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drugs

Drug Use on Premises:

Guidelines for Direct Access Services

Kevin Flemen

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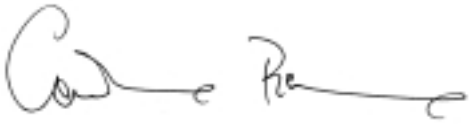
Foreword

Meeting the multiple needs of homeless young people who use illicit substances is very difficult – there are no easy solutions and many agencies feel inadequate in attempting to meet these complex needs.

Homelessness and drug use are clearly inter-linked and agencies should be encouraged to meet the demands of this client group. Until service providers begin to address this area of work fully, many homeless people, young and old, will continue to be excluded from the very provision that was intended for them and that they need and want.

This report provides practical information and advice to providers of direct-access services, which will go a long way in helping to address the joint issues of needs and competence. The report defines the few legal restrictions placed on organisations by the Misuse of Drugs Act (1971), whist giving clear guidance on good practice. It will be a valuable resource to policy makers and commissioners of services developing comprehensive and responsible services across the country.

The Camelot Foundation is delighted to be associated with this important report which provides clear and concise guidance to providers of direct access services on why and how they should address this area of work.



Caroline Pickering

Chair of The Camelot Foundation

About Inclusion

Inclusion is a partnership between Release and The Camelot Foundation, supporting professionals working directly with marginalised, excluded and vulnerable young people.

The goal is to:

- Be a resource that will help front-line workers further their understanding of new developments
- Incorporate policy and practice guidelines
- Deliver innovative work practices to vulnerable young people most at risk of developing drug-related problems.

In short, inclusion will focus on making the transition from theory to practice, enabling workers to access the latest research and developments in the field of working with young people vulnerable to drug misuse

This work is delivered across the UK through the following:

Research and Development

- Liaison with existing statutory and voluntary organisations, agencies and local projects
- Identify innovative models of service delivery
- Development of models of good practice
- Reviews of existing and new literature
- Visits to different areas of the UK to explore existing work

Dissemination and Support

- Promotion of inter-agency working arrangements
- Production of resources and publications for service providers
- Provision of tailored training for organisations and groups working with excluded young people
- Co-ordination of a series of regional conferences and fora to share innovation and good practice
- Practical support through policy and practice development

Introduction

Organisations who work with people in housing need also work, by default, with people who use controlled drugs or use alcohol. There is a growing awareness that organisations need to work more effectively with substance-using homeless people.

Homeless people who use drugs have frequently been excluded from provision by virtue of their drug use; this is a situation that needs to change.

Such a change brings with it new challenges and new tensions; tensions between workers and service users, between service users themselves, between organisations and the wider community and between organisations and the police.

This paper identifies some of the barriers that have excluded drug users from provision, and explores strategies for overcoming these barriers.

Taking as its starting point the assertion that organisations in the field must develop and expand work with drug users, this paper suggests foundations on which inclusive policy and practice guidelines can be built.

A key aim of the paper is to clarify the situation relating to the use of drugs on premises, as controlled under the Misuse of Drugs Act (1971), and to offer strategies that are both legal and represent good practice.

This paper is aimed at direct-access services that work with people who are homeless and use drugs. It is directly relevant to night-shelters, hostels and day-centres. The sections regarding use of drugs on premises are also relevant to workers in a wide range of organisations, from youth clubs through to drop-in centres. The paper is not primarily aimed at organisations who house people with secure or assured tenancies, although such organisations may find much of the paper useful.

The information in this paper is relevant only to organisations in England, Wales and Scotland. Legislation in Northern Ireland makes this area even more complex and further clarification and legal advice should be sought by organisations working in this area.[1]

[1] Section 5 of the Criminal Law Act (NI) (1967) makes it an offence to fail to give information to a constable when a person knows that an arrestable offence has been committed.

Summary of Key Points

Section 1 An Overview of Homelessness and Drug Use

- The extent of drug use amongst people who are homeless or vulnerably housed and use drugs is substantially higher than those of comparable age who are not homeless.
- Work with homelessness and drug use frequently means engaging with a range of other issues, such as abuse, poverty, sexual exploitation, physical and mental health problems, poor educational achievement and disrupted family life.
- While they are homeless, people are excluded from or have difficulty accessing a range of other services or opportunities, including education, employment, drug treatment services, GPs and other aspects of health care.

Section 2 How Services Exclude and Recommendations for Good Practice

- People who are homeless and use drugs are often excluded from housing opportunities and direct access services set up to assist them.
- Attempts to prevent use on premises by prohibiting possession on premises are unlikely to be successful, but rather compel people to conceal their drug use.
- Organisations are not committing any offence by allowing users on the premises whilst in possession.
- With the exception of the use of cannabis (and opium) on premises, organisations are under no legal obligation to restrict use on premises.
- The need to avoid the discomfort of withdrawal for people who are physically dependent on substances needs to be balanced against the need to see clients when they are not so intoxicated that they cannot use services effectively, or are unacceptably disruptive.
- There is no obligation to permanently exclude service users who have supplied or are suspected of supplying drugs on premises. It is possible, and often appropriate, to apply a series of graded sanctions with permanent exclusion as a last resort.
- Developing effective joint working strategies is essential, from a senior planning level to the practical delivery of services at street level.

Section 3 Why Organisations Exclude and Recommendations for Good Practice

- A blanket policy of excluding all drug users does not differentiate between different patterns and levels of drug use, nor indeed the types of drug used.
- Some drug users do present difficult and challenging behaviour. However, many people who do not use drugs present equally difficult and challenging behaviour.
- It is desirable to reduce the mixing of young or inexperienced drug users or other vulnerable people with older or more experienced drug users.
- Effective and detailed initial assessment is an essential element in identifying the potential risk posed by a service user to staff and others. This must include assessment of drug use, mental health issues and previous episodes of violence.
- Increasing user participation in agreeing and implementing policies and sanctions is more effective than enforcing top-down strategies.
- An audit of training needs and the provision of high-quality training can do much to minimise any real or perceived skills gap identified by workers and volunteers.
- Organisations should think about the local community when drawing up rules and policies.
- Organisations owe a Duty of Care to residents and have an obligation to provide a safe working environment for staff and volunteers. It needs to take into account the vulnerability, risk and needs of all service-users.

