On Storage

The Storage and Handling of Prescribed Controlled Drugs and Other Substances In Non-Medical Settings

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KFx
Learning of Substance

Acknowledgements

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Disclaimer

The subject of handling and storing controlled drugs on premises is fraught with controversy and this document cannot offer a definitive interpretation of the current legal position.
We would strongly encourage organisations to seek guidance from the Home Office, the RPSGB, the Police, and a lawyer before undertaking the storage and distribution of controlled drugs and other medication.
No liability will be accepted by KFx for any criminal or civil legal proceedings arising from use of this document.

Status of this Document

This is a document in development. It emerged from a number of queries relating to the legality of storing controlled drugs and attempts to draw together all the conflicting resources and opinions on the subject. It will be sent to a number of organisations for their opinion and to refine the arguments herein. Hopefully subsequent editions of this document will be revised to reflect these changes and developments.

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This pack reviewed and minor amendments made November 2005. The review took place with the financial assistance of Shelter. This should not be taken as endorsement of the content by Shelter.

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1.1 About this paper:

This document concerns the handling and storage of a variety of substances in non-medical settings. It is intended to offer guidance to workers and organisations seeking to develop policy, train staff or deal with incidents relating to this complex issue.

The report looks at the reasons for and against storing substances, legal issues relating to storage, policy and practice issues, and explores ways forward.

It should be stressed that this is a consultation and discussion paper, and should not be considered a definitive legal or practice document. Any agency seeking to manage drugs on premises should seek legal advice and or advice from medical services to ensure that practice is both legal and safe.

1.2 Why this guidance is needed:

Over the past few years, more and more agencies are seeking to work with people who use drugs. A wide range of organisations including housing providers, advice agencies and people undertaking resettlement and support visits is undertaking this work.

It has become very apparent, in the course of this work, that the storage and handling of substances is a recurring challenge for these agencies. The more that one delves in to this problem, the more complex it appears to become. Several factors have contributed to these problems:

1) The number of people being prescribed controlled drugs has increased massively; as many of these people are being prescribed in community settings, community based agencies have, inevitably, encountered these substances more frequently.

2) A larger number of agencies are housing or working with people who are ongoing users of unlawfully-held controlled drugs and staff are encountering situations relating to these drugs more frequently.

3) There are contradictory criminal law, case law, civil law and good practice issues and these have led to confusion.

4) A few agencies are working in ways that could potentially leave them open to prosecution or could jeopardize the welfare of their service users or staff.

Unfortunately, without changes to the Misuse of Drugs Regulations and clear guidance from the Government, these confusions and contradictions will persist. Despite acknowledgements on the part of Ministers that the law is contradictory and unhelpful, none of the required changes have been forthcoming.

In lieu of such changes, this document attempts to draw all the available information into some sort of order and look at safe, lawful resolutions to this ongoing problem

1.3 Who does this report apply to:

The report is written for workers who, professionally, encounter substances, but whose profession does not give them the statutory authority to possess or store these substances lawfully.

The report therefore will be of limited relevance to the police, GPs, nursing staff in charge of hospital wards or registered care homes, pharmacists, customs and excise, forensic scientists et al.

The document is however fully relevant to housing and day centre workers, non-medical staff in drugs treatment agencies, support workers, social workers, teachers, clubs door staff and a host of other professionals.

2.1 Relevant Legislation:

The primary pieces of legislation of concern are the Misuse of Drugs Act 1971, The Misuse of Drugs Regulations (Misuse of Drugs Regulations 2001, and The Medicines Act 1968. Reference will also need to be made to the Care Standards Act 2000, The Misuse of Drugs (Safe Custody) Regulations 1974.

The situation is further confused by some caselaw, notably Dempsey and Dempsey (1986).

Along side the criminal legal issues relating to the above legislation, workers should also be conscious of the Civil Law issues that stem from the Duty of Care owed to clients.

This means that if an organisation or an individual acted in a way that was negligent, and this led to harm to an individual, then there would be scope for the individual (or their estate) to take action via the Civil Courts. Even when there are no criminal law concerns there will still be civil issues that need to be adequately addressed.

2.2 Which drugs are under discussion?

This document looks at the storage and handling of the following substances:

- **Controlled drugs** prescribed as medicines: This refers to drugs that are controlled under the Misuse of Drugs Act 1971, but still have medicinal use. These can lawfully be prescribed to patients;

- **Other medicines** which are not controlled drugs: this can include Prescription only Medicines, medicines available over the counter from pharmacists without a prescription and General Sales List medicines, available from retail outlets.

2.3 Controlled Drugs:

This paper is primarily concerns prescribed controlled drugs. Controlled drugs are most frequently referred to by Class (i.e. Class A, B & C). For the purposes of considering who may possess and supply controlled drugs it is more useful to look at the Schedules of controlled drugs. These define who may possess a controlled drug, under what circumstances, and with what restrictions.

SCHEDULE 1:
Possession and supply are prohibited other than by Home Office Licence which is granted for educational and research purposes only.

Includes: raw opium, LSD, Cannabis and Ecstasy

SCHEDULE 2:
A Home Office licence is required for import, export, production, and authority required to supply and for possession (e.g. prescription)

Includes: heroin, morphine, pethidine, methadone, quinalbarbitone, amphetamine and cocaine.

SCHEDULE 3:
A Home Office licence is required for import and export, and authority required for production, supply and possession (e.g. a prescription.)
Includes Temazepam, barbiturates (except quinalbarbitone), buprenorphine, diethylpropion, mazindol and phentermine.

