is nor reoccurrence of the supply.
- If these measures were ineffective or the incident was more serious, further steps would need to be taken, such as requiring the person to stop and move off the premises. However, if this step is ineffective you will have to take further steps to fulfil your obligations under Section 8. This may include measures such as evicting the person or giving notice to quit.
- If the incident involves a significant level of supply, or it has been a recurring issue, police involvement may be required.
- Records should be kept at each stage documenting what measures have been taken and the outcome

NOTES

Section 8 of the *MDA* makes it an offence to knowingly "*permit or suffer*" supply of controlled drug to take place on premises.

In the case of *Crown Vs Wyner and Brock* (the Wintercomfort Case), "*permit*" or "*suffer*" was interpreted as meaning the same thing. It was taken to mean:
"*If the defendants were unwilling to use any reasonable means that were readily available to them to prevent the prohibited activity, then they were permitting the act."*

Furthermore, it was directed that if there was a failure to implement these means effectively, then the offence was also committed.

This central issue is highly problematic, and further clarification from court rulings would be useful. The terms "*reasonable*" and "*readily available*" are imprecise. A variety of measures were highlighted during the above trial, some of which had been adopted as project policy. They included, but were not limited to:

- Supervision of all areas of the premises,
- Installation of CCTV or mirrors,
- The banning of people who were found supplying or suspected of supplying drugs,
- The display of notices,
- The enforcement of bans by staff,
- The move from open-access to closed-door policies,
- Changes to opening times and numbers on premises,
- Calling the police to remove banned people from premises,
- Passing the names of people known or suspected to be supplying drugs to the police,
- Closure of the project.

This interpretation of what constitutes "*reasonable means*" highlights the gulf of what may be deemed "*reasonable*" from a legal point of view and what is reasonable from the point of view of those running a service.

One of the measures proposed as a reasonable and available was that the police should be informed of known or suspected details. Certainly, where other measures to prevent supply have not succeeded, the police could be involved. An unwillingness to take that step could constitute a failure to use a reasonable means available.

At present, the closure of a project, albeit on a temporary basis, could be deemed to be a "*reasonable measure readily available*" by a jury. The failure to adopt such a measure if other measures had proved ineffective would, therefore, indicate an unwillingness to use such a "*reasonable*" step and, as such, be evidence of permitting the prohibited activity.

Agencies facing this situation should contact funders and other agencies to demonstrate that closure or similar measures were neither reasonable nor readily available to them.

SUSPICION OF SUPPLY: THIRD PARTY INFORMATION

PROCEDURES

- Acknowledge the information, and ensure that it is recorded in appropriate places.
- Advise the informant that the information will be looked into.
- Discuss matters raised with other workers, identify if they share concerns.
- Ensure that staff apply a high level of vigilance.
- Discuss the matter with the accused, in a non-confrontational manner, to establish facts.
- Where applicable, ask to undertake a room-search.
- If these steps support the accusation, then further action will need to be taken, as described at supply, [p38.]

- If there is no corroborating information, workers should log the steps taken in looking in to the accusation, that there was no evidence to support it, and record any further action taken, such as warnings given.
- Where the informant subsequently asks why nothing was done, they should not be given additional information, but advised that the matter was looked in to, and you will always look into such matters when brought to your attention.
- All information and actions should be recorded.

WORKERS' OWN SUSPICIONS

PROCEDURES

Where no information is received from third parties, but workers are suspicious of behaviour, a similar set of steps could be followed, including challenging, discussing with colleagues, increased vigilance and, where appropriate, checking rooms.

NOTES

Workers will often not actually know that supply is taking place on the premises. It is more likely that they suspect supply is taking place, or have information from third parties that supply is taking place.

Policy should make it clear that workers will act on every episode where there is a suspicion that supply is taking place. There is a risk otherwise that workers could be accused of "turning a blind eye" to supply taking place.

USE ON PREMISES

SAMPLE WORDING

"The organisation will not tolerate the use of any drugs on or near the premises that puts staff, volunteers or other clients at risk of harm or prosecution or causes distress.

The law requires us to prevent cannabis smoking on site and we will use reasonable measures to meet our legal obligations.

Where staff know or suspect use is taking place they will always take action. This could range from advice and support to enforcement action, which in some circumstances may include you being asked to leave, and may include the police being involved."

USE OF ILLEGALLY-HELD CONTROLLED DRUGS: CANNABIS AND OPIUM

EXAMPLES: *SMOKING CANNABIS*

LAW

Where workers know that cannabis (or opium) are being smoked on the premises they are obliged, under the *MDA* s.8d, to take steps to stop it happening. Failure to do so would be an offence under the Act.

PROCEDURES

- Some action must always be taken, and the guiding principle here should be that the action should be both reasonable and readily available.
- Staff are not obliged to act in a way that would put their own safety at risk.

Any intervention should be safety driven:

- Ensuring the safety of the worker encountering use
- Ensuring the safety of staff and other service users
- Ensuring the safety of the person using – for example to assess overdose risk or if they have injured themselves.

If there is concern about the safety of wellbeing of the person using, or their behaviour puts others at risk, emergency services may need to be involved.

Where safe to do so:

- The person should be challenged immediately, unless there are real concerns about personal safety. In such a setting, the behaviour should be challenged at the earliest available opportunity.
- The person should be instructed to cease the activity immediately. If they do so, then the organisation's obligations under Section 8 (in relation to cannabis) have been discharged.
- If they still have substances on them, they should be given the option of surrendering them, destroying them or removing them from the premises, as per the section on Possession [p27.]
- If the person has used and is under the influence of a substance, see the section on Intoxication [p46.]

Once the critical episode has been resolved, later responses will need to reflect a breach of policy.

Workers should proceed by:

- Ensuring staff are aware of the incident and are vigilant for reoccurrence,
- Warning the person that future transgressions will be dealt with more robustly, if this is the first incident.
- Reminding the client that if they are still in illegal possession of controlled drugs this means that they are committing an offence under the *Misuse of Drugs Act (1971)*, and workers will highlight the legal risks that this carries for the client.
- Ensuring that information about drugs and relevant support agencies is available to the client so they have the opportunity to look at reducing their drug use or reducing the risk of drug-related harm as appropriate.

- Taking more robust action if this is a recurring problem, possibly including verbal or written warnings, acceptable behaviour contracts, suspension of services for a set period, termination of tenancy, commencement of eviction procedures or police involvement as appropriate. The nature of the action should be taken in consultation with other team members, senior managers and other agencies as appropriate.

Breaches of drugs policy, responses initiated, and reasons for those responses should be recorded, see record keeping at [p54.]

NOTES

Unlike most other controlled drugs, organisations **are** obliged to stop people smoking cannabis on site. This is due to the vagaries of Section 8. This creates a surreal situation where organisations have more obligations in relation to cannabis smoking on site than they do with (for example) heroin injecting.

The ludicrousness of the legal position notwithstanding, successive governments have, sadly, been unwilling to change the law and so organisations must endeavour to work within it.

Having said this, organisations need to recognise that, in many situations, seeking possession or ending accommodation due solely to cannabis use will be disproportionate, and so exploring other methods of challenging use – through education, harm reduction and warnings, is to be preferred where possible.

KFx have developed an additional protocol relating to negotiating agreed working practices with the police; these are available on the KFx website.

OTHER ILLEGALLY-HELD CONTROLLED DRUGS

EXAMPLES: *HEROIN, COCAINE, ECSTASY*

LAW

If a person is known to be using illegally-held controlled drugs (other than cannabis or opium) on the premises, the person in question is committing an offence of possession of controlled drugs under the *MDA*.

The organisation is not, however, committing an offence under Section 8 of the *MDA* where it is known that drugs other than cannabis or opium are being used.

The organisation is still required to address their obligations under health and safety and their duty of care; they should also be conscious of their obligations to manage antisocial behaviour.

Proposals were made to extend S8(d) to cover all "*controlled drugs unlawfully held*" but this extension was repealed by the *Drugs Act (2005)*.

PROCEDURES

Workers should ensure that information about drugs and relevant support agencies is available to the service user, in order that they have the opportunity to look at reducing their drug use or reducing the risk of drug-related harm as appropriate.

Where the use is not presenting a risk to others, initial responses should be safety driven and include:

- Ensuring the safety of the worker encountering use
- Ensuring the safety of staff and other service users
- Ensuring the safety of the person using – for example to assess overdose risk or if they have injured themselves.

If there is concern about the safety of wellbeing of the person using, or their behaviour puts others at risk, emergency services may need to be involved.

The use of drugs in a way that creates risk for other clients cannot be tolerated. Examples of this include:

- Using in the presence of other people – e.g. in communal areas, dormitories, shared rooms.
- Discarding injecting equipment carelessly.
- Leaving spilt blood.
- Sharing equipment or paraphernalia.

Where use is taking place in communal areas workers should assess if it is safe to stop it there and then; if they feel it is safe to do so then they should request that the behaviour stops. If it is not possible to stop it at that point, then the safety and wellbeing of other residents should be considered.

Once the initial incident has been resolved, it should be made clear that the risk-taking behaviour must stop. Options may include increased vigilance, issuing warnings, or suspension of services as appropriate.

The action plant should be taken in consultation with other team members, senior managers or other agencies as appropriate.

Breaches of drugs policy, responses initiated, and reasons for those responses should be recorded.

Where workers become aware of use taking place in private areas (e.g. resident's own room), workers should:

- Still ensure that the client's actions are not putting others at risk, and
- Assess client's wellbeing and
- Reminding the client that they are committing an offence under the *Misuse of Drugs Act (1971)*, and highlighting the legal risks that this carries for the client,
- Highlighting the health and welfare implications of the drug use
- Reminding the client that incidents that create risk for staff or other clients will not be tolerated.

Workers should ensure that information about drugs and relevant support agencies is available to the client, in order that they have the opportunity to look at reducing their drug use or reducing the risk of drug-related harm as appropriate.

Where the episode suggests that the nature and level of the person's use is not appropriate for a medium tolerance environment (e.g. the presence of ongoing injecting, heavy crack use) then review of accommodation and support should take place.

NOTES

The above notwithstanding, the organisation recognises that possession of these drugs is illegal and does not approve, condone or support the use of these drugs.

Where they are being used, the organisation will always take some action, and initiate some response.

The above approach is suitable for organisations working with on-going use within a high or medium tolerance model; organisations who don't intend to work with ongoing use should use an alternative version of the *Sample Drugs Policy*.

USE OF OTHER DRUGS

EXAMPLES: *NOVEL PSYCHOACTIVE SUBSTANCES, SOLVENTS, POPPERS, CAFFEINE, BETEL*

LAW

These and other substances are not covered under the *Misuse of Drugs Act*, but some are covered under other legislation. The possession or use of these drugs does not constitute an offence unless in Custodial Settings where their possession will be covered by the Psychoactive Substances Act.

The supply of some of these drugs is an offence, but, as the drugs are not controlled under the *MDA*, they do not fall under S8 of the *MDA*.

PROCEDURES

Despite the legal considerations above, the use of these drugs may present a risk to other clients, staff or the individual. The following responses could be adopted:

- The use of these drugs is not allowed in shared or communal areas, unless in socially accepted forms such as tea, coffee, chocolate. This is to prevent exposure of non-users to these drugs, to reduce distress to other clients and to encourage consistency in the treatment of drug users where possible.
- Where they are being used elsewhere, for example in the client's own room, the organisation will always take some action, and initiate some response.