Section 4 Injecting

- While homeless, injecting drug users are likely to find it difficult to reduce or stabilise their drug use and make the transition from injecting to other routes of use.
- Homeless injecting drug users represent a group in great need of effective intervention, yet they are often excluded from services.
- The banning of injecting equipment may dissuade injecting drug-users from using services and discourages them from carrying a plentiful supply of clean equipment and sharps bins.
- Organisations should be seeking to ensure that drug users who inject have access to a supply of clean equipment and safe places to dispose of them.
- It is easier to identify and meet the needs of injecting drug-users if they are within an environment that allows them to acknowledge and seek assistance for their drug use.
- It is not a legal requirement to prevent injecting of heroin or other drugs whilst on premises, and services may have a Duty of Care to ensure that they can do so in a safe and hygienic fashion.
- The incidence of unsafe disposal can be reduced by the provision of accessible, discrete disposal sites (sharps boxes) in the building.

Section 5 Drug Use on Premises: The Law and Good Practice

- A good working relationship with the police is essential in many situations.
- Section 8 of the Misuse of Drugs Act places an obligation on occupiers and managers of premises to discourage and prevent drug-related activities on premises.
- A key obligation imposed by the Act is the duty to deal with the use of cannabis on premises.
- Anyone who has the authority to exclude someone from the premises could be considered to be "concerned in the management" and so needs to be aware of this legislation.
- Drug policies should not be solely concerned with what is and is not legal. They should additionally take account of other substances and scenarios that can impact on the organisation, the needs of other service-users, staff and volunteers, funders and the wider public.
- Organisations do not have a legal obligation to exclude people who use cannabis or other drugs on the premises, solely an obligation to ensure that the activity ceases.
- There is no legal impediment on organisations that allow use of controlled substances other than cannabis or opium on premises.
- An organisation is under no legal obligation to exclude service-users who have used substances (including cannabis) elsewhere, and subsequently seek access to premises.
- An organisation is under no legal obligation to exclude service-users who are found to be in possession of substances whilst on premises.

SECTION 1

An Overview of Homelessness and Drug Use

1.1 Homelessness and drug use – the scale of the problem

There is a growing body of research evidence that reveals the extent of drug use amongst people who are homeless or vulnerably housed. The figures are very high - 76% (Carlen, 1996), 85% (Downing-Orr, 1996), 88% (Flemen, 1997), to 89% (Hammersley & Pearl, 1997).[2]

These figures are substantially higher than those of comparable age who are not homeless, as revealed in national studies such as the British Crime Survey (1996) in which 24% of people aged between 16 and 29 reported use of an illegal drug in the past year.

The figures are also substantially higher than those demonstrated by internal monitoring by hostels and day centres. Such studies have typically revealed a very low level of substance use amongst users of such services.

These low levels of reporting are mainly attributable to low levels of disclosure by service users and screening policies implemented by services.

In environments where current or past drug use may represent a barrier to immediate accommodation or future resettlement, there is a clear motive for concealing one's drug use. A study of service users in Glasgow noted:

'Screening simply encourages applicants to deny substance problems and enter services with their problems undetected.'

[Hammersley & Pearl, 1997]

This desire to conceal drug use also hampers an organisation's ability to assess problems and refer on to other services, which, in turn, reduces a service user's access to treatment and support.

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[2] Different studies focussed on different age ranges, and different substances. The total age range covered by the studies was 16--30. Hammersley and Pearl (1997) include alcohol use, and asked respondents to locate themselves on a Severity of Dependence Scale for each substance used. Flemen (1997) includes alcohol use "if it is perceived by the client as problematic". Carlen (1996) includes respondents using some kind of illegal drug or legal drugs such as solvents.

1.2 The Relationship between homelessness and drug use

The relationship between homelessness and drug use is complex, and it is not the purpose of this paper to consider this relationship in detail. However, it is important to acknowledge that work with homelessness and drug use frequently means engaging with a range of other issues, such as abuse, poverty, sexual exploitation, physical and mental health problems, poor educational achievement and disrupted family life. When considering people who are homeless, the ACMD report Drug Misuse and the Environment notes:

'Within this needful population with its multiple problems, drug misuse is today prevalent as one further problem within the wider mix. It may sometimes constitute the individual's primary and most handicapping disorder, be central to an understanding of why that individual is homeless, and as a strong factor in perpetuating that person's state of homelessness.'

[Drug Misuse and the Environment: ACMD: Home Office,1998]

The need to tackle the interlinked issues of homelessness and drug use is acknowledged within Government. The Social Exclusion Unit report on Rough Sleeping (HMSO, 1998) notes that there is:

'Too little provision for those with high support needs, ... [and that resettlement] is more likely to be successful if housing is combined with help for non-housing problems such as employment, drugs, drink and mental health.'

1.3 Exclusion from other services

While they are homeless, people are excluded from or have difficulty accessing a range of other services or opportunities, including education, employment, drug treatment services, GPs and other aspects of health care.

Gaining accommodation is an important aspect of resolving many issues, above and beyond the immediate need for accommodation. Klee and Reid (1998) note:

'In the face of complex needs it is unlikely that all their problems will be instantly solved by providing accommodation. This would ideally be a first step, but would only represent a start on the path back to social integration, stability and health.'

The complexity of the problem means that complex solutions are required.

Joint working initiatives are needed that include:

- Direct access services – day-centres and night shelters
- Short and long-term hostels
- Housing associations and resettlement agencies
- Drug projects
- Outreach teams
- The police
- Probation services
- Employment, education and training initiatives
- Primary health care projects
- Mental health teams

Increasing access to emergency and short-term accommodation is an essential first stage in the process of permanently rehousing people who are homeless.

SECTION 2

How Services Exclude and Recommendations for Good Practice

People who are homeless and use drugs are often excluded from housing opportunities and direct access services set up to assist them. This exclusion may be a direct or an indirect consequence of policies and practices implemented by such organisations.

2.1 Directory entries and admission criteria

Admission criteria may specifically exclude people who use drugs or alcohol. Examples of this include:

- Will not accept alcoholics, drug addicts.
- Will not accept current drink or drug-users.
- Will not accept current alcohol, mental health, drug or gambling problems.

[Hostels Directory: RIS, 1998]

Admission criteria in directories such as the Hostels Directory represent a first point of contact both for referral agencies and clients who self refer. Many potential clients who may be wholly appropriate and whose drug or alcohol use is unproblematic and managed are excluded by admission criteria such as those above.