SCHEDULE 4
Part 1: Authority is required for production supply, and possession:
Includes the Benzodiazepines (except Temazepam), GHB, Ketamine
Part 2: as above but no authority is required for their possession, import or export.
Includes: Anabolic Steroids.

SCHEDULE 5:
Some controlled drugs, included in preparations in small quantities can be bought "over the counter," and include mild pain-relief medicines, cough medicines and diarrhoea treatments. No authority is required to possess them, but it is needed for their production and supply.

A complete list of controlled drugs by Class and Schedule is posted on the KFx Website at http://www.ixion.demon.co.uk/class%20and%20schedule.htm

2.4 Definitions: Key Terms

Much of the confusion relating to managing medication stems from the following key words: Possession, Supply, Conveying, Dispensing, Administering.

Possession and Supply: Possession and supply of controlled drugs without authority is an offence under the Misuse of Drugs Act 1971. The Misuse of Drugs Regulations defines who can possess or supply controlled drugs of each Schedule, and with what conditions.

An edited list of the authorised groups is included in Appendix 2. They give explicit authority to certain key groups to possess and supply each Schedule of drug.

While certain professionals (e.g. carriers, police, customs, forensic labs, pharmacists and certain others) are given this authority, other key groups are notable by their absence. This includes teachers, social workers, housing workers and day centre workers. They are not extended authority to possess these substances by virtue of their occupation.

Possession as a patient: Schedules 2, 3 and 4

Misuse of Drugs Regulations 10(2)

A person may have in his possession and drug specified in Schedule 2, 3 or Part 1 of Schedule 4 for administration in accordance with the directions of a practitioner, unless the person lied in order to obtain the prescribed drug, or failed to notify the doctor that he was already being supplied with that drug by another doctor.

Implications: The regulations specify the key groups who have legal authority to possess controlled drugs. The regulations do **not** extend the authority to other lay bodies with a few exceptions. This would include the process of ***conveying*** (see below), ***administering*** which is discussed in more detail below, and where a drug has been found unattended or confiscated when it is being held illegally, also discussed below.

Conveying: Workers in generic settings not included in the Misuse of Drugs Regulations (e.g. a worker in a hostel or a day centre) may lawfully be in possession of a controlled drug in order to convey it to a person who is entitled to possess it, as detailed in S.5(4)b of the MDA:

> "*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 2001 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. This last point is born out by the ruling in Dempsey and Dempsey (see below).

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.

Dispense and **Supply**: in a medical sense are usefully defined by the Department of Health[1] as follows:

> **Dispensing** is defined as "*to make up or give out a clinically appropriate medicine to a patient for self-administration or administration by another, usually another professional…"*
>
> **Supply** is defined as "*to provide a medicine directly to a patient or carer for administration."*

The same document goes on to note that "*there is **no legal difference** between 'dispense' and 'supply'….The act of dispensing includes supply."*

The Misuse of Drugs Act 1971, (s.4) makes it an offence to supply **Controlled Drugs** except where regulations permit such supply. The definition of **supply** in this setting is wider the medical interpretation above, and can be interpreted as a transfer of control with some perceived benefit to the recipient (such as use, or sale of the drug).

Implications: Based on the above, it appears that an organisation or individual that had possession of a drug and passed this on to a client for the purpose of them taking the drug would, in effect be supplying the drug. In a situation where such supply involved a controlled drug and the supply fell outside the relevant regulations, then the implication is that the supply would not be lawful.

The regulations are very specific as to which groups enjoy the authority to supply controlled drugs and this authority is not extended to hostel staff, youth workers, teachers or other professionals unless specifically authorized by the Home Office.

Administering: the DoH interprets this as meaning "*to give a medicine either by introduction in to the body, whether by direct contact with the body or not (eg orally or by injection), or by external application (e.g. application of an impregnated dressing.)*[2]

Although this may appear to be pedantry, there is an important distinction that needs to be drawn between dispensing/supplying and administering. The Misuse of Drugs Regulations specifically allow for prescribed controlled drugs as follows:

> **7**(1) Any person may administer to another any drug specified in Sch. 5
> (2) A doctor or dentist may administer to a patient any drug specified in Schedule 2,3, or 4
> (3) Any person other than a doctor or dentist may administer to a patient, in accordance with the directions of a doctor or dentist, any drug specified in Section 2,3, or 4.

[1] Review of Prescribing, Supply and Administration of Medicines: DoH: 1999
[2] ibid, p11

However, the process of 'administering' is not the same as 'dispensing' or supplying. In most housing situations it will not be appropriate, feasible, desirable or necessary to be undertaking 'administering.'

The Home Office is aware of this distinction, but argues that "*any reasonable jury would find that the meaning of the word administration stretched to issuing the drug in accordance with the directions of the practitioner.*" However, the same Home Office source goes on to say that *"…There is no caselaw on this matter so we cannot be certain about this.*"[3]

Illustrations:

(a) Bob lives in a hostel, and is a former injecting drug user. He has a deep-vein thrombosis, and has restricted mobility. He is currently prescribed methadone and is meant to pick this up daily from the pharmacy. In order to assist this process, hostel workers have arranged for a nominated worker to collect his methadone from the pharmacy each day.

This process of **conveying** the controlled drug to a client authorised to possess is legal.

Good practice attached to this would include:

- A written agreement from the client, agreed with the pharmacist, for the collection process to take place;
- A protocol to ensure that the prescribed medication is supplied to the client as soon as practical, that the client signs for their methadone;
- If it is not feasible to pass the medication directly to the client, the prescribed drugs are returned to the pharmacist and this process is documented.