Where the use is not presenting a risk to others, responses could include:

- Highlighting the health and welfare implications of the drug use,
- Reminding the client that incidents that create risk for staff or other clients will not be tolerated.
- Workers should ensure that information about drugs and relevant support agencies is available to the client, in order that they have the opportunity to look at reducing their drug use or reducing the risk of drug-related harm as appropriate.

The use of drugs in a way that creates risk for other clients cannot be tolerated. Examples of this include:

- Using in the presence of other people – e.g. in communal areas, dormitories, shared rooms,
- Sharing these substances with others,
- Using flammable drugs in an unsafe way, such as while smoking.

In such circumstances the risk-creating behaviour must stop. Options may include increased vigilance, issuing warnings, or suspension of services as appropriate.

- The nature of the action should be taken in consultation with other team members, senior managers and other agencies as appropriate.
- Breaches of drugs policy, responses initiated, and reasons for those responses should be recorded, see record keeping at [p54.]

USE OF LEGALLY PRESCRIBED DRUGS

EXAMPLES: *METHADONE, VALIUM, PAROXETINE, INSULIN*

LAW

No offences are being committed if a client is using these or other legally prescribed drugs while on premises.

PROCEDURES

The use of prescribed medicines, when taken as per the prescriber's instructions, is to be supported and encouraged.

Where medicines are being used it must not create other risks or distress. To minimise such risk, the following procedures could be adopted:

- The use of legally prescribed drugs is not allowed in shared or communal areas. This is to reduce the exposure of non-users to potentially dangerous drugs such as methadone, the administration of injectable drugs, and reduces the risk of theft or sharing of other drugs.
- Such drugs should, where possible, only be administered in the client's own room, or in another appropriate part of the building identified for this use. Clients should be aware that non-compliance with these rules will be treated as a breach of the drugs policy and sanctions may need to be applied.
- Drugs should only be used in accordance with the prescriber's instructions. Where this does not happen, action will need to be taken. This may include working with the client and the prescriber to rectify the situation.

USE OF NON-PRESCRIPTION MEDICINES

EXAMPLES: *ASPIRIN, PARACETAMOL, NIGHT NURSE.*

PROCEDURES

The use of non-prescribed medicines is not allowed in shared or communal areas. This is to prevent confusion in relation to drugs being used, and to encourage consistency in the treatment of drug users where possible.

- Such drugs should, where possible, only be administered in the client's own room, or in another appropriate part of the building identified for this use. Clients should be aware that non-compliance with these rules will be treated as a breach of the drugs policy and sanctions may need to be applied.
- Drugs should only be used in accordance with the manufacturer's instructions. Where this does not happen, action will need to be taken.

This may include:

- Highlighting and explaining the risks to the client.
- Working with the client and other agencies to rectify the situation.

NOTES

The use of these non-prescription medicines, when taken appropriately and in accordance with the manufacturer's instructions, is an important aspect of healthcare. However, such use must not create other risks or distress. In addition, some non-prescribed medicines may be misused, creating risks for the client and for others.

USE OF TOBACCO

SAMPLE WORDING

"Tobacco may only be used in designated smoking areas. It should be used with consideration for other clients."

LAW

Law:

Day Centres and some parts of hostels will be smoke free premises as part of the Health Act 2006, which came in to force in 2007. Communal interior parts of Hostels will need to be smoke free but smoking could be permitted in suitable designated areas and non-shared bedrooms.

PROCEDURES

Smoking areas should be identified. These should meet all statutory requirements.

NOTES

Since 2007, it can be an offence, punishable by fine, to allow smoking in smoke-free premises. Further information at http://www.smokefreeengland.co.uk/

USE OF ALCOHOL

SAMPLE WORDING

"Alcohol may only be used in designated drinking areas. It should be used with consideration for other clients."

LAW

No offences are being committed where alcohol is being used on premises.

PROCEDURES

Drinking areas should be identified. These should be "non-essential areas," i.e. not areas that non-drinkers are obliged to use such as dining areas or reception areas.

NOTES

This phrasing relates to organisations who intend to work with on-going users including those who use alcohol. This means that the organisation will need a policy which is sufficiently alcohol-tolerant to work effectively.

Alcohol is a significant challenge for organisations and causes more management issues and behavioural problems than most other substances.

In response to this, organisations are often tempted to adopt a less tolerant model in relation to alcohol – and impose rules and approaches which are at odds with the organisation's aims.

Specific measures which are often implemented, and the problems therein include:

Prohibition of alcohol on site: while this measure is feasible for organisations that do not intent to work with alcohol users it is not appropriate for those with significant alcohol issues. Prohibition of use on site will tend to mean that people who do drink will do so in the vicinity of the building, causing an issue for neighbours. It will also increase the likelihood that drinking will become covert.

Removal of alcohol: the removal of alcohol from a person or their room without their consent, or unless there are significant safety issues, would be potentially risky and may not be legally permissible.

PROCEDURES

As with use of any other substances workers should:

- Use a 'safety first' approach to assess the risk to staff, other residents and the person drinking
- Where there is an identified risk, this should be managed first, using emergency services if required.
- If there is assessed to be no imminent risk to the person, they should be encouraged to surrender or discard any remaining alcohol that they have on them, or may choose to leave the premises with the alcohol.
- Surrendered alcohol should generally not be returned but it may, exceptionally, be appropriate to do so, especially where there is a significant risk of alcohol withdrawal.
- See the section on INTOXICATION [p46.] for suggested next steps.

After dealing with the critical incident, review should take place to look at potential responses including support packages, Acceptable Behaviour Contracts, sanctions or termination of stay as appropriate.

INTOXICATION ON PREMISES

SAMPLE WORDING

"People who wish to use any part of the service should be 'fit to participate' in that part of the service. If your behaviour means that you are not fit to participate you may not be able to use some or all of the organisations services.

Anyone whose behaviour is disruptive, whether due to drugs or not, will be challenged and asked to change their behaviour. If they refuse to do so they may be asked to leave communal areas or to leave the building.
Emergency services will be called if intoxication or related behaviour causes significant risk to any people affected including the user, staff, residents or the wider public."

PROCEDURES

- Always adopt a safety-first approach. When assessing an intoxicated person, the imperatives are the safety of staff, other clients, the intoxicated person and the wider public, in that order.
- If staff have concerns about their own safety or the safety of other clients they should address this first, and consider calling the emergency services.
- If there are serious concerns about the intoxicated person's safety, and this cannot be managed safely "in-house" then the emergency services should be called. It is not safe or acceptable to simply require significantly intoxicated residents to leave the building as this brings risks both to the user and the wider public.
- If the situation is unclear, but doesn't currently warrant emergency interventions, workers should try to contain the situation, keeping it calm. If the situation deteriorates, emergency services may be required. If the situation improves, or the person is less acutely intoxicated then fitness to participate can now be assessed.
- Where a person appears to be intoxicated, but doesn't represent a significant risk to themselves or others the choice will be to:
  - leave the premises if safe and appropriate to do so, returning when sober

- remain on site but stay away from communal areas
- remain on site and engage depending on how “fit to participate” they are.

- Where the person in intoxicated but still “fit to participate” then they could be allowed to participate if appropriate and safe to do so. Alternatively they could be encouraged to leave communal and shared areas.
- A client displaying disruptive behaviour will initially be taken aside, and a worker will explain why their behaviour is creating disruption. They will be offered the choice of moderating their behaviour, leaving the building and its vicinity for a while, or retiring to their room in a residential setting.
- If the problem persists, the person will be required to leave the building or communal areas , until behaving acceptably.
- Should these strategies prove unsuccessful, and a client continues to display disruptive behaviour and refuses to leave, the police will need to be called.
- Staff should receive training on dealing with difficult and dangerous behaviour.
- The incident should be reviewed with the resident when it is safe and appropriate to do so and any sanctions required should be introduced.
- All such incidents should be logged in the Incident Book.

NOTES

Some services will find they can balance people coming in who may have used but their behaviour creates no challenges and so can be accommodated without significant problems. Such an approach would be more suitable for working with managed and recreational use.

The organisation has an obligation to provide a safe arena for all staff and clients, where people are not subject to threatening, abusive, offensive or violent behaviour. Where clients display such behaviour, whether due to substance use or not, action will need to be taken.

The emphasis here is on addressing behaviour rather than the drug use per se. The idea of being fit to participate means that it may be appropriate for a client to come in for a shower or to collect belongings but may not be appropriate to take part in a group session for example.

ANTISOCIAL BEHAVIOUR

SAMPLE WORDING

"Service Users have a responsibility for their behaviour and that of their guests. Antisocial behaviour is not acceptable, and will result in action being taken where you or your guests are responsible for antisocial behaviour.

This includes antisocial behaviour both on the premises and in the vicinity of the premises.

Antisocial behaviour may or may not be drug-related. It includes things like leaving drugs paraphernalia in public places, causing disturbance or nuisance to neighbours, noisy, threatening or abusive behaviour, lots of late night visitors or other problems.

Where you or your guests are responsible for antisocial behaviour we will take action to stop it and this could include you being excluded or evicted from the service.

The police have the power to remove you from your property and seal the property if they and the court think that your property is associated with Class A drugs and nuisance or serious disorder."

LAW

New powers were created under the *Antisocial Behaviour Act (2003)*. When the police have grounds to think a premises is associated with the production, use or supply of class A drugs was and the property was associated with disorder or serious nuisance, then the police can issue, after consultation with the local authority, a Closure Notice.

This document is served on the premises, and would inform those connected with the premises that an application is being made to close the premises, say when and where the closure hearing would take place, and restrict access to the building to the owner of the building or people who normally stay there.

Once a closure notice has been issued, the police would seek a Closure Order from the Magistrates Court. The court will issue a Closure Order if they believe that the use or supply of Class A drugs has been taking place, that it has been connected to disorder or serious nuisance, and that without issuing a Closure Order, there is likely to be further nuisance or disorder.

PROCEDURES

- The organisation should make it clear to clients and residents what could constitute antisocial behaviour and the possible consequences of such behaviour.
- Support and guidance may be necessary to help people manage their own behaviour or that of friends or guests.
- Warnings may be required in the event of persistent antisocial behaviour.
- Where serious anti-social behaviour is a problem, and the property in question is associated with Class A drugs, the police may be able to seek a Closure Order. This would have an impact on other clients.
- Episodes of antisocial behaviour, and the steps taken to challenge it should be recorded and may be needed if eviction needs to take place or a decision is made to seek a closure order with the police.
- Organisations should develop protocols with the police and the local authority to establish how these closure powers would be used locally.

NOTES

Measures to tackle antisocial behaviour are a key aspect of government policy. The powers included under Section 1 of the *Antisocial Behaviour Act (2003)* do highlight the importance of service providers ensuring that their clients do not have a negative impact on the wider community.

While it is not very likely that these powers would be used against a hostel, day centre or needle exchange, there is scope to do so, and so organisations will need to respond effectively to episodes of antisocial behaviour, especially when these are drug-related.

INJECTING EQUIPMENT AND SHARPS BINS

SAMPLE WORDING

"This project does not aim to house people who currently inject anything other than for medical reasons. Unless you have made staff aware that you need to inject medicines and this has been agreed, there is no reason for having injecting equipment or sharps boxes in the project. As such the possession of any such paraphernalia aside from medical reasons is a breach of the policy."

If you do inject we will need to identify suitable housing for you where this can be accommodated safely.

In shared bathrooms, sharps bins are available to all service users for the safe disposal of razor-blades, toothbrushes, or other potentially contaminated sharps. All service users should dispose of such items safely. The presence of these boxes is not a sign we will tolerate injecting on site."