Some organisations have developed more inclusive entry criteria, such as:

- People with substance misuse problems only accepted if they have a recognised support structure in place.
- No automatic exemptions, but may not accept those likely to put other residents, staff or members of the public at risk.
- Have policy of non-rejection. Will accept any young person wishing to live at the project except in very exceptional circumstances.

[Hostels Directory: RIS, 1998]

Such directory entries avoid the blanket exclusion of the majority of clients, and increase accessibility.

Once organisations move away from blanket exclusion policies, the following criteria may be useful for assessing potential service-users' suitability for housing with regard to their drug use:

Safety: Is there a risk of overdose?
Do they use in a way that puts themselves or others at risk e.g. drinkers who black-out while smoking, careless discarding of works?
Is there a history of violence while intoxicated?

Financial: Is the drug use stable, and affordable?
Is there a regular weekly spending or irregular binges?
Can the drug use be managed alongside other household expenses?

Support: Does the person have support networks e.g. drug agency or counselling services, support groups, non-using friends, colleagues or statutory services?

Skills: Does the person have budgeting skills?
Does the person have basic lifeskills?
Does the person have social skills?

Such a list of criteria does not, of course, preclude the need for risk assessments, for the safety of both staff and for service users. Indeed, the more flexible the referral and admission criteria, the more important it is to have a thorough assessment procedure to ensure appropriate placement and relevant support is in place.

Concerns regarding any of the above criteria do not have to preclude the person being housed. Rather, they may suggest areas that should be addressed, to ensure that any subsequent offer of housing is likely to succeed.

2.2 Barring possession of drugs on premises

A number of organisations forbid the possession of controlled drugs on premises. People found to be in possession of such drugs may be barred or evicted.

Such polices are hard to enforce successfully and are, anyway, of dubious benefit.

People who are homeless and using drugs have a limited number of options when it comes to storing drugs. They could try and find somewhere to stash drugs while on the premises, but this is most unlikely, as is the likelihood of consuming or disposing of all drugs before entering.

Far more likely is that the drugs will be concealed on the person and any cursory inspection of the service user by staff will not reveal them.

The consequence is that both drugs and drug users enter premises without staff being aware or having the opportunity to make positive interventions.

When possession of drugs is discovered, the service user may be barred, their housing need and drug use remaining unaddressed.

Possession of drugs on premises does not necessarily equate with use on premises. Attempts to prevent use on premises by prohibiting possession on premises are unlikely to be successful, but rather compel people to conceal their drug use.

Furthermore, although service users in possession of controlled drugs are themselves committing an offence, an organisation is not committing any offence by allowing users on the premises whilst in possession.

2.3 Barring use of drugs on premises

Most organisations have rules that forbid the use of controlled drugs on the premises. Many also forbid the use of alcohol on premises. In addition, some forbid entry to people who have recently used or appear to have recently used drugs or alcohol.

Young people may be barred from facilities or evicted from accommodation for breaching these rules.

With the exception of the use of cannabis (and opium) on premises, organisations are under no legal obligation to restrict use on premises. See Section 5 for clarification of issues relating to use on premises.

It is difficult to apply such exclusion policies consistently and fairly. Some substance use, such as the use of alcohol, is easy to detect due to the smell. Other forms of substance use may be less apparent, and so harder to screen out.

Policies that require service users to be wholly dry whilst on premises exclude, by default, service users who are dependent on alcohol. It may not be possible and is likely to be very difficult for such a client to access services or remain in services unless they have had sufficient alcohol to prevent withdrawal symptoms.

A similar problem exists for services that require opiate users to be drug-free when attending appointments or whilst on premises. Such a client is likely to require enough of their drug of choice in order to make effective use of services.

Resolving the situation for people who are physically dependent on substances is a complex balancing act. The need to avoid the discomfort of withdrawal needs to be balanced against the need to see clients when they are not so intoxicated that they cannot use services effectively, or are unacceptably disruptive.

Rather than blocking access to any service users who have recently used a substance, it is more helpful to establish what levels of behaviour warrant temporary exclusion from premises, or exclusion from communal areas. While such an approach makes it difficult to establish hard and fast rules, it also does not exclude service users who need to have used their drug of dependency before accessing services.

2.4 Barring supply of drugs on premises

All organisations forbid the supply of drugs on premises, and a small number of people may be excluded from premises for such activities.

Organisations have less leeway here, as the legal obligations governing supply of drugs on premises are clear (see Section 5). However, there is no obligation to permanently exclude service users who have supplied or are suspected of supplying drugs on premises. It is possible, and often appropriate, to apply a series of graded sanctions with permanent exclusion as a last resort.

The term drug dealing is highly value laden and brings with it connotations of people supplying substantial quantities of drugs. In reality, most supply within organisations is small scale between peers. While such a distinction is not applicable in law, it may be relevant in applying sanctions to people dealing within premises.

The decision to involve the police is a contentious one. While there is no legal obligation to involve the police where the supply of drugs is involved, many organisations may understandably see this as the most appropriate and safest way forward.

2.5 Self-exclusion and equal opportunities

Drug users may choose to self-exclude from provision, anticipating that they will not get treated sympathetically by organisations with strong anti-drug policies, or approaches geared solely towards abstinence and treatment.

Addressing issues such as the admission criteria described above may go some way towards encouraging people who use drugs to approach services.

In addition, actively pursuing anti-discriminatory policies may also improve the accessibility of such services. In working with people who use drugs, an approach should be adopted that encourages clients to feel able to discuss any needs that they may have and for workers to be non-judgmental, informative and open to such discussions.

Organisations can also effectively reach young homeless drug users by building links with local drug agencies and street outreach teams.

Other young people who use drugs, but do not perceive themselves to have a drug problem, may choose not to use some hostels, especially those aimed at drug users.

The point is made and reiterated throughout this paper that drug users are not a homogenous group and have different needs and require different levels of support.

2.6 Improving access

Organisations that have restrictive opening times or use appointment systems may also find that they reduce their accessibility to people who are homeless and use drugs. People who have even slightly chaotic lifestyles often find it difficult to keep appointments, and so will under-use services that implement such structures.

Access may be improved in the following ways:

- Opening times that are flexible, appropriate to the client group and dovetailed with other services
- Less reliance on appointments; drop-ins may be more staff-intensive but are more accessible for most service users, especially for initial contacts
- Investment on posters, leaflets and cards that are attractive and aimed at the key target groups
- Literature that includes maps and travel directions
- Lists of link and referral agencies that are up-to-date

2.7 Joint working

Working with substance misuse is a specialist area; the Social Exclusion Unit report on Rough Sleeping notes:

> 'help with drug and alcohol problems, primary health care, jobs, education and training, and benefit delivery are the responsibility of mainstream services, not the DETR or the RSI. These services are often hard for rough sleepers to access, because they are generally worse placed to know how to use them.'