(b) Anna is living in a residential home and is prescribed methadone mixture. She lost her right arm following severe injecting complications and so staff have to assist her taking her medication, by opening the bottle, and assisting her to drink the methadone.

This process equates with **administering** a controlled drug to a patient authorised to possess it.

Where such a process is required to assist a person to take a drug, it should be undertaken in line with good-practice guidelines from the Royal Pharmaceutical Society of Great Britain.[4]

[3] Home Office correspondence, January 2001.
[4] The Administration and Control of Medicines in Care Homes and Children Services: RPSGB: 2003

(c) A hostel has three residents prescribed controlled drugs; these are stored in a safe. The drugs are returned to residents on demand, and residents are encouraged to use them in accordance with the prescriber's instructions.

This process equates with **dispensing** or **supplying** a controlled drug. Our understanding is that this process would only be strictly lawful if undertaken by those lawfully authorised under the Misuse of Drugs Regulations and is likely to be illegal if undertaken by others not so authorised.

2.5 Statutory Defences to Possession: Destruction and Disposal:

In addition to the authority to possess controlled drugs detailed above, an additional statutory defence is provided under section 5(4) of the Misuse of Drugs Act 1971:

1: He knew or suspected the substance to be a controlled drug.

2:He took possession for the purpose of:

(a) preventing another person from committing an offence, *or*

(b) continuing to commit an offence in connection with that drug, *or*

(c) delivering it into the custody of a person lawfully entitled to take custody of it

3: As soon as possible after taking possession he took all steps reasonably open to him either to: destroy the drug *or* to deliver it into the custody of a person lawfully entitled to take custody

If a decision is made to destroy a drug, it needs to be done in a lawful manner, which also protects the worker concerned from allegations.

This section only applies in situation where a drug is held unlawfully (clauses a & b) or has been found or handed in and is being passed on to a worker to pass on to an authorised body (clause c).

Medicines including controlled drugs

Substances believed to be controlled drugs in a medicinal form can be handed in to a pharmacy. This would include abandoned or lost medication.

- Protocols should be agreed with a local pharmacy willing to accept old or discarded medication;

The Pharmacy should be notified in advance that a worker will be bringing substances to the pharmacy, and a record kept of this notification;

- The pharmacist should provide a stamped receipt confirming substances have been handed in.

Non-medicinal products including controlled drugs

These should either be destroyed or handed in to the police.

While the old Misuse of Drugs Regulations (1985) included a definition of "destruction" this is not included in the revised Misuse of Drugs Regulations 2001. Further, the revised regulations cast some doubt on the destruction of controlled drugs by people other than those authorised by the Misuse of Drugs Regulations.

Further clarification will need to be sought from the Home Office on the legality of lay organisations undertaking such destruction.

- Destroying is not wholly straightforward. Flushing down the toilet is not lawful as it contravenes Environmental Protection Legislation. Substances such as cannabis resin or herbal cannabis may not so easy to dispose of in this way.
- An effective strategy for rendering small amounts of powder or herbal matter non-recoverable may be to vacuum clean them up. Only the most dedicated user would attempt to recover drugs from a bag of cleaner waste!
- It may be more practical to take them to the police for disposal.

Handing in to the Police:

- The person finding the drug must not pass it on to another worker, but should either destroy it or take it to the police themselves.
- Destruction should take place in the presence of a senior worker, who witnesses the process.
- A record should be kept of the incident.
- Where the quantity of drugs found suggests supply may be taking place, the Police should be involved immediately.
- 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, and a record made recording the time of the call, the number of the officer receiving the call and a police reference number.
- Police liaison should be agreed allowing the delivery of controlled drugs to the police on a "no questions asked" basis where appropriate.

Retaining for police collection:

Some Police Forces and organisations have in place agreements where the organisation will hold confiscated drugs until the police can collect them. We do not advocate this approach as we believe that it increases the risk of threats or intimidation against staff by service users who know confiscated drugs are being stored. Nor do we feel that this approach is wholly legal. We would encourage organisations to ensure that any substances that are confiscated or found should be destroyed or handed in as soon as reasonably practical.

2.6 Case Law: Dempsey and Dempsey (1986) 82.Cr.App.R

Dangerous drugs – possession – defendant taking possession of controlled drugs for the purpose of removing it from a person lawfully entitled to use it – whether offence against Misuse of Drugs Act 1971

The unfortunate case of Dempsey and Dempsey – and specifically the interpretation placed on the law as applied to Maureen Dempsey in the case – may have ramifications for the storage of controlled drugs in hostel and other settings.

Maureen Dempsey was arrested whilst in possession of methadone lawfully prescribed to her husband, Michael Dempsey. He had passed it to her for her to look after, and did so for safekeeping and to prevent him from overdosing.

Maureen Dempsey was arrested and charged with possession of a controlled drug; after her subsequent conviction the case was heard at the Court of Appeal.

The Court of Appeal considered three grounds for her lawfully being in possession of the methadone, and found that none of these applied:

Defence under 5(4)b: "that knowing or suspecting it to be a controlled drug, he took possession of it for the purpose of delivering it in to the custody of a person entitled to take custody of it and that as soon as possible after taking custody of it he took all steps as were reasonably open to him to deliver it in to the custody of such a person"
The court held that this defence was not applicable saying:

> "*Maureen did not come within the terms of those words at all. She did not take possession of it for the purpose of delivering it into the custody of a person lawfully entitled. She took possession of it for the purpose of removing it from the custody of a person lawfully entitled. Nor do we think that it can be said that as soon as possible after taking possession of it she took all such steps as were reasonably open to her to deliver it in to the custody of such a person. Indeed in order to comply with those words she would have been obliged to hand the ampoules back to Michael directly she had received them."*

Regulation 10(2) of the Misuse of Drugs Regulation 1973: "Notwithstanding the provisions of section 5(1) of the Act, a person may have in his possession any drug specified in Schedule 2 or 3 for administration form medical, dental or veterinary purposes in accordance with the directions of a practitioner."