LAW

There is no legal impediment for making sharps bins available to clients. The distribution of needles and syringes is specifically exempt under *MDA*. Amendments to the legislation now make it lawful to distribute acids, filters, spoons, swabs and water to injectors. There are no restrictions on the possession of such equipment, or of sharps bins.

Organisations are obliged, under their duty of care and health and safety obligations, to ensure that premises are safe, and that reasonable precautions are taken to prevent foreseeable risk. In environments where the presence of used injecting equipment is a foreseeable risk, steps must be taken to reduce this risk, such as through the provision of sharps bins.

PROCEDURES

Sharps disposal bins should be made available in the following locations:

- Small bins for staff to carry in the event of clearing discards
- Available to residents identified as having medical need for such bins
- Safe disposal points in shared bathrooms for razors and other contaminated sharps

On finding injecting equipment in a room or on a person:

- Do not remove sterile, unused equipment from private space without prior discussion with the resident
- If equipment has been found in communal space, it will need to be removed.
- If the person has further need of the equipment then they should be allowed to remove it from the building. Equipment found in shared space could be returned if not doing so would put the person at greater risk. The person shouldn't be allowed unsupervised access to the building whilst in possession of the equipment unless this is unavoidable. This is to prevent use on site.
- The possession of injecting equipment should trigger a review of the person's support needs and accommodation.

NOTES

Agencies who anticipate working with ongoing injectors should not be using a Low or Moderate Tolerance policy. It Is not desirable, if avoidable, to have non-users and recreational users housed alongside ongoing injectors as it may increase incidence of injecting amongst vulnerable young people and other residents. It may increase conflict. The Moderate Tolerance policy restrictive in terms of harm reduction measures that would be applicable in higher tolerance settings. Hence the prohibitions on possession of injecting equipment outside of a medical context.

FINDING NEEDLES AND HOW TO HANDLE THEM

SAMPLE WORDING

"If residents find unsafely discarded equipment they should not handle it themselves but should instead seek help from a member of staff. Trained staff will deal with small quantities of discarded needles."

PROCEDURES

- Residents should not handle other people's discarded equipment and clear explanation of what they should do on finding needles should be provided on moving in.
- Residents should be encouraged to wear appropriate footwear in shared/communal parts of the building.
- Regular inspections of 'hot-spots' should take place including bathrooms and garden areas.
- Staff should always take care in situations where discarded needles may be encountered, such as when moving mattresses or other soft furniture, and handling bin bags. Workers should assume that needles will be present even if premises were not thought to be used by known injectors.
- All staff should have had training in how to handle injecting equipment and how to use Personal Protective Equipment (PPE) correctly.

Equipment on site to handle equipment should include:
- Latex or latex-free gloves for simple sharps handling
- Small sharps boxes with non-return mechanism
- Tongs and large aperture boxes for multiple sharps
- Needle proof gloves for clearing bedding, undergrowth etc
- Mirrors and grabs for clearing inaccessible areas.

On finding single discards in plain view the following process should be used:
- The worker should take a small sharps bin to where the needle has been found. Using appropriate equipment, they should put the needle in the sharps bin. Latex gloves will often be the most appropriate resource for picking up single needles. Needles should not be re-sheathed.
- Sharps bins should be checked prior to carrying to ensure that they have not been pierced. A pierced sharps bin should be placed in a larger bin prior to transportation.
- For larger quantities of discards or where there is concern about hidden hazards, specifically-trained staff should take on the clean up or an external contractor should undertake the job.

If there is spilt blood in the area, see body fluid – spills, [p51.]

NEEDLESTICK INJURIES

PROCEDURES

In the event of a prick, scratch or puncture by a needle, the following procedure should be followed immediately:
- Remove the needle somewhere safe where it can be retrieved and will not cause harm to others.
- Over a sink, squeeze the injury to encourage bleeding for a few minutes, and place under tepid running water.
- Wash and clean the site with iodine or soapy water.
- Dry and apply a plaster or other dressing.
- The person should present to A&E within 48 hours and will be assessed for the most appropriate course of treatment. This could include Hep B vaccinations, monitoring of liver function and assessment of need for HIV post-exposure prophylaxis.
- A senior worker should be informed and the incident recorded in the Accident Book.
- Support and counselling should be made available to the injured person.
- Review should take place of how the injury took place and remedial measures required to prevent it recurring.

NOTES

Infection via a needlestick injury is relatively unlikely as this is an inefficient route for transmission. This is particularly the case for HIV and HCV; however, this does not preclude the need to take care when handling sharps a there are no vaccinations for these viruses.

Organisations should establish a named contact at a local hospital or health centre so that assessment for prophylaxis treatment can be undertaken rapidly.

TRANSPORTING FULL SHARPS BINS

LAW

It is an offence to transport controlled waste if you are not a registered carrier. Controlled waste is household, commercial or industrial waste. It can be from a house, school, university, hospital, residential or nursing home, shop, office, factory or any other trade or business. It does not have to be hazardous or toxic to be controlled waste. Failure to register could carry a £5000 fine. Failure to meet your duty of care when transporting waste can carry an unlimited fine.

PROCEDURES

Sharps bins can be dealt with using the following procedures:

- Sharps bins should primarily be removed and replaced by arrangement with the local council Environmental Services or the local Needle Exchange Scheme, as appropriate.
- The organisation will also be registered in the environment agency's register of waste transporters. This allows the organisation to transport sharps bins or other controlled waste legally.
- No staff member should transport sharps bins out of the building until they are familiar with the Duty of Care attached to this role. This is as follows:

When you have waste:

- The law says you must stop it escaping from your control. You must store it safely and securely. You must prevent it causing pollution or harming anyone.
- Make it secure. Keep it in a suitable container.
- If you give waste to someone else, check they have authority to take it.
- Describe the waste in writing. You must fill in and sign a transfer note for it. You must keep a copy of the transfer note. To save on paperwork, you can write your description of the waste on the transfer note.

NOTES

In order to reduce work in this area, it is desirable that handling of sharps bins be undertaken by needle exchanges. However, where no such arrangements exist, or would be impractical, agencies will need to register as a waster carrier.

Charities and voluntary organisations do not need to be registered as a waste carrier. You must instead be registered in your local environment agency's register of waste transporters. This is free of charge. Agencies should contact the Environment Agency for further details

INOCULATIONS

NOTES

All staff should be advised during induction to consult their GP regarding Hep B vaccination.

BODY FLUID - SPILLS

NOTES

A spillage kit containing cleaning cloths, bleach, rubber gloves and plastic bags should be kept available and restocked and staff instructed on the safe cleaning of spillages.

OTHER PARAPHERNALIA

EXAMPLES: *POSSESSING RIZZLAS, POSSESSION OF SCALES, POSSESSION OF A CRACK PIPE, POSSESSION OF A BONG*

SAMPLE WORDING

"We do not condone residents bringing drug paraphernalia on site and, where we think this is associated with illicit drugs we will always discuss this with you.

- If we become aware of paraphernalia that belongs to you we may need to take further action. If the paraphernalia suggests supply might be taking place, we will act under the sections of this policy about SUPPLY.

- If the items that we have found suggest cannabis smoking is taking place we will take action as described in the section on USE of DRUGS – CANNABIS.
- If the paraphernalia represents a risk to staff or other residents we will remove it and discuss the matter with you. This may result in some sanctions being imposed.

LAW:

There is no specific prohibition on possessing equipment, although the supply of some equipment is prohibited unless the law specifies it is acceptable to give it out.
Possession of paraphernalia which has traces of drug on it can result in charges of possession of a controlled drug.
The presence of some paraphernalia – such as that which indicates supply of drugs or smoking of cannabis is taking place, would equate with 'knowingly' under Section 8 of the MDA and so further action would be required.

PROCEDURES

- Workers should generally not remove paraphernalia unless it creates a significant risk to staff or service users.
- If an item is removed and it is not one of the items permitted for distribution, it will need to be destroyed and should not generally be returned to the service user.
- If an item suggests supply is taking place, workers should lock the room and decide if Police action is warranted. If it does, the Police should be called.
- If Police involvement is not required, the resident should be challenged and enforcement action taken when it is safe and appropriate to do so.
- If the paraphernalia indicates another section 8 offence such as smoking cannabis, then the room should be sealed if possible and enforcement action taken if the client is absent when they return to the building.
- If the paraphernalia represents a significant risk it will need to be removed and should not generally be returned to the client.
- In other circumstances when paraphernalia is found, but it is not associated with significant risk or a section 8 offence, a more measured approach can be taken including education and awareness raising and sanctions if required.

NOTES:

The possession of these items of paraphernalia is not illegal but may suggest other illegal activity – including those covered by Section 8 of the MDA. Where this, or risk is created by the paraphernalia, further action will need to be taken.

SUSPECTED OVERDOSE

SAMPLE WORDING

"If you or a friend become unwell after using any drugs, or you are worried that you or someone else may be overdosing you should always seek help as fast as possible. This means finding a member of staff. If you are living somewhere without staff on site, you should call an ambulance. Even if you know how to carry out first aid you should also contact a member of staff or emergency services.

The organisation's priority will always be to ensure the safety of residents and any overdoses will be treated as a medical emergency first and foremost rather than seeking to 'punish' people for breaking the rules.

Residents should also remember that <u>not</u> getting help for seeking help or contacting emergency services can increase the risk of legal problems should anything go wrong. The safest course of action for everyone is to seek help.

This organisation supports making Naloxone available to be used in the event of opiate overdoses. Staff will use Naloxone in line with their training and national guidelines."

PROCEDURES

- Residents who are considered at risk of opiate overdose should not be accommodated within a Low Threshold environment and appropriate alternative accommodation identified as a priority.
- The organisation will provide first aid training, and ensure that each shift has one qualified first-aider on shift in staffed housing settings.
- In organisations where Naloxone is kept on site, staff will have training in how and when to use it.
- The organisation will ensure that fully stocked first-aid kits are available; these will also contain Resus-Shields for delivering mouth to mouth.

It is potentially dangerous and misleading to assume that the client has taken any drugs; there may be other reasons for their symptoms. In all incidents where a client appears ill or unwell, the following process should be followed:

- The client should be reassured that the priority is their well being, not taking disciplinary action. They should be encouraged to say if they have used any drugs, are taking medication, or if there is other relevant information.
- If necessary, an ambulance should be called at this point.
- If any drugs have been taken, they should be retained to pass onto the ambulance crew for identification.
- Care should be taken in case syringes have been discarded; the areas should be made safer.
- Where possible, staff should try to get relevant information from other clients, and make a note of this information.
- The situation should be closely monitored.
- If a client is found unconscious or becomes unconscious or stops breathing, first aid should be delivered by a trained first-aider.
- An ambulance should be called.
- Naloxone should be deployed in line with training and national guidance
- The incident should be recorded in the Accident Book and in the client's notes.
- When the client returns, the incident trigger an urgent review of their accommodation and support package.

So, although the "safety first" imperative still stands in relation to managing overdoses, assurance cannot be given to residents that such incidents will not result in loss of housing.

RECORD KEEPING

SAMPLE WORDING

The organisation keeps records of drug-related incidents and these will be shared amongst members of staff on a "need-to-know" basis. Information may be recorded in personal files, incident or accident books as required.

Residents are entitled to see any written information about them kept on file. However some information may need to be withheld to protect the identity of other residents. If you disagree with something that has been written about you, you may discuss this with staff to address this situation.

LAW

All records kept by an organisation could be used in a court case, and could be an essential element of either prosecution or defence submissions.