Developing effective joint working strategies is essential, from a senior planning level to the practical delivery of services at street level. Organisations delivering services to people who are homeless should be represented on local forums, and at a senior level on statutory bodies, especially Drug Reference Groups (DRGs) and Drug Action Teams (DATs).

Links with local agencies should be developed and consolidated, and not restricted to a flurry of activity during staff inductions, as is often the case. There are many strategies for achieving this including reciprocal visits, open days, establishing referral protocols, and links with named workers.

Organisations that seek to work more closely together will need to address the perennial thorny issue of confidentiality. Approaches such as obtaining permission from service-users to share information with other agencies are becoming more commonplace, and this is to be welcomed where it results in a more effective service for the client.

2.8 Satellite work

Satellite or peripatetic initiatives may prove effective in delivering specialist services to people who are homeless and in touch with housing organisations or day-centres. Satellite work is a method of working whereby a specialist organisation delivers regular sessions within another, typically non-specialist, agency. It is intended to bridge the gap between the specialist needs of a target group who choose not to make use of specific provision, and the incapacity of non-specialist organisations to meet that need.

The satellite model of delivery can be effective in a wide range of contexts, such as the delivery of primary health care, drug, alcohol, mental health, legal, benefit, employment and other specialist issues.

Satellite work increases access to services for marginalised and vulnerable groups, and in turn can support the long-term process of change and reintegration.

SECTION 3

Why Organisations Exclude and Recommendations for Good Practice

3.1 Introduction

It is clear that a great deal of provision for people who are homeless or vulnerably housed intentionally or unintentionally excludes people who use drugs. It is less clear exactly why such exclusion takes place. Certainly, many organisations are apprehensive when it comes to housing or working with people who use drugs. A key step in improving the accessibility of such provision is to address some of these fears and misgivings.

Many organisations are concerned about legal aspects of working with drug users, specifically the use of controlled drugs on premises, or drug dealing on premises. These concerns stem from a specific section of the Misuse of Drugs Act (1971), Section 8. This section concerns those involved in the management of premises and creates some offences relating to allowing use or supply on premises.

Section 8 of the Misuse of Drugs Act and methods of responding to it are considered separately in Section 5.

3.2 Drug Users – a management issue

Organisations may perceive drug users to present more management problems than non-users. Organisations may seek to preempt these problems by excluding all drug users.

Such a blanket policy does not differentiate between different patterns and levels of drug use, nor indeed the types of drug used. It does not distinguish between drug use away from the premises, and drug use on the premises.

Such a policy does not differentiate between drug-related and non-drug related behaviour problems. Some drug users do present difficult and challenging behaviour. However, many people who do not use drugs present equally difficult and challenging behaviour. Both users and non-users are liable to get angry, have mood swings, damage property, get into fights, steal or in other ways present challenges to workers.

Attempts to exclude potential troublemakers by excluding all drug users are therefore unlikely to succeed.

In the absence of draconian measures such as frequent drug testing, it is not possible to exclude all drug users from a service. The net result of such approaches is as follows, argue Hammerseley and Pearl:

‘screening simply encourages applicants to deny substance problems and enter services with their problems undetected. What homeless services need is not more stringent screening, which simply excludes naïve or honest substance users…’

[Hammersley & Pearl,1997]

3.3 Issues regarding drug users and non-users

Organisations may seek to avoid housing users and non-users together. In some instances such policies are intended to "protect" non-users from exposure to users, or to provide a drug-free environment for those seeking to remain drug-free.

Clarity is essential as to the purpose of provision. If the aim is to offer a direct-access service to a wide range of people, attempting to provide a drug-free environment would conflict with the primary aim.

There is an appealing logic to policies that seek to create a "drug-free" environment for the benefit of service users. If the aim, purpose, funding and local need is for such a service, then it may be a wholly appropriate response.

It is important to recognise that such provision is only one element of maintaining a drug-free lifestyle. Other strategies such as on-going counselling, relapse prevention strategies, and other coping techniques are likely to be needed. Staff recruitment and training needs to reflect the aim of the organisation. Simply providing a drug-free environment is likely to be insufficient.

It is desirable to reduce the mixing of young or inexperienced drug users or other vulnerable people with older or more experienced drug users. This may be an obligation imposed under an organisation’s Duty of Care, as discussed in Section 3.9. Again, the emphasis is on the quality and nature of the drug use rather than the existence of drug use per se. Such information can only emerge from detailed and open assessments.

There may be concerns about exposing service users to accidental injury such as through contaminated injecting equipment. This issue is considered later in the paper, (Section 4).

3.4 Friction between different groups of users

It must again be acknowledged that drug and alcohol users are not a homogenous group. People who use different substances or have different levels of use apply prejudice to each other in much the same way as non-users do to users. Friction between different groups of substance users is often a feature of hostels and day centres.

Organisations may seek to avoid these problems by excluding some or all of these different groups, for example, housing alcohol users but not opiate users.

It is important to acknowledge that there is a valuable role for specialist services that have been established to work with particular client groups, such as those with mental health problems, alcohol or drug problems. Prioritising certain groups and having specialist services is not the same as exclusions and can be an effective way of working. However, such organisations still need to recognise the complex and multiple needs of these clients.

Organisations seek to create a welcoming and supportive environment for all service users. Most hold and display policies that discourage the use of racist, sexist or homophobic language. Far fewer hold or display policies offering similar recognition of the discrimination faced by drug or alcohol users. Service users (and, in some arenas, workers) use highly pejorative terms such as ‘junkie’, ‘smack-head’, ‘alky’ or less pejorative, but equally value-laden terms such as drug-addict. It is important that attitudes, stereotypes and language that create and maintain drug-related discrimination are challenged, within the auspices of an organisation’s equal-opportunity policy.

Increasing user participation in agreeing and implementing policies and sanctions is often a neglected area. Trying to enforce "top-down" strategies with no sense of user-ownership can be less effective than approaches that consult and act on input from service users. Processes of user-involvement become meaningless if they are allowed to become token exercises.

Consistency of approach is an important factor in reducing friction between groups and individuals. If any one group perceives that they are being treated differently or unfairly, friction and conflict is likely to be the result. Thus, if the use of heroin in one’s room is prohibited but drinking is allowed in communal areas, then friction is likely to result, and vice versa.