The court of appeal held that "*In our judgement that regulation has no application in the present case."*

Regulation 6(f) of the Misuse of Drugs Regulations 1973: "Any of the following persons may, notwithstanding the provisions of section 5(1) of the Act, have any

controlled drug in his possession, that is to say-…(f) a person engaged in conveying the drug to a person authorised by there Regulations to have it in his possession."

The court of Appeal argued:

> *"Again on the hypothetical facts…that has no application. I read the hypothetical facts again: that the defence will be that this man gave drugs to his common law wife to prevent him from taking an overdose, and this was something which was commonly done between them. There is no suggestion there that Maureen was engaged in conveying the drug to a person authorised to have it in his possession."*

Maureen Dempsey's appeal against her conviction for possession of a controlled drug was dismissed by the Court of Appeal.

Comment: Whilst an obscure case, Dempsey and Dempsey makes it clear that the Court of Appeal felt that none of the above defences were valid where person A was storing a legally prescribed controlled drug on behalf of person B.

By replacing Maureen Dempsey with a housing worker storing methadone on behalf of a client, it would be hard to find that a different legal ruling could be arrived at. Based on this, storage of controlled drugs by non-authorised bodies is not lawful.

3: The Home Office's various positions:

Various parties have brought these legal concerns to the attention of the Home Office and other bodies, and have produced mixed responses.

Probation Circular 4/98 (Guidance on Working with Drug Misusers and Bail Hostels):

This circular gave explicit instructions that:

> 4.1 Residents using prescribed medication should not be permitted to collect it from a pharmacy or retain it themselves…
>
> 4.2 Prescribed medication should be kept in a secure cabinet. Nominated members of staff should be responsible for dispensing all medication…
>
> 4.4 If a resident is thought to be under the influence of non-prescribed substances staff should refuse to administer prescribed medication without first seeking medical advice…

Comment: Based on the above legal points and the new developments relating to Care Standards, this position does not appear to be legal, and various organisations have brought this to the Home Office's attention.

The responses have included the following:

1) In a written response in November 2000, Charles Clarke MP, who then had responsibility for drugs within the Home Office said:

…you raise a new and possibly complex set of issues….Case Law and the legislation are confusing and we are seeking legal advice. This should clarify whether legislative amendment is needed or whether the position might be clarified by way of guidance…In the interim they [Home Office officials] will also write to ACPO and the CPS to draw their attention to this possible lacuna….The risk of an erroneous prosecution is small, but it would be sensible to minimise this while seeking a permanent answer/solution.[5]

2) In response to the same enquiry from another organisation, Home Office officials offered a different interpretation, saying:

…your enquiry led to our legal advisers looking at a number of other related scenarios, where it appears that the law is inadvertently being broken. This has therefore taken some time to resolve. I have not yet received final advice from our legal advisers…

As set out in your letter, approved hostels which follow the guidance set out in PC48/1998 with regard to controlled drugs may possibly be commiting an offence of possession of a controlled drug. Following the finding in the Court of Appeal in Dempsey and Dempsey (1985) it is fairly clear that section 5(4) of the MDA 1971 would not provide a defence for approved hostel staff who follow the guidance we have issued. However in our preliminary discussions with our legal advisers we have agreed that our guidance is sensible and appropriate and there are no current plans to change this. So we do wish hostel staff to continue to do as they have been doing, and follow the guidance set out in PC8/199.

We believe that the chances of a member of staff in an approved hostel being charged with possession, in the circumstances where they were holding the drug on behalf of a resident…to be very minimal.

However, if such a charge were to be made, we believe that there may be a defence in Regulation 10(2) of the Misuse of Drugs Regulation 1985. This states that a person may have in his possession any drug in Schedule 2 (e.g. methadone) or 3 for administration for medical purposes in accordance with the direction of a practitioner. Whilst we certainly do not wish hostel staff to physically administer drugs, our view is that if a hostel staff member were charged with possession…then any reasonable jury would find that the meaning of the word administration stretched to issuing the drug…There is no caselaw on this matter and we cannot be certain about this…but we are confident that 10(2) would provide a reasonable defence…

This is only a short term solution, and so to avoid doubt the Home Office Action Against Drugs Unit are planning to amend the regulations to make the point clear. However this cannot be done for some time yet. In the meantime AADU will also be

[5] correspondence: Charles Clarke MP to Release: November 2000

writing to the police and the CPS advising them of our view, and that they will also be amending the regulations when a legislative opportunity arises.[6]

3) In further correspondence, a practitioner in Scotland wrote to the Home Office proposing a new interpretation, namely that "*because the drugs have been dispensed they are the patients' property and therefore not covered by the Misuse of Drugs Act and there are no legal implications to address*[7]*.*

A different respondent from the Home Office responded saying *"I am content with the interpretation and proposals…in your letter."*

4) As recently as September 2003, the Home Office confirmed that they were "*in the process of drawing up changes to the Misuse of Drugs Regulations to make it lawful for possession of CDs in such places."*[8]

5) As part of the preparation of this document, a draft copy was sent to the Home Office, with a request for comment.