Documents relating to interventions made with a client enjoy a degree of protection under the *Police and Criminal Evidence Act (1984)*. Section 12 of PACE concerns the protection of 'personal records' and defines them thus:

documentary and other accords concerning an individual (whether living or dead) who can be identified from them, and relating -
(a) to his physical or mental health
(b) to spiritual counselling or assistance given or to be given to him
(c) to counselling or assistance given to him, for the purpose of his personal welfare, by any voluntary organisation or by any individual who -
(i) by means of his office or occupation has responsibilities for his personal welfare; or
(ii) by reason of his court order, has responsibilities for his supervision.

Magistrates cannot issue search warrants for such 'excluded' documentation; warrants can be issued by a circuit judge.

PROCEDURES

An Incident Book will be maintained. This book will record all incidents including drug-related incidents. This is an open access book which may, if required, be shared with the police to demonstrate that the drugs policy is being followed. As this is an "open" document no sensitive information should be recorded in this file.

The Incident Book should be a bound book, not a loose-leaf file.

On each drug-related incident, including episodes of suspicion and third-party information, the incident will be recorded in the Incident Book.

Staff should endeavour to record information as soon as possible after the incident.

Information in the incident book should be limited to the following:

- The date and time of the incident.
- The name or client-code of the client(s) involved
- A reference to the client's personal file
- The initials of the worker dealing with the incident.

Full details of the incident and action taken should be recorded only in the client's personal record.

Information should be recorded in an accurate and professional manner.

Records relating to people who are banned (i.e. a "bans book") should similarly only record the identity of the person, the duration of their ban, and a date of re-admittance. All other information should only be recorded in the client's personal file.

NOTES

All drug-related incidents, and responses to them, must be accurately recorded. The recording should, however, balance the need to record incidents and the need to protect the rights of clients.

The police can apply for a warrant to gain access to written information including those involved in the supply of drugs. After a warrant has been issued, organisations would be obliged to hand over written documents or face criminal charges. Sensitive or incriminating information should only be recorded in an individual's personal files, not in more generic files such as logbooks, ban books or daybooks. While all written records can be seized, some, such as client notes, enjoy a greater degree of protection than others such as log-books.

CONFIDENTIALITY

SAMPLE WORDING

"We offer a service that aims to protect your right to privacy. In most circumstances we will not discuss anything about you outside this organisation without your consent.

We may be able to offer you a better service if we can discuss your situation and needs with external agencies. We will normally only do this with your permission.

However, if your actions or behaviour represents a serious risk to the safety or well being of other clients, staff, the community or the organisation, or other agencies we may have to disclose information without getting consent.

If we become aware of serious criminal activity, such as drug supply we may need to share information about this with the police."

PROCEDURES

- Staff should explain the organisation's confidentiality policy to all new clients, and ensure that they understand the policy.
- Staff cannot offer a wholly confidential service; in certain situations, staff may be obliged to discuss matters with external agencies, even if this is against the client's wishes.
- Confidentiality rests with the organisation, not with the individual staff member,
- Clients should be encouraged to give their informed consent to allow workers to share relevant information with other agencies, on a "need to know" basis where such information sharing would benefit the client.
- Clients should be aware that information relating to them would be disclosed where there is a legal obligation to do so.

Clients should be aware that information may be disclosed if there is perceived to be a serious risk to the safety or well-being safety or well being of other clients, staff, the community or the organisation.

NOTES

Organisations frequently talk about offering a confidential service, when in fact they cannot and should not describe themselves as such. In some situations, a policy of confidentiality actually acts to the detriment of clients. To this end, a move towards informed consent, allowing workers to share pertinent information with other agencies, can benefit clients, and should be encouraged.

At the other end of the spectrum, situations may emerge where organisations are obliged to share information about a client; the desire to maintain a confidential service cannot and should not stand in the way of legal obligations to disclose information. Given these limitations relating to confidentiality, it is essential that both staff and clients are clear with regards the organisation's policy towards offering a confidential service.

POLICE INVOLVEMENT

SAMPLE WORDING

"The organisation will maintain effective working relationships with the Police. Where the law requires it or the situation warrants it the organisation will ensure that it supports the police in their work."

LAW

Police can search premises in a variety of circumstances, including:

- When they have the consent of the occupier
- When a warrant has been obtained
- Following an arrest, the police are allowed to search premises the detained person occupies or has control over
- To capture an escaped prisoner
- To arrest someone for a public order offence or certain arrestable offences
- To protect life or to stop serious damage to property.

Other laws give police specific power to enter premises. Obstructing the police or hampering a police enquiry can result in prosecution.

PROCEDURES

The organisation will endeavour to maintain good, effective relationship with the police at all times. Staff will fully cooperate with the police whenever there is a legal obligation to do so.

In addition, staff will involve the police in any incidents where police assistance is required. The senior worker on shift will assess such incidents as to whether they require "fast" or "slow" responses:

- "Fast" response situations (e.g. serious violence) will mean dialling 999.
- "Slow" response situations (e.g. seeking assistance in disposing of drugs) can involve phoning the local station and speaking to local officers who are familiar with the organisation.

Senior police representation will be encouraged on management or advisory boards.
Outside of these situations confidential information will not normally be shared with police unless there is specific reason to do so such as serious offending, or serious concern about risk or safety.

Concerns about police requests for information or other issues should be referred to senior management, who will discuss the matters with senior police officers.

NOTES

Organisations seek to maintain an effective working relationship with the police. It is recognised that working with people who use drugs illegally may create a tension between the organisation, police and clients.

In most circumstances organisations will not be obliged to volunteer information about drug users or suppliers. The police may ask organisations to provide this information, but organisations do not have to do so. They can continue to offer a confidential service up to this point.

The Wintercomfort Trial highlighted another scenario where organisations may find themselves obliged to disclose information to the police about known or suspected dealers. Under Section 8, organisations are obliged to prevent the supply of controlled drugs taking place on the premises. They can do this in a number of ways, ranging from instructing the person to stop the prohibited act, through to applying sanctions including banning the person from the premises. Provided that these measures succeed in preventing the supply taking place, then organisations have succeeded in discharging their responsibility under Section 8. They do not have to go on and provide details of the person in question to the police, though they may choose to do so.

However, if the measures that the organisation has taken do not succeed in preventing the supply taking place, then they are still liable under Section 8 and further steps need to be taken. These could include disclosing information about people supplying drugs to the police. This would enable the police to prevent the supply taking place and thus discharge the responsibility on managers under Section 8.

To recap then, while there is normally no obligation to disclose information to the police, there is an obligation to prevent the supply of drugs taking place under Section 8. This latter obligation may require organisations to voluntarily disclose information to the police about the supply of drugs, if other measures adopted have not prevented the supply of drugs taking place on premises.

Some organisations are adopting policies of voluntarily disclosing information about the supply of drugs to the police. While it is clear to see the pressure on organisations to adopt such practices, they are also likely to do a great deal of damage to relationships between organisations and their clients. Such an approach is clearly appropriate in cases of large-scale dealing for profit on or near premises. It is however a less appropriate response to more typical scenarios regarding users who also sell drugs. There is a need for balance here, between the needs of users and the demands of the police. The voluntary disclosure to the police of all people supplying or suspected of supplying drugs may tip the balance too far the wrong way.

VISITORS

SAMPLE WORDING

"If you invite visitors into the building, or your room, you share responsibility for their behaviour. If they break organisation rules, action will be taken against them, and the person who invited them onto the premises.

If you have a visitor or a guest who is causing you a problem, please inform a member of staff.

If a visitor or guest is responsible for antisocial behaviour and you are unable or unwilling to prevent this, you should be aware that this will jeopardise your continued use of the provision/tenancy/license."

LAW

There is a grey area as to who would be legally responsible for drug-related offences committed by guests while on premises. Certainly, when offences took place in communal areas they would be the responsibility of the organisation. However, if a guest undertook prohibited activities in a resident's own bedroom, the legal position is less clear.

It may be that the resident, and only the resident, would be liable under Section 8 of the *MDA (1971).* However, there is a risk that the organisation could be held to be responsible. In the absence of further clarification, organisations should err on the side of caution, and assume that the organisation may be held legally responsibly for the actions of guests.

PROCEDURES

- Clients should be made aware that, if their guests break the organisation's rules, sanctions would be applied both to the guest and the client.
- If visitors are persistently causing a nuisance within the project they should be excluded from the premises. If required, an injunction could be obtained to prevent reoccurrence of any problems.

HOME VISITS BY WORKERS

"Home visits are an important part of the support available to you. We want these visits to be a useful part of resettlement. Please make sure that you are "fit to participate" in home visits; this includes:

- Not being intoxicated so you can't participate
- Not using during visits unless this has been agreed between you and the support worker
- Not having visitors during a support visit unless agreed with the support worker
- Having consideration for your visitor during the visit and behaving appropriately.

Please make sure your property is safe for visits to take place. This includes not leaving anything dangerous around like used equipment.

If you are using your property to produce or supply controlled drugs, please be aware that this is a serious criminal offence. The organisation would need to take further action which could include informing the Landlord (where relevant), police or ending your tenancy.

If you are unable or unwilling to work within these terms, then we may not be able to continue to offer support visits. Where support visits are a condition of your tenancy this may mean we seek to end your tenancy unless support visits can take place."

LAW

Some support workers will also be part of the 'body' which is '*concerned in the management*' of a property. The law in this area is not clear, but an interpretation of when support workers doing home visits are 'concerned in the management' is included in the KFx Legislation briefing.

Where the home visits are made by organisations who are also the landlords, the visiting workers are, to an extent "*concerned in the management*." Where such workers become aware that a property is being used for production or supply, there may well be an offence under Section 8 of the *MDA*. This will require the organisation to take action to prevent the production or supply continuing.

Where use is taking place on site – even during a visit – the worker would not be committing a criminal offence by remaining present (unless cannabis was involved). While many organisations would break off a visit if use takes place, this is a matter of policy not law.

The situation is more confusing where floating support provision is not directly provided by the landlord or the landlord's agent – as is commonly the case with Supporting People projects. In such situations, the following policy position is useful:

- Floating support interventions will generally be confidential;
- However, when floating support workers become aware of any of the following they should consider reporting it to the landlord:
- Serious section 8 offences which bring a realistic risk of prosecution,
- Serious offending
- Behaviour likely to cause significant risk to people on the premises or neighbours
- Serious antisocial behaviour

PROCEDURES

- Solo home visits should not take place until a full risk assessment has taken place.
- Prior to solo visits, the 'rules' relating to home visits should have been discussed with the client.
- If on arrival, or at any point during a visit, the worker feels that it is unsafe or inappropriate to continue the visit, they should leave as soon as practical.
- If the worker is concerned about the safety or wellbeing of their client or other people in the property, the worker should contact emergency services when it is safe and practical to do so. Workers should not put themselves at risk during a support visit and should always err on the side of caution.

Supply and Production

- Workers should not remain in a property if they are aware that production or supply of controlled drugs is taking place there.
- Workers should only challenge this behaviour if they feel that it is safe and appropriate to do so; it's usually going to be better to leave.
- Further action will need to be taken to prevent the production or supply which may include warning letters, joint working with landlords, enforcement action, police involvement, eviction.