3.5 Communal and private space

It may be useful to differentiate between communal and private space when drawing up and implementing policies. So, while drinking, or injecting or other drug-related behaviour may be unacceptable in communal areas, it does not impact on other service users in private space, and may therefore be accommodated.

Dormitory-style facilities do not have the luxury of distinguishing between private and communal space. In such circumstances, it may prove more difficult to cater for a wide range of different behaviours and needs without high levels of friction and conflict. Moving away from such provision is highly desirable wherever possible.

The above concerns not withstanding, it remains legally impossible to allow consumption of cannabis on premises, and so cannabis users may be treated differently (and they may perceive unfairly) to other substance users. It is important to make it clear why this happens. The issue of use on premises is covered in greater detail in Section 5.

3.6 Drug users and violence

There may be a perception that people who use drugs are more likely to threaten or assault staff, or in other respects present a hazard to staff. It may be hoped that screening for and excluding drug users creates a safer working environment for staff.

Drug use has been viewed as a contributory factor in a number of serious assaults and killings within voluntary-sector organisations and the wider community. A knee-jerk response may be to exclude drug users and thus reduce the risk. Such an approach is flawed for a number of reasons.

As with any other attempts to manage drug-related behaviour through the exclusion of all drug users, such strategies do not differentiate between substances used, the nature and quality of substance use, and the increased likelihood of violence due to this drug use. Not all drug use increases the risk of violence. Violence may be present during cessation of drug use as much as during use itself.

Other factors, especially the presence of mental health issues, are also significant factors and attention should be paid to these.

One of the recommendations of the Newby Report is that:

'Homeless people assessed as vulnerable by reason of their mental illness should automatically be referred for assessment by social services unless this has already been carried out.'

A significant proportion of people who are homeless present with both drug and mental health issues – "dual diagnosis" as it is often termed.

Increasingly, organisations are recognising the extent of dual or multiple diagnoses and responding with training in the area, joint-working initiatives between drug services and mental health teams and, in a few cases, the creation of dedicated dual diagnosis posts.

Effective and detailed initial assessment is an essential element in identifying the potential risk posed by a service user to staff and others. This must include assessment of drug use, mental health issues and previous episodes of violence.

Potentially dangerous service users can slip through the most rigorous screening processes. Staff training in dealing with difficult and dangerous behaviour is therefore highly desirable.

3.7 Staff training

Staff or organisations may perceive that working with people who use drugs is a specialist area of work and that they do not have the skills and abilities to meet these demands.

An audit of training needs and the provision of high-quality training can do much to minimise any real or perceived skills gap identified by workers and volunteers. Shop around; some training is excellent, whilst some is not so good. Training should:

- Give information about drugs, their appearance and effects
- Look at drug-related problems
- Challenge stereotypes and attitudes to drug users
- Increase confidence of staff in working with drug users
- Increase the ability of staff to work with drug users
- Improve staff ability to make assessments and referrals
- Enable staff to deal with drug-related incidents
- Give up-to-date legal information
- Include notes and hand-outs
- Be tailored to your specific organisation
- Help explore policy needs
- Be up-to-date

Working with people who are homeless and people who use drugs may well be challenging and difficult. It is important that organisations recognise this and ensure that adequate support and supervision networks are in place for workers and volunteers.

3.8 Public concerns

Some organisations are heavily reliant on public donations. Public perception may be that there are "worthy" homeless people – those who are victims of circumstance or misfortune, and "less worthy" homeless people, such as those who use drugs and alcohol. Such a perception may encourage organisations to downplay the extent of drug use amongst homeless people, or even to target responses towards non-users.

The unwillingness of organisations to acknowledge publicly the extent of drug use amongst homeless people stems, in part, from the widely held view that drug use is deviant or morally unacceptable. Organisations should seek to challenge these perceptions.

It is important that organisations move towards publicly acknowledging that drug use amongst people who are homeless or vulnerably housed is a serious issue. It is also important to recognise that drug-related problems may result from being homeless, and concepts such as "blame" are neither appropriate nor helpful. Failing to acknowledge the issue reinforces the perception of "worthy" and "unworthy" homelessness.

The wider community may well be opposed to organisations housing or working with drug or alcohol users "on their doorsteps". The National Day Centres Project noted:

‘Day centres around the country are being blamed for causing local increases in street drinking and begging, creating an unsafe and disruptive environment on the streets.’

[NDP Newsletter no. 10, October 1997.]

Given such a hostile environment, organisations may opt to work with non or ex-users and so avoid such conflicts.

On a national scale, organisations need to challenge attitudes described in 3.8 (above). On a local level, the National Day Centres Project describes some of the emerging responses to this issue:

'Some projects are responding to this in different ways. Some projects are able to make publicity work a high priority and actively challenge any myths or misconceptions that are reproduced in the local media. Some are engaged in local forums meeting regularly with residents, traders and the police. And others are encouraging the development of users' groups to speak out themselves about their experience of homelessness.'

[NDP Newsletter no. 10, October 1997]

Organisations should think about the local community when drawing up rules and policies. Preventing drug use within premises merely for it to take place in an adjacent public arena is not acceptable. Sanctions can and should be applied to unacceptable behaviour within the vicinity as well as on premises.

Residents and service-users are reminded of their responsibilities, not just to workers and other residents but also to the local public and to future residents. On the one hand, the threat of eviction, exclusion or police involvement may deter some residents from use on or off premises. Instilling and reinforcing a sense of personal responsibility is equally, if not more important.

Approaches such as mediation have been used by organisations to resolve incidents or behaviour that has caused nuisance to neighbours. Such approaches can successfully achieve positive change and resolution without requiring either abstinence or the extreme measure of eviction.

3.9 Duty of Care

The opposite of a strict anti-drug policy is not a chaotic, "anything goes" environment. Such an approach is clearly unsafe for all concerned.

Organisations owe a Duty of Care to residents and have a duty to provide a safe working environment for staff and volunteers. Duty of Care varies from organisation to organisation, and case to case. It needs to take into account the vulnerability, risk, and needs of all service-users, as well as the role of workers within the project.

A duty may exist to reduce drug-related risk, but this does not necessarily mean preventing possession or use on premises. When working with people who are using drugs, the Duty of Care might include a duty to provide appropriate support and advice, and to be fair in how sanctions such as exclusions are used.