The respondent from the Home Office argues that hostel workers and others could be classified as *"persons engaged in conveying the drug to a person who may lawfully have this drug in their possession…"*

The respondent goes on to say
"In short it can be argued that the hostel workers can possess and supply these controlled drugs for this purpose. I would think that it is unlikely that they would face prosecution where it can be shown that they were acting in such a way in order to ensure the safety of the residents, but of course I must stress that this is a personal opinion only as I am unable to predict how the law would be interpreted in court….

…I do appreciate that the legal position of those involved in some way with the supply and possession of controlled drugs in settings not specifically mentioned in either the Act or the Regulations is unclear…..There is a requirement to clarify the law in this area."[9]

Commentary: The above correspondence supports the contention that storing controlled drugs is not necessarily lawful and that legislative change is needed. Although the Government has found time to change paraphernalia legislation, reclassify cannabis and reschedule some benzodiazepines and GHB, there have been no changes to the regulations on storage.

The Home Office (with the exception of the aberrant interpretation 3 above) recognise that there is not a cast iron defence for storing controlled drugs and, while prosecution is unlikely, it remains possible (indeed we would assert probable) that the action is unlawful.

[6] Correspondence: Home Office – Approved Hostels to Gloucester Probation Service Jan 2001
[7] Correspondence Home Office – Scottish Hostel et al January 2001
[8] Correspondence: Home Office – KFx: September 2003
[9] Correspondence: Home Office – KFx June 2004

4 Safe Custody Regulations

If an organisation does decide that it wishes to store controlled drugs on behalf of clients then it will be good practice to ensure that this takes place within the requirements laid down by the Misuse of Drugs (Safe Custody) Regulations 1973.

These requirements are specifically aimed at pharmacy businesses, nursing homes and other premises authorised by the Misuse of Drugs Regulations to possess and supply controlled drugs.

As other premises such as hostels do not appear to have the authority to store these drugs, they are not listed as being required to meet the standards of the Safe Custody regulations. However, their omission from this list should not be taken as meaning they are exempted from the regulations; rather they should be taken as demonstrating that they are not amongst the authorised bodies to undertake such storage.

The Safe Custody regulations specify the type and construction of storage boxes to be used, and requirements relating to inspection.

It should be stressed that conforming with the requirements of the Safe Custody Regulations do not make storage of controlled drugs by generic services lawful. They are a legal obligation for those bodies authorised by the regulations to store and supply controlled drugs.

The storage of controlled drugs in generic housing setting does bring with it an additional risk – security of staff. Some large hostels may find themselves storing substantial amounts of drugs for residents. A 100 bed hostel, storing methadone for a third of their residents for a Bank Holiday weekend could be in possession of in excess of six litres of methadone. This could make the building a tempting target for robbery or for assault on staff.

5 Civil Issues and the Duty of Care:

Alongside the criminal legal issues relating to the storage and handling of controlled drugs, the handling of medicines can bring with it complex issues relating to the duty of care that organisations owe to their service users.

Undertaking interventions such as distributing medicines extends the envelope of this duty of care and means that workers may find themselves required to assess and make decisions of a medical nature.

This is an important extension of the Duty of Care; it is one that should be considered carefully and appropriate training, policies and protocols will be needed to minimise risk and ensure that such work is undertaken appropriately.

The prospect of a mistake being made – such as the wrong drug being returned to a resident – brings with it scope for litigation.

The following two scenarios are intended to explore how managing medication on behalf of clients can create dilemmas for organisations, and lead to challenges as to how organisations fulfil their duty of care to their clients.

Example 1: Donna is prescribed methadone by her Doctor; the hostel where she stays stores it for her and keeps it in a safe. One afternoon, Donna comes to the office to ask for her methadone. The worker thinks that she appears drowsy and thinks that she may have used another opiate.

The dilemma: The worker is faced with the choice of returning the drug to Donna, or making a decision not to return it at this time. If the drug is returned to Donna, and she does overdose, this could be construed as breach of the duty of care.

However, refusing to return the methadone to Donna is also a difficult decision; she is lawfully prescribed the drug, is entitled to have it back, and a worker could find themselves breaching the duty of care by refusing to give her medicine back to her.

Either way, the worker is now in the unenviable position of making a medical decision about either withholding or returning the methadone.

Example 2: Bob is prescribed diazepam; the hostel where he stays stores this on his behalf. Bob has a history of fitting. He uses crack cocaine and sometimes drinks. He returns to the hostel on Friday night at 10pm, smelling strongly of alcohol. He asks for his diazepam and staff feel uncomfortable returning it to him.

The Dilemma: While the situation is similar to the position in example 1, it has the added problem that Bob may well start fitting if he does not receive his medication. There is a risk of withdrawal and a risk of overdose. And because of the time when the incident has happened, it will be hard to get medical or police support to resolve the situation.

Policy and Procedure responses:

If a decision is made to store and dispense controlled drugs or other medicines on a client's behalf, the following policy and procedures may help to address the scenarios described above:

1) Trained staff will be in place to assess the level of risk;
2) Workers should try to keep the service user calm, and identify what other substances have been used
3) Workers will explain potential risks to the client
4) Where a worker has any doubt as to the appropriateness of returning medication to a client, they should seek guidance from the prescriber, NHS Direct or another agency as required.
5) Workers should follow any such guidance unless their own safety could be jeopardised by a client who is threatening workers.

6) If the client is at risk of overdose they should be monitored, an ambulance called if necessary and first aid provided if required.
7) A record should be kept of the incident
8) The client's current housing and medical regime should be reviewed at the earliest opportunity.

6 Managing Medication: implications under the Care Standards Act 2000:

Some housing agencies have been advised that if they store and dispense medicines on behalf of their residents, then this means that they are classed as a Care Home for the purpose of the Care Standards Act 2000.