Use

- When use is taking place on site, workers should use their judgement as to whether to leave or not. They should consider this in terms of their own safety and well-being, that of the client, and how useful the visit is likely to be.
- There is no expectation that workers will remain present when drugs are being used; however, there may be times when a worker feels that it is productive and useful to remain present at such times.
- No worker should remain present if they feel that the situation is not safe or they feel uncomfortable with remaining present.
- If the worker has any concerns about the wellbeing of the resident, the worker could stay to ensure their safety, if safe to do so. Alternatively, help from colleagues or emergency services may be required if it is not safe for the worker to remain, but the resident is unsafe to be left.

Intoxication:

- If the resident is thought to be intoxicated the key priorities are to ensure staff safety and the safety of the individual.
- If necessary, the staff member should leave if the level of intoxication warrants it. The emergency services should be called if required.

- If it is not an emergency situation the worker should decide if it is productive and appropriate to remain. If the visit is terminated, the client's wellbeing should be reviewed before leaving to ensure they are still safe.

After all incidents of use or intoxication, the resident's support and accommodation package will need to be reviewed and revised.

NOTES

There has been some discussion about whether workers should remain present when substances are being used. In some settings (e.g. visits by needle exchange workers) this allows for the opportunity to supervise injecting and advise on technique. As such this can be a useful aspect of harm reduction.

In other settings, workers have complained that it seems disproportionate to break off a meeting solely because their client has lit a spliff.

Having said that, some workers will find being present during use distasteful or upsetting, and it may bring with it additional risks.

As such the policy position above leaves space for a worker to decide what they wish to do without obliging them to stay or go.

EQUAL OPPORTUNITIES

SAMPLE WORDING

"All clients have a right to be treated with respect, fairness and dignity by both workers and other clients. This organisation will work with people who use drugs and those who do not.

The organisation will treat, as a breach of the Equal Opportunities Policy, abusive, threatening or offensive language or behaviour which discriminates against people who use drugs or alcohol."

PROCEDURES

- Staff and clients should avoid using language that reinforces negative images of people who use drugs. Terms such as "smack-head," "junkie," or "alkie" are derogatory, negative and stigmatising. The use of such language should be challenged.
- Literature and resources used within the building should not reinforce stereotypes relating to drug users.
- The use of concepts such as "addict" and "addiction" should be used with care, as they can become unhelpful labels.
- The terms 'clean' and 'dirty' as synonyms for "abstinent" and to describe using are inappropriate and, while individuals may choose to use such terms in reference to their own use, such terms should not be used by staff.

NOTES

Many aspects of problematic drug use are linked to issues of low self-esteem, self-image, and social stigma attached to drug use. Creating a safe arena where people can explore their drug use without being labelled or derided is an important element of any support work with people seeking to address their drug use.

STAFF CODE OF CONDUCT

SAMPLE WORDING

"Staff must not use any controlled non-prescribed drug, or alcohol, or non-medicinal drugs controlled under the Medicines Act during working hours. Such use will constitute a serious disciplinary issue, and may result in dismissal.

Staff should not work when incapacitated due to the effects of such drugs, or after-effects of such drugs. They are instead required to take annual leave or use TOIL if available. The use of sick leave in such circumstances will be treated as a serious disciplinary issue.

Staff who are prescribed controlled drugs (e.g. methadone) should ensure that their medication is securely stored while at work, and should ensure that they do not drive or operate machinery while using such medication.

Tobacco may be smoked in designated smoking areas.

If a member of staff develops substance-related problems, the organisation will seek to assist them in resolving this, and time off for counselling, treatment or other assistance will be made available, in consultation with the Project Manager.

The organisation will always seek to provide assistance to staff members in such situation but the offer of such assistance does not preclude termination of employment should it be deemed appropriate."

4. APPENDICES

APPENDIX 1: FURTHER INFORMATION

Additional reading material

On the KFx website:

- Managing Drugs on Premises: Working within Section 8 of The *Misuse of Drugs Act 1971* and Section 1 of the *Antisocial Behaviour Act 2003*: KFx: 2006 (rev)
- Tenants and Drugs - Guidance for Landlords: KFx: 2006 (rev)
- Policing Cannabis: Joint working protocols for managing cannabis use in residential settings: KFx: 2004
- Drugs and the Law: a briefing for housing workers and other professionals: KFx 2004
- Room for Drugs: Flemen, K: Release: 1999
-

The above resources are cross-posted to the Drugs and Housing Website at www.drugsandhousing.co.uk

Other resources

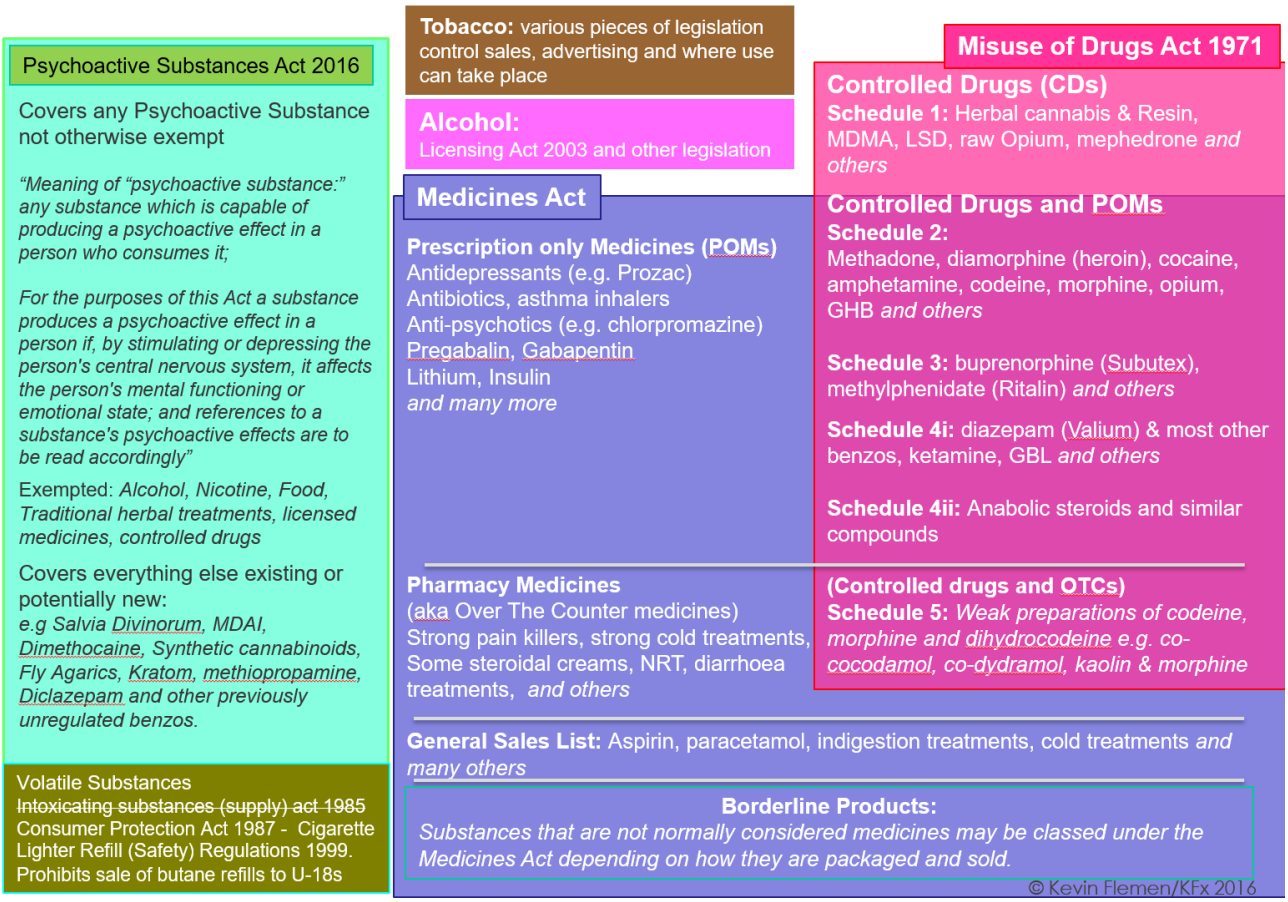
- Youth homelessness and substance use: Wincup, Buckland and Bayliss: Home Office: 2003
- Drug Services for Homeless People - a good practice handbook: Randall; Drugscope/Homeless Directorate:
- Home and dry? Homelessness and substance use in London: Jane Fountain and Samantha Howes. Crisis 2002
- Tackling Drug use in Rented Housing: DTLR:Robinson & Flemen: 2002
- *Sample Drugs Policy* and Support Notes: Cymforth Cymru: 2008 http://www.cymorthcymru.org.uk/pdf/policy/cc-sample-drugs-policy-2008.pdf
- The Spectrum Of Possibility: A guide for Housing Providers: NORDAAT: 2007 http://www.nordat.org.uk/pubs/guidance_info/modelforhousingproviders2009version2.pdf
- Safe As Houses: Steve McKeown: Shelter: 2008: http://england.shelter.org.uk/professional_resources/policy_library/policy_library_folder/safe_as_houses_an_inclusive_approach_for_housing_drug_users/safe_as_houses_an_inclusive_approach_for_housing_drug_users.pdf

Contacts

KFX	
E-Mail:	mail@kfx.org.uk
Websites:	www.kfx.org.uk and www.drugsandhousing.co.uk

HOMELESS LINK	
Mail:	Homeless Link, Gateway House, Milverton Street, London SE11 4AP
Tel:	0207 960 3010
E-mail:	info@homelesslink.org.uk
Website:	http://www.homeless.org.uk/

APPENDIX 2: CONTROLLED DRUGS, PRESCRIBED MEDICINES & OTCS & NPS



Drugs in the MAGENTA box in the diagram below are Controlled Drugs, as defined by the *Misuse of Drugs Act* 1971, and subsequent amendments. This means that all the rules, offences and powers included in the *Misuse of Drugs Act* relate to these drugs.

Those controlled drugs that are in the magenta box only (at Schedule 1) are considered to have no medical use at present and so aren't prescribed as medicines.

Drugs in the BLUE Box are medicines. Some are only supplied on prescription (POMs) while others can be bought only from pharmacists (Pharmacy Medicines, OTCs)) and some can be bought from other shops (General Sales List).

Where the magenta and blue boxes overlap, these are Controlled Drugs (CDs) that have legitimate medical uses and so are covered by both pieces of legislation. Drugs in Schedule 2,3, and 4i are Prescription Only Medicines. They can be prescribed, but non-prescribed possession and supply can bring all the penalties of the *MDA*. Schedule 4ii CDs are also POMs, but it is not an offence to possess them without prescription. It is still an offence to supply them unless authorised to do so.