Conversely, a duty may also exist to protect service-users from harassment by other residents, including those who are intoxicated, and to prevent harm arising from the supply of drugs on the premises.

If a service-user suffers loss as a result of a breach of Duty of Care, the organisation can be sued for negligence, a civil offence, and could be required to pay damages if found guilty.

SECTION 4

Injecting

4.1 Introduction

A significant proportion of younger people who are street homeless inject drugs. In a study of homeless drug users in London[3], 670 discussed their method of use; of people contacted in street settings, hostels and day-centres, 19% identified themselves as currently injecting. Of people contacted in street settings only, 49% identified themselves as currently injecting.

Drug users who are homeless and inject are especially vulnerable to harm, including:

- infection due to unhygienic injecting practices
- lack of access to primary health care
- lack of access to clean injecting equipment
- lack of clean, safe environments in which to inject
- risk of an overdose going undetected

Injecting drug users who are homeless may find it difficult to access drug treatment programmes such as methadone prescribing. While homeless, they are likely to find it difficult to reduce or stabilise their drug use and make the transition from injecting to other routes of use.

Clearly, homeless injecting drug users represent a group in great need of effective intervention, yet they are often excluded from services.

4.2 Responses to injecting on premises

Few areas of drug use attract as much disapproval as injecting behaviour. Numerous organisations have made extensive efforts to prevent or discourage injecting on premises, through regular toilet checks or the installation of coloured light bulbs.

Such approaches are rarely wholly successful. At best, they may discourage some users, who will still need to inject elsewhere, which is simply shifting the situation. At worst, users will still inject, but through poor lighting or fear of disturbance, will make a poor job of it and inflict worse damage to themselves.

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[3] Flemen, K: Smoke and Whispers; Turning Point: 1997

Organisations who undertake regular toilet checks should respond appropriately to incidents of injecting. They should allow the person who is injecting to finish in their own time, giving them space and privacy. They should be encouraged to tidy up the area afterwards. At a later time, the incident should be discussed with the person, but such a discussion should not take place immediately after the incident.

Some organisations ban the possession of injecting equipment on premises, while others make it a condition that such equipment is handed in to staff whilst on premises.

The banning of injecting equipment may dissuade injecting drug-users from using services. Alternatively, it discourages them from carrying a plentiful supply of clean equipment and sharps bins, as these are hard to conceal. Organisations should be seeking to ensure that drug users who inject, do have access to a supply of clean equipment and safe places to dispose of them. A locker within a day-centre or a room within a hostel are the only arenas where homeless injectors can store their equipment.

Policies that encourage users to place equipment in the care of staff can be helpful, with the following provisos. Users who do not want to disclose their drug use, perhaps through fear of a hostile reception, are unlikely to hand in their equipment, especially when first entering premises. Similarly, where policies still prevent use on premises, users who want or need to inject will have to do so covertly. They can hardly ask for their equipment back if the process of using could lead to being barred.

Such strategies are intended to reduce or prevent injecting on premises. However, it is easier to identify and meet the needs of injecting drug-users if they are within an environment that allows them to acknowledge and seek assistance for their drug use. If injecting behaviour is stigmatised and forced underground, users may feel compelled to hide injecting equipment or dispose it of less safely.

4.3 Injecting on premises and the law

It is not a legal requirement under Section 8 of the Misuse of Drugs Act to prevent injecting of heroin or other drugs whilst on premises. In addition, a small number of drug users are legally prescribed drugs in an injectable form, ranging from insulin through to methadone and diamorphine. They are legally entitled to use them, and an organisation may have a Duty of Care to ensure that they can do so in a safe and hygienic fashion.

4.4 Sharps bins

The unsafe disposal of injecting equipment represents a key cause of concern for both workers and service users, and organisations are obliged to ensure that such risks are minimised.

Training around and implementation of good hygiene procedures for staff and service-users can reduce the fear and risk of exposure to pathogens, as can the effective use of sharps bins.

The incidence of unsafe disposal can be reduced by the provision of accessible, discrete disposal sites (sharps boxes) in the building – within residents' rooms and within bathrooms or toilets.

Some critics argue that the provision of sharps boxes on premises is condoning drug use. However, it is very apparent that the converse argument does not hold true – the absence of sharps boxes does not discourage people from injecting. Given this, it is preferable to put sharps boxes out and so reduce the likelihood of injury due to carelessly discarded equipment.

Sharps bins are essential for the safe disposal of any contaminated waste, not just injecting equipment. Shaving equipment and toothbrushes may also represent a transmission route for Hepatitis and HIV, and hence pose a risk for both staff and other residents. They should be disposed of accordingly, and thus there is a clear need for sharps bins even if no injecting drug users are present.

4.5 Distribution of injecting equipment

The distribution of injecting equipment is specialised work and should only be undertaken by workers who are adequately trained. It would, however, be acceptable and legal to store clean, unused injecting equipment on behalf of clients.

As part of an ongoing process of personal development, injecting drug users should be encouraged to locate regular supplies of injecting equipment, advice on safe injecting and regular health check-ups. Such assistance may be best rendered by a local needle exchange, and so injecting drug users should be encouraged to access such services.

4.6 Disposal

Only organisations trained and licensed to do so should transport used sharps bins. The local needle exchange, health authority or council environmental health team should undertake this task.

Training and resources should be available for all staff on dealing with spillages or carelessly discarded hazardous waste.

SECTION 5

Drug Use on Premises: The Law and Good Practice

5.1 Introduction

Organisations often cite the law as a key impediment that restricts their ability to work with drug users. This chapter attempts to clarify the legal position, and offer good-practice guidelines built on these legal foundations. Good practice guidelines are italicised.

For readers who are unfamiliar with drug legislation, information on the subject is included in Appendix 1.

Legislation in this section applies to law in England and Wales and is applicable in Scottish law. It does not apply in Northern Ireland, where Section 5 of the Criminal Law Act (NI) (1967) makes it an offence to fail to give information to a constable when a person knows that an arrestable offence has been committed.

5.2 Relations with the police

There may well be a tension between service providers and the police over these obligations and rights. The police may, for example ask agencies for the identities of people in contact with them, who supply drugs. They may seek to gain access to hostels or day-centres without going through the necessary processes. Organisations may not be legally obliged to co-operate. At the same time, organisations working with homeless people who use drugs are highly dependent on goodwill from the police.

A rapid response from the police can be essential in volatile or threatening situations. The police can support services and treat service-users sympathetically. A good working relationship with the police is essential in many situations.