This would mean that the housing provider would be obliged to register with the Care Standards Commission, and required to meet the relevant standards. Failure to do so would be a criminal offence.

This interpretation stems from Part 1, S.3 of the Care Standard Act 2000 which states:

…an establishment is a care home if it provides accommodation, together with nursing or personal care, for any of the following persons.

They are-
(a) persons who are or have been ill;
(b) persons who are or have had a mental disorder
(c) persons who are disabled or infirm
(d) persons who are or have been dependent on alcohol or drugs.

Using a most literal interpretation, the process of managing a person's medication for them represents an aspect of personal care or possibly nursing.

As part of the consultation process relating to this briefing, we are seeking clarification from relevant bodies to ascertain if managing medication on behalf of a client means that the provider is indeed a care home. In lieu of a definitive ruling from the Care Standard Commission, individual organisations should consult this body for a local interpretation. Contact details are in the appendix.

7 Conclusions on the Criminal Law aspects on the management and controlled drugs:

Hostel workers, day-centre workers, teachers and other such professionals are not specified in the Misuse of Drugs Regulations as having the authority to posses or supply prescribed controlled drugs. In light of this, possession or supply of these drugs is likely to be illegal.

The Regulations do allow for any person to administer such prescribed controlled drugs to a patient in accordance with a practitioners direction. However, a distinction needs to be drawn between administering and supplying controlled drugs. Administering is lawful; supply is not unless specifically authorised by the Misuse of Drugs Regulations.

We would stress that the likelihood of an organisation being prosecuted for storing lawfully-prescribed controlled drugs is very low. **However,** it is our opinion that the storage of such drugs outside of specifically authorised settings remains unlawful.

As such, organisations that pursue such an approach may be requiring staff to work outside the law. This has implication in terms of employment law, charitable status and insurance cover.

Furthermore, the decision to handle and manage medication may bring with it an increased duty of care, and may have implications under the Care Standards Act, requiring the organisation to register as a Care Home.

The Home Office is aware of the need for legal amendment to clarify the situation on storage and this development is now long overdue.

In light of the above, we would strongly encourage organisations NOT to store controlled drugs or other medication unless there is a clear and overriding medical need to do so.

8 Management strategies for prescribed controlled drugs in residential settings:

8.1 Why store controlled drugs and other medicines?

Agencies may make a decision to store prescribed controlled drugs for a number of well-intentioned reasons. Following workshops and seminars with a large number of organisations across the UK, the following have emerged as some of the primary reasons why organisations pursue this course of action.

Prevention of sharing and supplying:
Agencies are aware of their obligation to prevent the sharing and supplying of controlled drug. The agency hopes that by taking all controlled drugs and other medication in to storage, such activity can be prevented.

Prevention of bullying and harrassment:
Agencies are concerned that vulnerable clients may be harassed or bullied in to sharing their medication. By storing medication, this problem could be alleviated.

Prevention of theft or loss of prescribed drugs:

In order to reduce theft of drugs from shared rooms, communal areas and dormitories, agencies will seek to store prescribed controlled drugs. In arenas where service users have no secure storage facilities, this has often been seen as the only viable option.

Assist compliance with prescribing regime:
In some arenas, the storage and dispensing of medication including prescribed controlled drugs is part of a strategy to assist clients in taking their medication. This approach is most frequently implemented in settings working with vulnerable clients, especially those with complex and multiple needs.

Condition of prescribing imposed by a GP
A number of agencies have reported that GPs have only consented to prescribe certain medication on the proviso that support or housing agencies control and dispense the medication on behalf of the clients. Under the insistence of GPs, agencies have taken on this role.

Other reasons:
Agencies may decide to store controlled drugs for their clients for a number of other reasons including:

- Direction from Government;
- Assisting chaotic or distressed clients;
- Protect the safety of children;

Given that the storage by staff of prescribed controlled drugs in generic housing settings or any other arenas not specified in the Misuse of Drugs Act or related

regulations does not appear to have a robustly legal foundation, we would not advocate this approach. However, conscious that such medicines need to be managed both safely and in a legal way, effective strategies still need to be but in place.

In many settings , the long term aim is to work with the client to prepare for greater degrees of independence, often independent living with little or no ongoing support.

Self-management of medication will be an intrinsic part of this, and so, where feasible, supporting a move towards self-management of medication is to be encouraged.

It should be stressed that self-management may not always be appropriate, and other options for managing this are discussed below.

8.2 Assessment

Workers, in conjunction with the client, prescriber and external other agencies, should assess risk to client. This assessment should include:

- medicines currently prescribed, and potential for misuse
- other substances being used by client and potential for interaction
- Mental well-being of client, including previous relevant history of overdose
- Client's motivation and compliance towards current medication

Using the outcomes from the above, responses can be developed within the following framework:

Tier 1: Little or no risk: client should experience little or no problems in taking responsibility for medications

Tier 2: Low to moderate risk: client may need support to assist in following medicine regimes.

Tier 3: Moderate to high: there is a past history of problems involving prescribed medication and these are likely to be damaging to health. The organisation will need to work extensively with prescribers, pharmacists, support agencies and client to ensure safe use of prescribed drugs.

Tier 4: High: The client is unlikely to be able to self-manage their medication and there is a high likelihood of a serious overdose unless other measures are put in place. Specialist provision, possibly including prescribing and dispensing on site may be required.