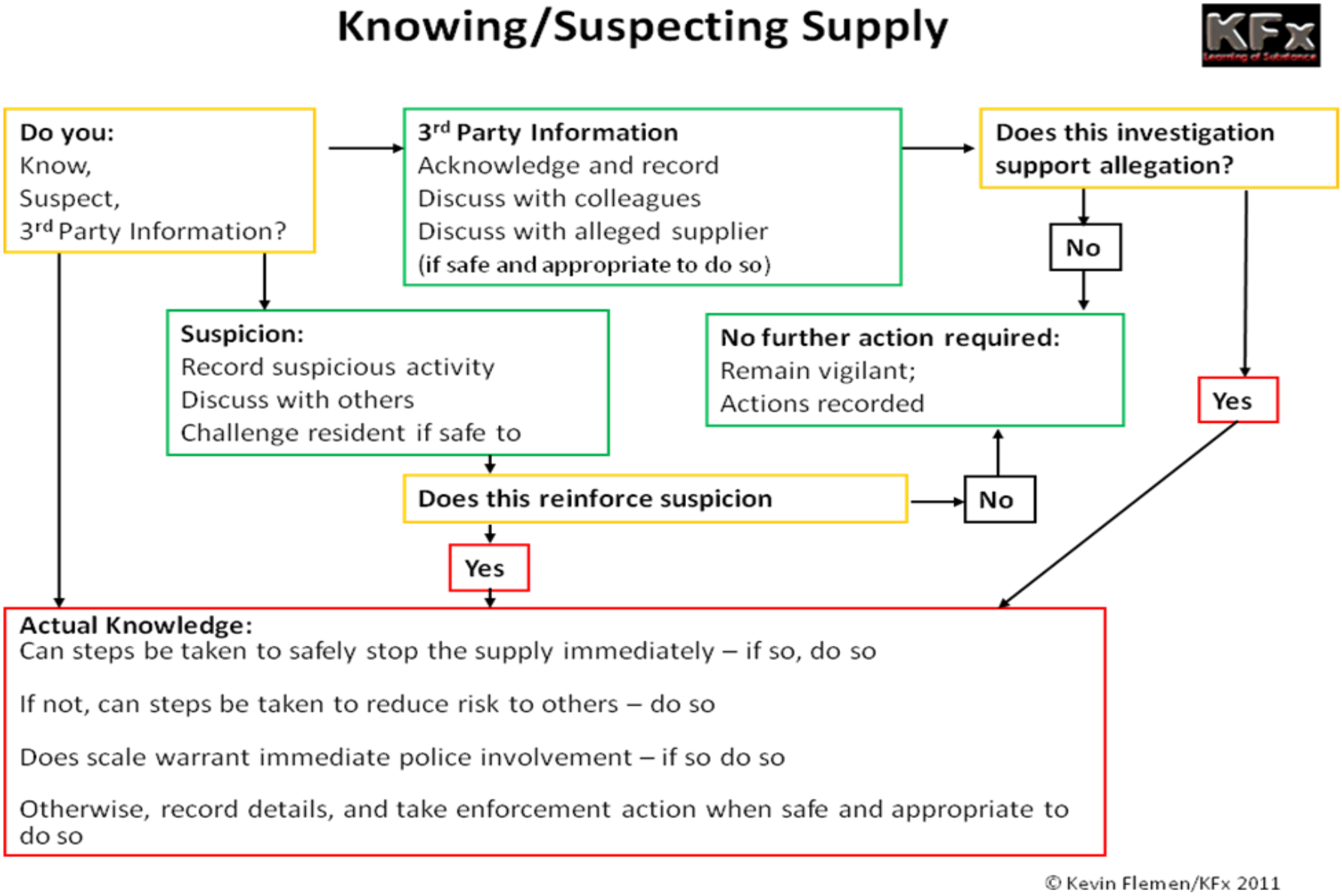
Schedule 5 CDs are relatively weak preparations, and so are considered lower risk. They are available from Pharmacies without a prescription.

Drugs which are only in the blue box are not controlled drugs and so the rules, powers and penalties of the *Misuse of Drugs Act* do not apply.

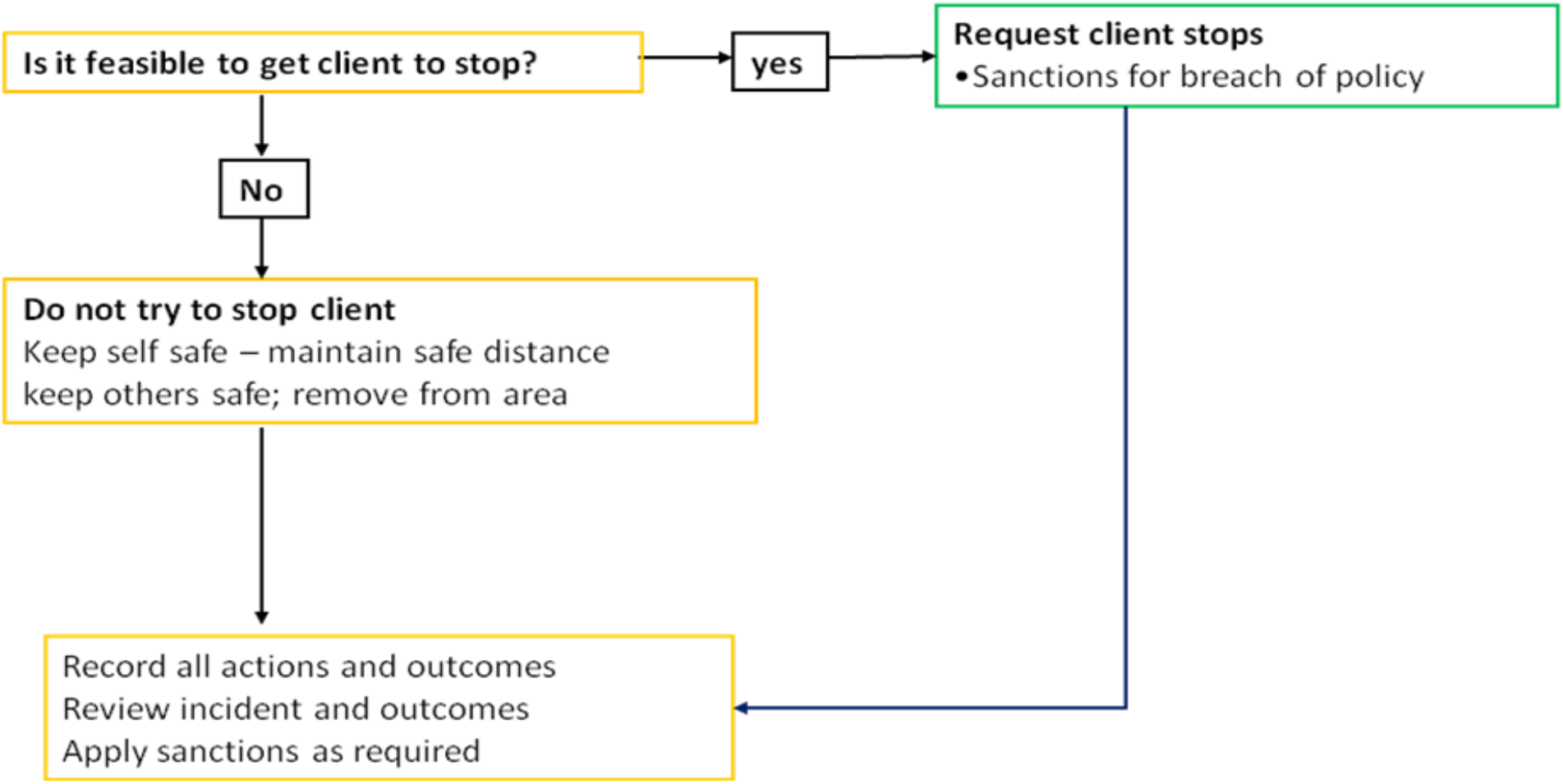
Psychoactive substances not classed as CDs, medicines, foods, alcohol, nicotine or otherwise exempt automatically fall under the Psychoactive Substances Act 2016. This makes it illegal to supply a psychoactive substance for intoxication. It also makes it an offence to possess such substances in custodial settings.

SCH	DRUGS/CLASS		RESTRICTIONS	WHO MAY SUPPLY	WHO MAY POSSES
1	Mescaline, DMT, AMT, Ecstasy, LSD Raw opium	A	Possession and supply are prohibited other than by Home Office Licence which is granted for educational and research purposes only.	Holders of a Home Office Licence granted for research only.	Police, Customs, person licensed by Home Office. Worker handing to police or destroying drug.
	Cannabis, MMCAT, ethylphenidate	B			
2	Cocaine, Diamorphine (heroin) Dihydrocodeine (Injectable), Dipipanone, Fentanyl, Methadone, Morphine, Pethidine, Phencyclidine, Codeine, methamphetamine	A	A Home Office licence is required for import, export, production, supply and possession. Regulations apply relating to the storage, record-keeping and prescribing of these drugs. Possession or supply without authority is a criminal offence.	Doctor Pharmacist Police, Customs and Excise Person in charge of Hospital or nursing home, The sister or acting sister of a ward, theatre, or other department of hospital or nursing home. Person authorized under group authority from the Home Office or with written authorization from the Home Office.	Practitioner Pharmacist A person in charge of a hospital or nursing home A person may possess a CD for his own use or for administration to another, in accordance with the directions of a doctor. i.e. when the drug has been prescribed by a doctor. Person engaged in conveying the drug to a person who may lawfully possess it. Worker handing to police/pharmacist or destroying drug.
	Amphetamine, Methaqualone	B			
3	Barbiturates Methylphenidate (Ritalin)	B			
	buprenorphine, Temazepam diethylpropion, mazindol phentermine, Flunitrazepam (Rohypnol),	C			
4i	Benzodiazepines (e.g diazepam) but not flunitrazepam or temazepam GammaHydroxyButyrate (GHB) Ketamine	C B	Possession or supply without authority is a criminal offence. These drugs are exempt from the restrictions on import and export. There are no safe custody or record keeping requirements under the Misuse of Drugs regulations.		
4ii	Anabolic steroids	C	While authority is required for production and supply, it is not required for possession. While it is illegal to supply these drugs without authority, it is not an offence to possess them.		As above: In addition, possession without authority in a medicinal form is not an offence.
5	Weak preparations containing small amounts of a controlled drug in a non-recoverable form. e.g Kaolin and Morphine mixture	A	These drugs are exempt from the restrictions on import and export. There are no safe custody or record keeping requirements under the Misuse of Drugs regulations. Authority is required to supply the substances but not to possess them.		