Encouraging police involvement at a senior level is highly desirable. Agreeing work policies and practices with senior police officers, while offering no guarantees for the future, can at least result in a framework governing most day-to-day situations. Such situations could also be resolved in conjunction with the local Drug Action Team (DAT).

5.3 The Misuse of Drugs Act (1971): Section 8

The section of the Misuse of Drugs Act of most concern to those involved in running premises is Section 8. The Act places obligations on occupiers and managers of premises to discourage and prevent drug-related activities on premises. It states:

A person commits an offence if, being the occupier or concerned in the management of any premises, he knowingly permits or suffers any of the following activities to take place on those premises that is to say

- producing or attempting to produce a controlled drug
- supplying or attempting to supply a controlled drug to another...or offering to supply a controlled drug to another
- preparing opium for smoking
- smoking cannabis, cannabis resin or prepared opium.

Certainly, the legislation creates some obstacles for organisations seeking to provide services for young people who use drugs. A key obligation imposed by the Act – and hence a key reason for exclusion from provision – is the obligation to deal with use of cannabis on premises.

The influential Advisory Council on the Misuse of Drugs highlight this issue in their report Drug Misuse and the Environment (1998), noting:

'In providing misusers with treatment, rehabilitation or other forms of intervention which stop short of prohibiting cannabis use on the premises these services break the law; or if they enforce the prohibition they have to evict the misuser exposing him to the harms which the treatment is intended to prevent. **For services it is an unsatisfactory position which should be reviewed**.' [our emphasis]

[ACMD: 1998].

Organisations should consult locally and nationally when preparing or updating policies. For further clarification, always contact a lawyer or Release.

5.3.1 Who Section 8 applies to

Section 8 affects anyone who is the "occupier or concerned in the management of any premises". In other words directors, managers, deputy managers and team leaders – and possibly anyone in some sort of control of premises – all need to be familiar with the content and implications of this briefing.

Other workers and volunteers need to be aware of the Act too. They will be the people who implement any drug policy and, as such, need to understand the implications of their actions. Anyone who has the authority to exclude someone from the premises could be considered to be "concerned in the management" and so needs to be aware of this legislation.

5.3.2 What is meant by "premises"

In the current context, "premises" refer to hostels and night-shelters, day-centres and other settings such as drop-ins. Any building within the project would be defined as premises, as would any enclosed yard or garden.

Other settings, such as mobile outreach services operating from a bus, may well be affected. It is likely that, while stationary and being used as a static resource, such venues would be covered by the Act.

5.3.3 Good practice

Drug policies should not be solely concerned with what is and is not legal. They should additionally take account of other substances and scenarios that can impact on the organisation, the needs of other service-users, staff and volunteers, funders and the wider public.

Implementation of a drug policy will also require full staff understanding and commitment to the policy, which may involve training. Clients should have the policy explained to them on admission and the policy should be clearly displayed for clients alongside local initiatives for drug and alcohol users.

5.4 Concluding notes on Section 8

The obligations placed on organisations by Section 8 of the Misuse of Drugs Act are not as onerous as is often thought. The Act clearly creates obstacles for working with people who use cannabis, and those engaged in supplying substances. However, this still leaves a great deal of scope for working with people who use drugs.

Organisations do not have a legal obligation to exclude people who use cannabis or other drugs on the premises, solely an obligation to ensure that the activity ceases. If this can be achieved without resorting to exclusion, this is clearly highly desirable. Temporary or permanent exclusion may be necessary in the case of repeated episodes of use or supply on premises.

There is no legal impediment on organisations that allow use of controlled substances other than cannabis or opium on premises.

An organisation is under no legal obligation to exclude service-users who uses other controlled substances on the premises, including users who inject on the premises.

An organisation is under no legal obligation to exclude service-users who have used substances (including cannabis) elsewhere, and subsequently seek access to premises.

An organisation is under no legal obligation to exclude service-users who are found to be in possession of substances whilst on premises.

It is essential that policies be built upon firm legal foundations, taking into account the obligations created by Section 8 of the Misuse of Drugs Act. Once the legal requirements have been addressed, it is possible to look at other policy areas that are not legal requirements under the Misuse of Drugs Act.

SECTION 6

Scenarios

The following common scenarios are intended to clarify how the Misuse of Drugs Act (1971) works in practice.

"If I knew someone was smoking cannabis in their room in a hostel, and did not act to stop this, would I be committing an offence?"

Law: Yes, the action of knowingly permitting or suffering someone to smoke cannabis (or opium) on the premises would be an offence under Section 8.

However, it is not necessarily a straightforward question. It depends on how you – and ultimately the law – interpret the words "permit" and "suffer".

One could passively permit an activity by simply taking no action to prevent it. So, ignoring an activity could be interpreted as passively permitting or condoning it, or one could actively permit an activity by perhaps encouraging it, participating in it or by inciting it.

Good Practice: *In this scenario, stopping the offence could be as simple as simply extinguishing the joint or spliff. Once it is no longer being smoked, the worker has discharged their obligation under Section 8.*

If the client re-lights the joint, then it must once again be addressed under Section 8, as the offence is again being committed.

The service-user is still committing the offence of possession and this should be explained to them as part of ongoing drug education.

The incident should be recorded in the logbook.

"When I am on the premises, I am not always aware of what is happening elsewhere in the building. If I were in the building and a drug-related offence took place, would I be guilty of an offence under Section 8?"

Law: No, you need to have knowledge of the activity to be guilty of the offence. If you do not know that the activity is happening, you cannot be guilty of the offence**.**

Good Practice: *Ensure that clear lines of communication and responsibility are in place. Workers and volunteers need to be aware of their responsibilities in dealing with drug use on premises, and what action needs to be taken. Workers should record any incidents and the action taken. While this demonstrates awareness of drug-related offences, it also demonstrates that action was taken.*

"It's difficult to keep an eye on our building; there are lots of blind spots where people might use cannabis or set up deals."

Law: As above.

Good Practice: *Organisations are under no legal obligation to search out people who may be using drugs within the building. However, if it is known that there are unsupervised areas of the building where using or supply take place, then organisations may leave themselves exposed to accusations of ignoring the situation. Taking action may involve regular checks on such areas, or using CCTV.*

"Surely residents are entitled to privacy in their rooms. What goes on there is the residents' business."

Law: Section 8 does not place obligations on an organisation to seek out people using drugs. Therefore, there does not appear to be an obligation to closely monitor people in their rooms or indeed elsewhere. However, there is clearly an obligation to act once workers become aware of drug activity covered under Section 8.