8.3 Practical responses:

1) Rule setting:

a) The sharing of prescribed controlled drugs is an offence under the Misuse of Drugs Act, and people who do so risk prosecution. Organisations aware that such supply is taking place are legally obliged under Section 8(b) of the MDA 1971 to prevent it happening. Organisational policies often make reference to "dealing" or "supply." It may not be clear to service users that sharing of prescribed controlled drugs can constitute supply.

b) Workers should encourage users to disclose that they are bringing prescribed methadone or other prescribed controlled drugs into the building.

c) Policy should make it clear to residents that:

- *Medicines should remain in original packaging and clearly labelled*

d) Clients are expected to store, handle and take their medication in a responsible way and, where this does not happen, the situation will need to be reviewed.

e) Service users are asked to adhere to the organisation policy. This should make it clear that:

- *the use or possession of any substances IN A WAY THAT PUTS OTHERS AT RISK or CAUSES DISTRESS TO OTHERS cannot be tolerated, and as such may result in reduction of access to services, or exclusion from services.*

f) The sharing of any medication may have unexpected side effects for the other person. While a medication may be safe and appropriate for one person, it does not hold that it is safe for another.

g) That clients attempting to obtain controlled drugs from another service user should be considered in breach of the rules, and may result in sanctions being applied.

Often, there is a tacit assumption that there is a person attempting to supply substances to other (vulnerable) people. Often, the reverse is true with service users attempting to obtain substances from the (vulnerable) service user to whom they were prescribed.

2) Provision for secure storage:

Individual rooms:
In individual rooms, residents should be provided with somewhere to store medicines such as a medicine cabinet. However, in shared housing provision, some clients will be worried about thefts from rooms.

The introduction of ROOM SAFES has been adopted by some hostels. The model

adopted has been low-cost safes with digital key-pads, available from large DIY stores and catalogue shops.

Such safes have the twin benefit. They provide a safe storage facility for prescribed drugs ad other valuables; at the same time they can discourage break ins from rooms. When all residents know that valuables are locked in a safe, there is less incentive to break in. In the long-term, installing such safes can represent a cost efficiency that more than offsets the initial outlay.

Shared Rooms:

In shared rooms, the introduction of safes as outlined above (one per resident) is the easiest way to facilitate the safe storage of prescribed medication. It provides safety and security for both residents, and reduces risk.

Dormitory-style provision:

Dormitories remain a challenge and as long as such provision persists, there is no ideal solution.

•It is not acceptable either for the client or the organisation to have medicines left unsecured in dormitory-style provision.

•It is not practical for service users to ensure that their medication is in their possession and adequately supervised at all times.

•It is not realistic to insist that clients do not bring any medication in to the building yet, for the legal problems discussed above, it is not ideal that staff should take on storing such medication.

Agencies should discuss the situation with local agencies and prescribers, the police and funders and attempt to agree local protocols.

The compromise below, though contrived, meets both the legal and the safety issues.

•An area, which is under constant staff supervision, is needed. This needs to be an area to which service uses can gain 24-hour access: a general staff office should be adequate. A small bank of lockers can be installed in this area. Clients can store their medication in their locker and have a key of their own to the locker.

•The client can gain access to their locker at any time; the role of staff is limited to ensuring that lockers are not broken in to, supporting safe use, and responding to emergencies.

3) Joint working with prescribers:

Effective joint working with GPs, pharmacists and patients is a key aspect of managing prescribed drugs on premises. This will of course require the client's

informed consent.

Joint working could result in responses such as:

Increasing frequency of collection:
Rather than collecting large quantities of drugs on a monthly basis, we can explore weekly collections or, where required several times a week. This can reduce misuse of prescriptions and increase stability. By working with local pharmacists, such an approach does not have to massively inconvenience clients. Some organisations arrange delivery or collection with pharmacies to help facilitate this process.

Review with prescribers:
Most prescribing is intended to achieve a desired result. For example, a client may be prescribed tranquillizers to reduce anxiety or assist sleep. Or a client may have been prescribed anti-depressants to help improve mental well-being.

Where such prescribing is not being effective, and is not achieving it's intended outcome, then some sort of review may be required. This could involve the client, GP and key- worker. It may be necessary to revise prescriptions or identify alternative interventions.

Improved communication:
Organisations should ensure that good communication strategies are put in place between the organisation, prescribers and pharmacists. This should include information sharing protocols, out-of-hours telephone support, and crisis-management strategies.

Additional Interventions:
- Clients should be able to receive education and support to enable the person to self-manage their medication wherever possible.
- If a client is having difficulty managing their own medicines, then this should be reviewed at the earliest opportunity with prescribers to look at assisting the client.
- If a client is assessed as being unable to manage their own prescribed controlled drugs, then it may be necessary to identify appropriate alternative housing provision or additional resources with suitably qualified staff that are authorised to administer or supply controlled drugs to clients.
- Exceptionally, at a time of crisis, it may be appropriate to remove a controlled drug from a person in to safe storage to prevent serious harm. Such incidents should lead to the drug being returned to the prescriber or pharmacist at the earliest opportunity and a review of the client's capacity to manage their own prescribed controlled drugs.

9 For organisations that do store medicines for clients:

Any organisation that does store and handle medicines for clients should ensure that appropriate policies are in place regarding:
- Staff training
- Record keeping

- Handling procedures
- Dispensing procedures.