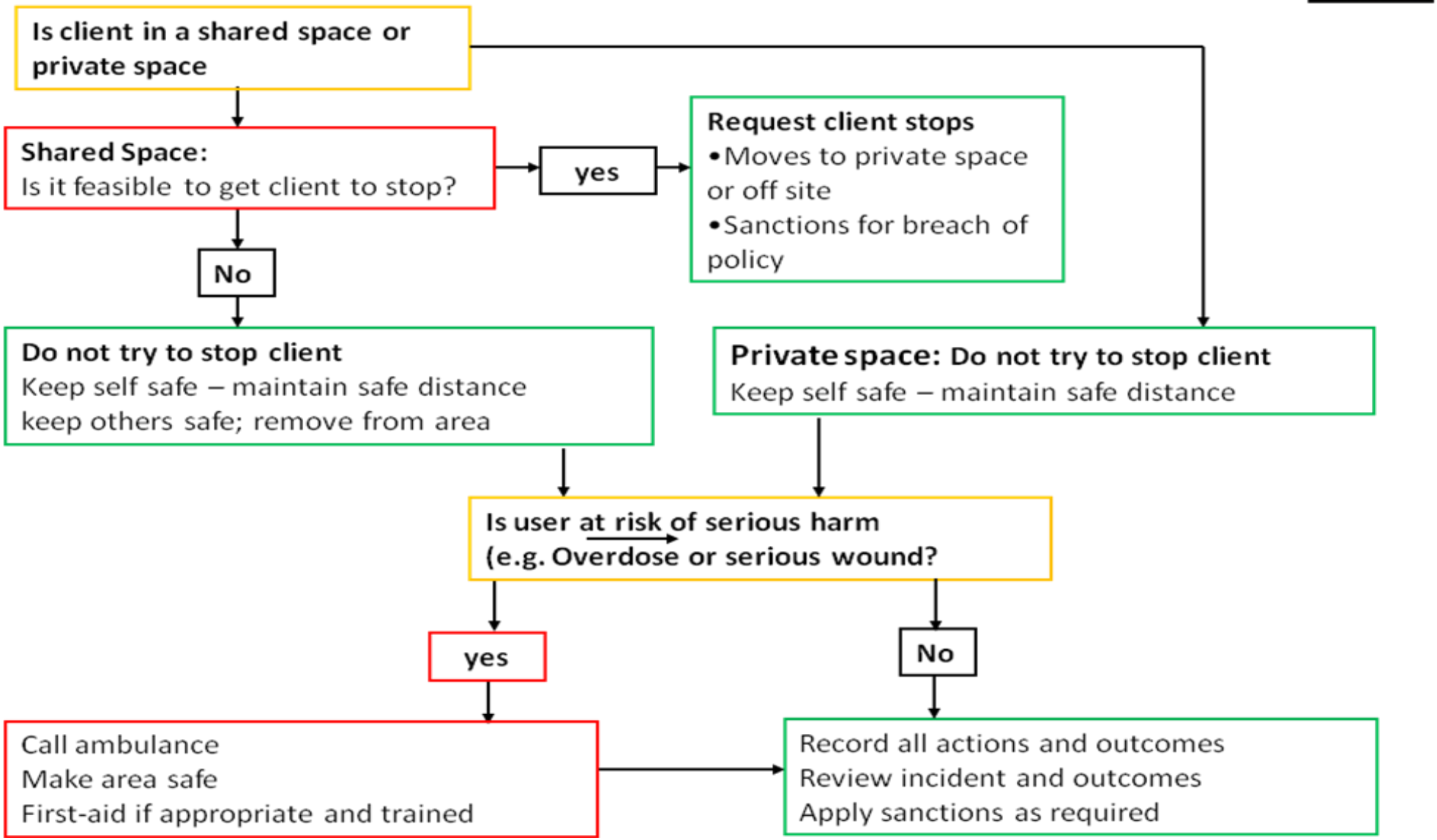
APPENDIX 3: DRUG INCIDENT PROCEDURE FLOWCHARTS



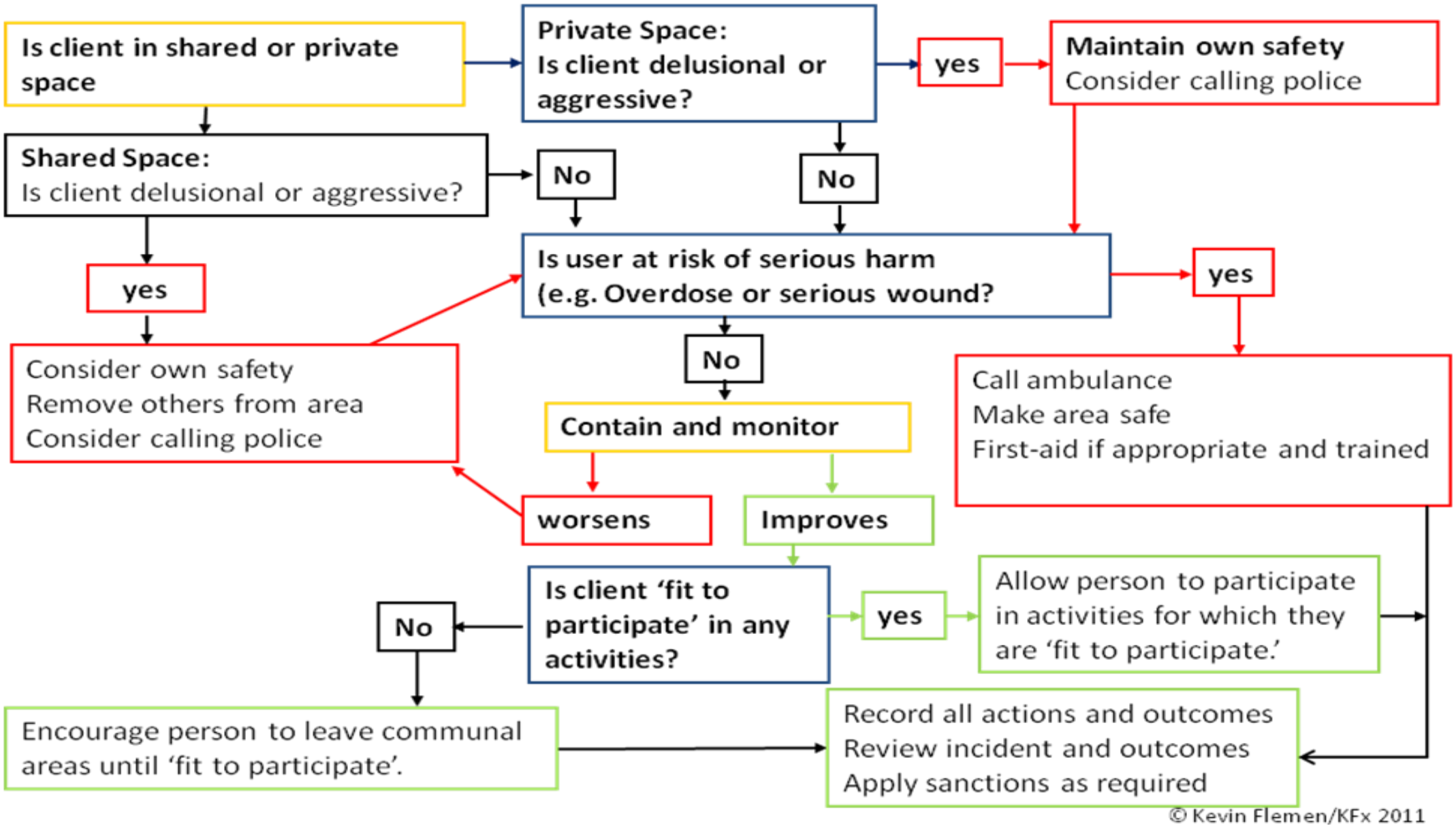
Use on Site (cannabis)



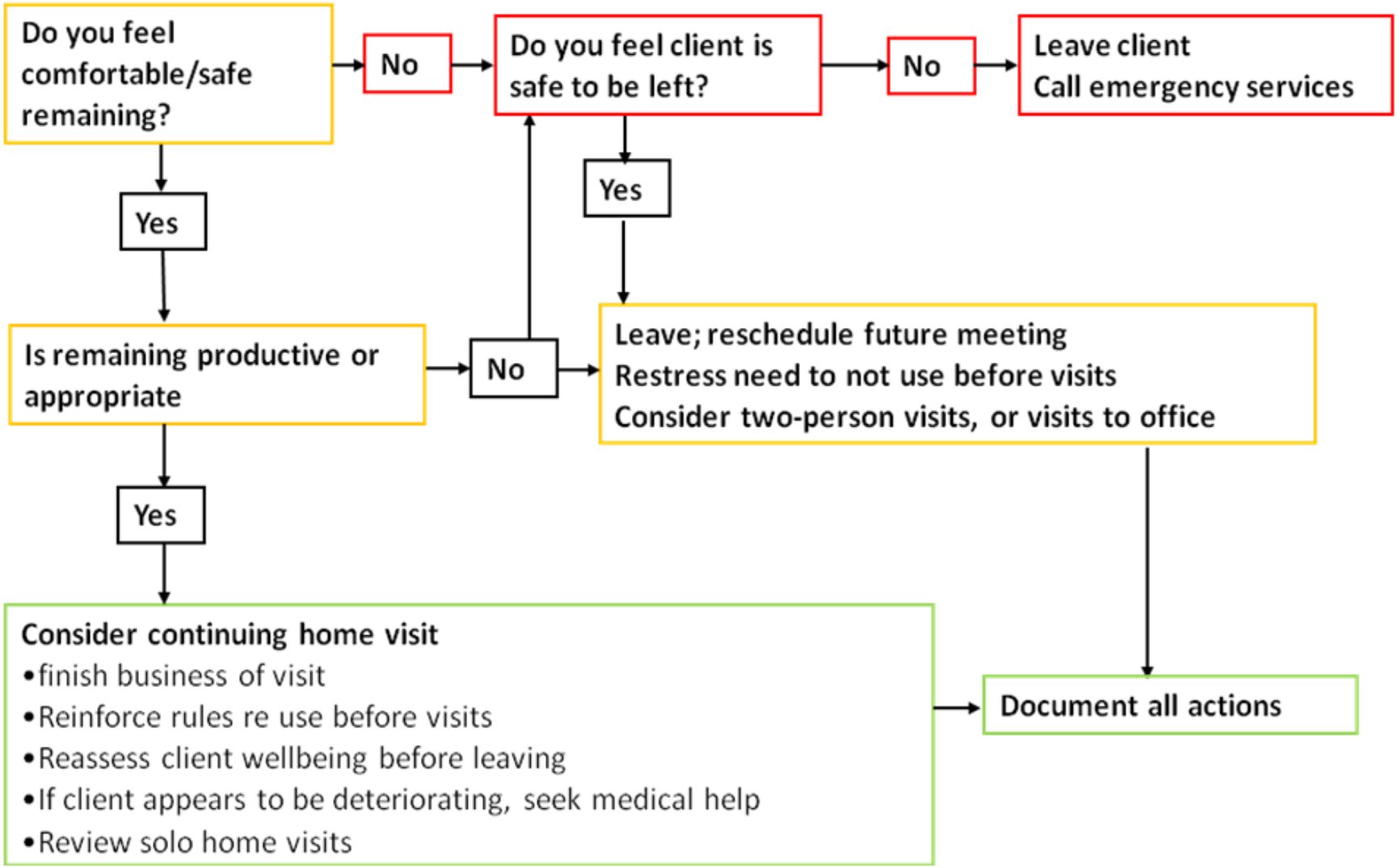
Use on Site (except cannabis)



Intoxication

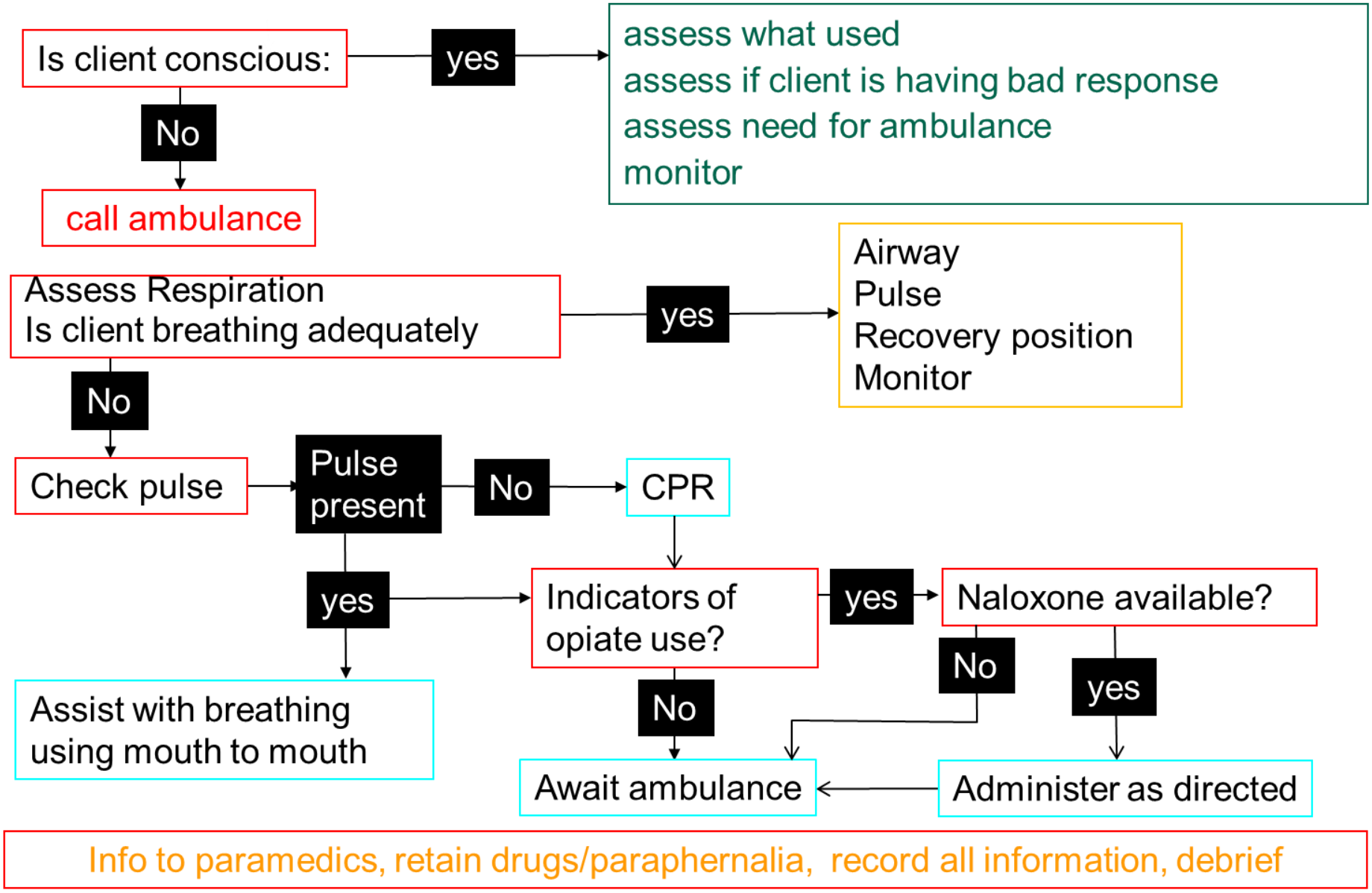


Use/Intoxication
Home Visit



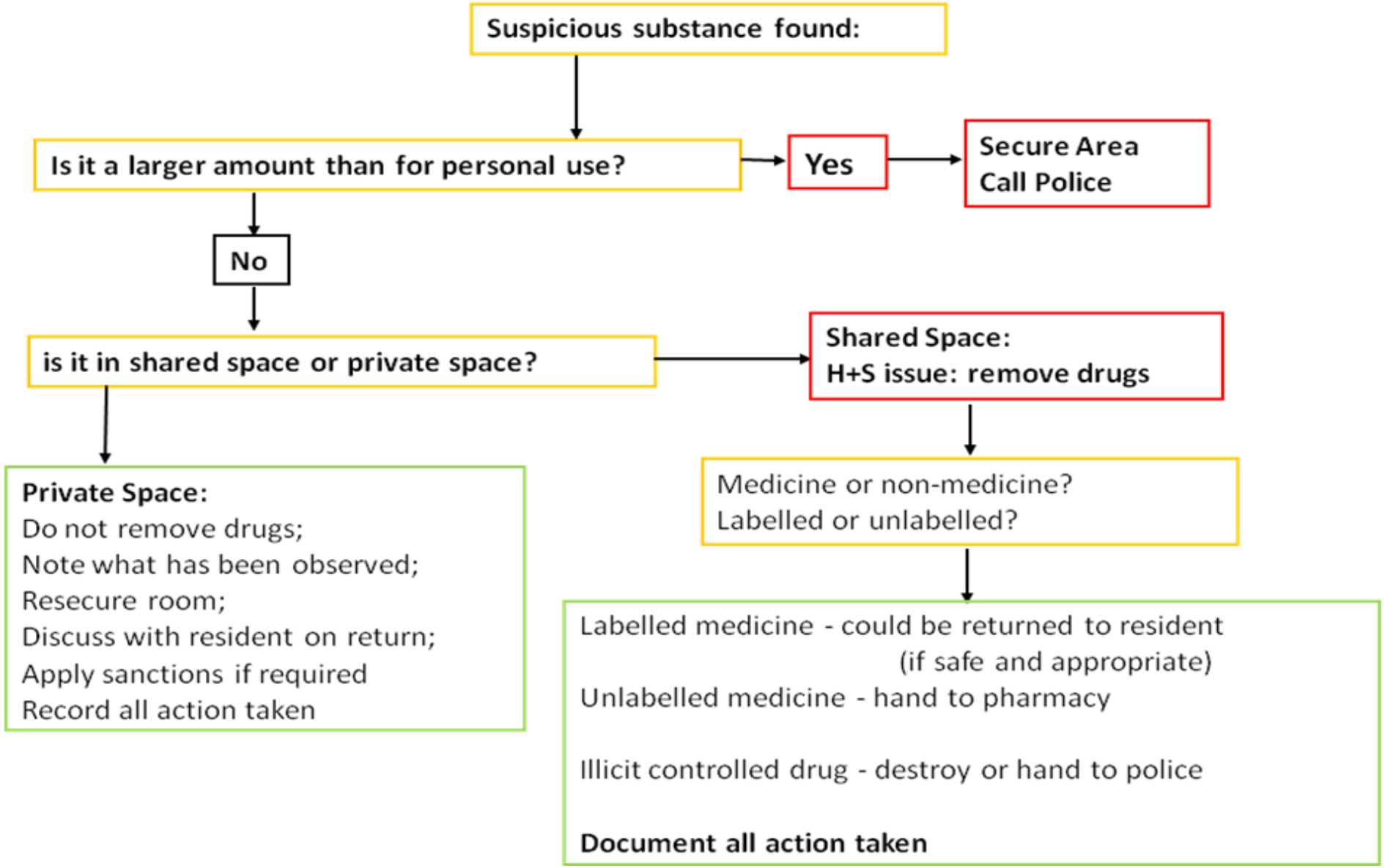
Opiate Overdose – Intervention

Make Sure You and Others around are SAFE first

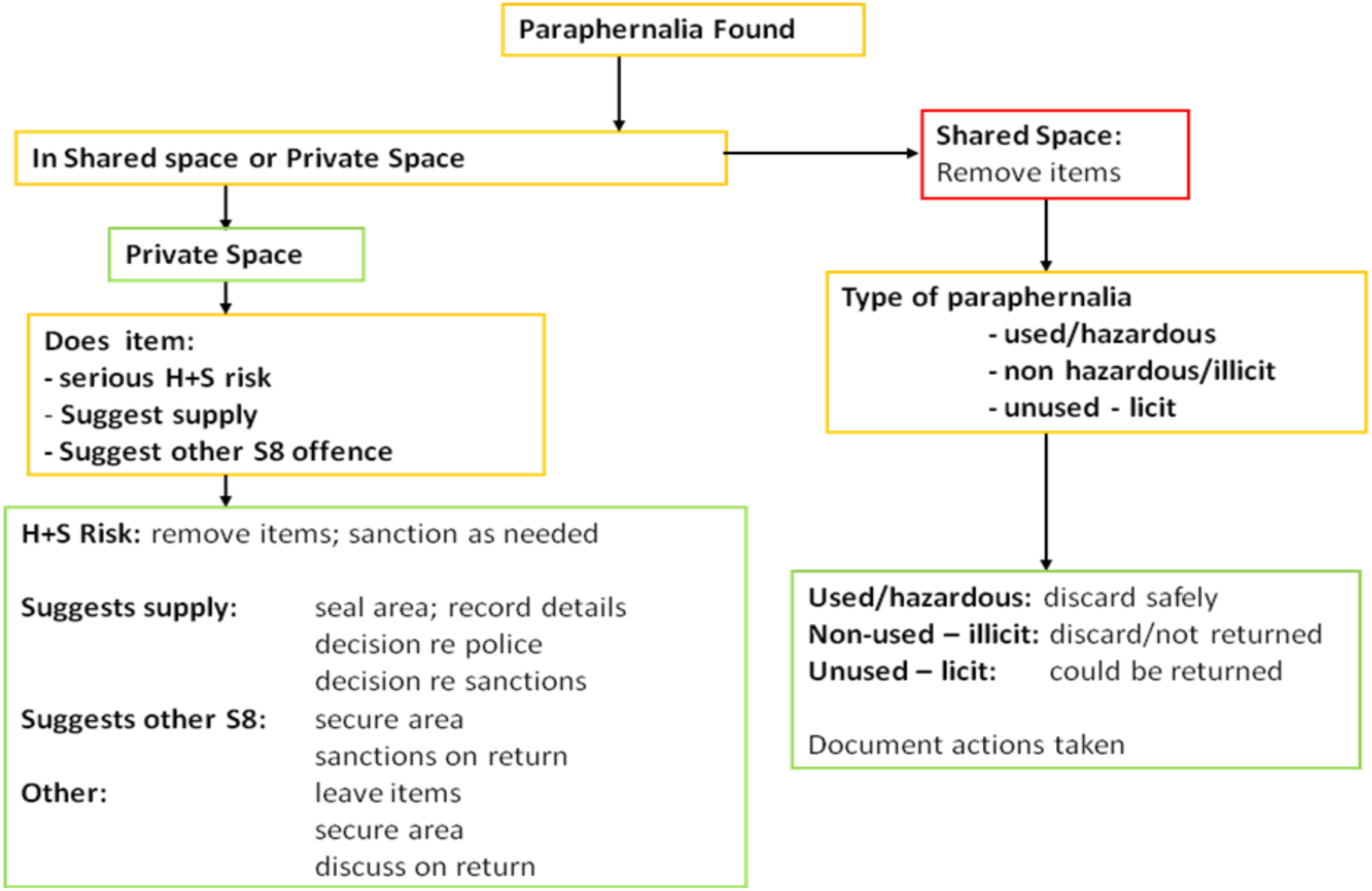


Info to paramedics, retain drugs/paraphernalia, record all information, debrief

Finding Drugs Flow-Chart



Finding Paraphernalia



Appendix 4: Drugs policy poster

Drugs policy

This project aims to work with people who:

- Do not generally use drugs or
- Use drugs but generally don't have a problem with their use or
- Sometimes use more than is good for them but are not dependent and do not inject drugs

We aim to support you to manage and where possible reduce your use. However, we recognise that you may sometimes choose to use drugs and we expect you to do this in a way that respects yourself, the organisation and other residents.

To achieve this the organisation operates a drugs policy.

The drugs policy should have been explained to you when you started using the service.

You are always welcome to look at the policy, to discuss it with staff, and to see how it affects you. It is important to highlight the following rules:

- We do not condone the possession or use of illegally-held controlled drugs on the premises. Where we know or suspect such possession or use is taking place, we will always take some action. This may result in you being asked to leave services, especially where we are concerned that such possession or use puts other clients at risk.
- Where we know or suspect such possession or use is taking place, we will always take some action. This will include a review of your suitability to remain in this type of housing, and could result in you being asked to leave.
- We will not tolerate the supply of intoxicating substances on these premises. If we know or suspect that you are involved in supply, we must prevent this happening. This may involve you being barred from some or all of the premises and may mean we have to involve the police.

We do not want you to be barred or excluded, so please make sure that you understand the drugs policy, and follow the rules for your own safety and the safety of others.

If you do not think that you will be able to abide by these rules please discuss this with your key worker at the earliest opportunity so we can identify alternative suitable housing.