For a detailed account of these, they should consult: Administration and Control of Medicines in Care Homes and Children's Services" (RPSGB: June 2003)

Appendix 1:

Sources and Bibliography

The Misuse of Drugs Regulations 2001

The Misuse of Drugs (safe Custody) Regulations 1973

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Storage of Controlled Drugs: Home Office to Release: 11/00

PC48/1998 – CDs in Approved Hostels – MDA 1971: Home Office to Gloucestershire Probation Service: 01/2001

Storage of controlled drugs in residential Homes: Home Office to Grampian Health Board: 01/2001

Appendix 2:

Authorities to possess and supply controlled drugs under the Misuse of Drugs Regulations 2001

[NB Please be aware that the following session is an edited list of key relevant bodies who are authorised to possess and supply controlled drugs.]

General Authority to Possess or Supply:

6(1) ...any person who is lawfully in possession of a controlled drug may supply that drug to the person from whom he obtained it

(2) ….any person who has in his possession a drug specified in Schedule 2,3,4 or 5 which has been supplied by or on the prescription of a practitioner for the treatment of that person or a person whom he represents, may supply that drug to any doctor, dentist or pharmacist for the purpose of destruction

(3) & (4): relates to vets and Wildlife Act

(5) …Any of the persons specified in paragraph (7) may supply any controlled drug to any person who may lawfully have that drug in his possession.

(6) …any of the persons so specified may have any controlled drug in his possession:

(7) The persons refered to in Paragraphs (5) and (6) are:
(a) a constable when acting in the course of his duties as such
(b) a person engaged in the business of a carrier when acting in the course of that business
(c) a person engaged in the business of the Post Office when acting in the course of that business
(d) an officer of customs and excise..
(e) a perosn engaged in the work of any laboratory to which the drug has been sent for forensic examination…
(f) a person engaged in conveying the drug to a person who may lawfully have that drug in his possession

Production and Supply of Schedule 2 and 5 drugs:

8(2)(1) Carriers:

- (a) A carrier
- (b) A person engaged in the business of the Post Office
- (c) A person engaged in conveying the drug to a person who may lawfully have it in his possession.

(2) Health Professionals

- (a) A Practitioner
- (b) A pharmacist
- (c) A person lawfully conducting a retail pharmacy business.

(3) Analysts, laboratories etc.:

(4) Various officials:
- (a) A constable in the course of his duties
- (b) A Customs and Excise officer.

(5) Hospital staff
- (a) The person or acting person in charge of a hospital or nursing home.
- (b) The sister or acting sister of a ward, theatre or other department of a hospital or nursing home.

(6) Persons Authorized by the Home Office:
- (a) A person authorized under a group authority by the Home Office.
- (b) A person holding written authorization from the Home Office.

(7) Persons lawfully in possession:
- (a) Any person who is in lawful possession of a CD may supply the CD to the person from whom he obtained it.
- (b) Any person who has in his possession a CD in Schedules 2,3,4,5 which was supplied on a prescription may supply the drug to a doctor, dentist or pharmacist for the purposes of destruction.

(8) Miscellaneous:
Special arrangements are made for the unusual situations encountered on ships and oil rigs. The following persons are authorized to supply any controlled drugs as set out below:
- (a) the owner or master of a ship which does not carry a doctor among the seamen employed in it.
- (b) The installation manager of an offshore installation.

Possession

Schedule 2 Drugs may be possessed by:
- (1) A practitioner
- (2) A pharmacist
- (3) A person lawfully conducting a Retail Pharmacy Business
- (4) A person or acting person in charge of a hospital or nursing home
- (5) Sister or acting sister in charge of a ward or department of a hospital or nursing home.
- (6) A person in charge of a laboratory
- (7) Public analyst
- (8) Sampling officer
- (9) Sampling officer (MA)
- (10) A person connected with a Drug Testing Scheme
- (11) RPSGB inspector

Schedule 3 & 4 drugs may be possessed by:
- (1) A practitioner

(2) A pharmacist
(3) A person lawfully conducting a Retail Pharmacy Business
(4) A person in charge of a laboratory
(5) Public analyst
(6) Sampling officer
(7) A person connected with the Drug Testing Scheme
(8) RPSGB inspector.

Schedule 3 drugs may be possessed by:

(1) A person in charge or acting person in charge of a hospital or nursing home which has no pharmacist responsible for the dispensing and supply of medicines.
(2) The sister or acting sister at such a hospital, in respect of drugs supplied to her by the person responsible for dispensing.
(3) A person in charge of a laboratory where the drug is one required for use as a buffering agent.

Possession as a patient: Schedules 2,3, and 4
Misuse of Drugs Regulations 10(2)

A person may have in his possession and drug specified in Schedule 2, 3 or Part 1 of Schedule 4 for administration in accordance with the directions of a practitioner, unless the person lied in order to obtain the prescribed drug, or failed to notify the doctor that he was already being supplied with that drug by another doctor.

Appendix 3:

Recommendations for legislative changes relating to storage:

Having identified that the current legislation and practice is neither workable nor safe, we suggest that the following legislative and practice changes be introduced.

These proposals were originally submitted to the Home Secretary in October 2000. There has since been no action to address them.

1) Misuse of Drugs Regulations amended by use of Statutory Instruments to authorise possession and distribution of Schedule 2,3,4 controlled drugs within certain defined criteria.

2) Groups to whom the authority should be extended to include schools, colleges, residential services, youth provision, housing providers, day centres, drugs agencies and others as required.

3) The extension of the authority will require the organisation to meet a series of requirements; the local police will assess these.

a) That safe storage facilities are put in place
b) That effective record keeping protocols are put in place
c) That handling and distribution of such drugs is restricted to full-time, paid staff who have been trained, and have completed any probationary periods of work

4) The Police should be consulted, and the organisation should comply with any recommendations made by the police regarding storage

5) Following such consultation, the police should have the power to issue a Notice of Authority which would allow the organisation to store such drugs for service users.