Good Practice: *While it is desirable to respect a resident's right to privacy, it is also important to ensure that each resident is safe, and that their rooms are also safe. This is likely to require regular inspections, to meet health and safety requirements. Residents should be made aware of such inspections and the purpose of them.*

"If residents have Assured Shorthold Tenancies, can I gain access to rooms if I suspect drug use?"

Law: Only if the tenancy agreement makes provision for such a re-entry. Most tenancy agreements include a clause forbidding the use of premises for immoral or illegal purposes, which would include possession of, or dealing, drugs. In the event of a breach of a tenancy agreement, organisations would normally have the right of access to investigate said breach.

In other circumstances, such as repeated intoxication or unsafe disposal of used injecting equipment, clauses referring to "nuisance or annoyance" to neighbours and others provides scope for investigating a breach of the agreement.

In circumstances where a resident has an Assured Shorthold Tenancy, but is known to be using cannabis or dealing from their room, action would need to be taken to discharge obligations under Section 8.

"I know someone is smoking crack in the toilets – am I committing an offence under Section 8?"

Law: No, you only commit an offence in allowing the use of cannabis or opium.

Good Practice: *While the organisation is not committing an offence under Section 8, the client or resident is doing so by being in possession of a controlled drug. This should be highlighted to them at an appropriate time as part of an ongoing drug education/harm-reduction programme.*

Organisation policy should make it clear which drugs cannot be used on the premises. Under Section 8, organisations do not legally have to stop the use of crack or drugs

other than cannabis or opium on the premises. However, organisations need to be cautious of falling foul of Section 19 (Incitement) and cannot encourage people to be in possession of a controlled drug.

Procedures should be adopted regarding secluded areas such as showers and toilets to prevent them being used for the consumption or supply of drugs.

"A volunteer tells me that one client has sold another some Speed in the building – where do I stand?"

Law: If you did not act, you could be committing an offence under Section 8. Knowingly permitting or suffering the supply or attempted supply of any controlled drug (not just opium or cannabis) is an offence.

Good Practice: *It is rare to catch someone in the act of supplying; more frequently, workers will have only strong suspicions. Organisation rules will need to make it clear that sanctions will be applied on grounds of suspicion: and state examples of what may constitute suspicion.*

"A long-term client has had their methadone stolen elsewhere. They are starting to feel ill, and I heard another client offer to give them some of their own methadone, which they are legally prescribed; surely this is not an offence?"

Law: Methadone is a controlled drug; if you know someone is offering to supply a controlled drug and permit or suffer this, you are committing an offence. The same goes for any other controlled drug. Under the Misuse of Drugs Act there does not need to be any monetary exchange for the illegal supply of drugs to take place.

Good Practice: *Use of prescribed methadone and sharing of this and other prescribed controlled medicine is extensive amongst homeless people who use drugs. In addition to being illegal, it is unsafe for all parties concerned. As part of ongoing drug education, explain to users why sharing medication is dangerous. Establish, as part of organisational drug policy, guidelines for the storage of personal prescribed medication on premises.*

"Can I store controlled prescribed drugs on behalf of residents on the premises?"

Law: Yes, this is legal, as long as the intention is to:

"take possession of it 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 steps as were reasonably open to him to deliver it into the custody of such a person." [MDA, section 5(4)]

Good Practice: *Ensure that storage facilities are secure and that accurate records are kept of what is being looked after and for whom.*

Drugs 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.

Taking custody of drugs for a client is not the same as administering them for them. Whilst workers can remind clients that they should take their medication, workers are not in a position to insist that clients take the correct amount at the right time. Nor can workers usually withhold any medication from a client.

"I can see a client smoking what I believe to be cannabis outside the building on the pavement. If I do nothing am I committing an offence under Section 8."

Law: No, to commit an offence under Section 8, the cannabis would have to be consumed on the premises.

Under the Housing Act (1996)(s.148), secure and assured tenants can be evicted if found guilty of an "arrestable offence" committed in the locality of the dwelling house.

Good Practice: *While organisations may not be legally accountable for actions taking place in the vicinity but not on the premises, the wider public are likely to view the organisation as responsible. It is in an organisation's interests to include guidelines on use in the vicinity as well as on the premises when preparing policy guidelines and drawing up tenancy agreements.*

"The cleaner has found some heroin in a resident's room. If I leave it there, would I be committing an offence?"

Law: No offence is committed under Section 8 by knowingly allowing possession of controlled substances on the premises.

Good Practice: *Workers do not have to remove and dispose of drugs. Policy and guidelines need to make it clear what position an organisation takes on this, and which drugs it applies to. For example, would it be appropriate to remove and dispose of cannabis found in someone's room? Alternatively, how about methadone found in a person's room, but actually prescribed to another resident?*

Users may experience severe ill effects and, in relation to some drugs such as benzodiazapines or barbiturates, life-threatening withdrawal through uncontrolled and unsupervised withdrawal. The removal and disposal of substances without the client's knowledge and consent should not take place.

The removal and disposal of controlled drugs found in a residents room may put resident's at risk of other forms of harm. They may be looking after it for someone else, or have been given it on credit to sell. In either situation, the resident may well be expected to make recompense or, alternatively face serious consequences.

"I am told that a hostel resident is growing a cannabis plant in their room. I know that they are committing an offence, but am I as well?"

Law: Section 8 makes it an offence to knowingly permit the production or attempted production of a controlled drug.

Good Practice: *This is one of the few drugs that is possibly going to be produced within settings such as direct access services, and even then it is quite unlikely.*

"A worker tells me that a hostel resident is sniffing butane gas in their room. Are solvents included in the Misuse of Drugs Act?"

Law: No, it is not illegal to permit someone to use solvents on the premises.

Good Practice: *Policy guidelines should make specific reference to the possession, supply and use of drugs not controlled by the Misuse Of Drugs Act, such as solvents and "legal highs" such as Khat.*

The average home is estimated to contain around thirty products that contain abusable volatile substances. The same is likely to apply to most direct-access services and organisations should ensure safe stewardship of abusable products, especially aerosols, impact adhesives, paints, thinners and related products.

Volatile substances are highly flammable and use on premises may constitute a fire risk.

"I've put notices around the building that say that using drugs is not allowed on the premises. Is that enough?"

Law: No, you would still be committing the offence if you knew people used cannabis or offered to supply or supplied drugs despite the notices.

Good Practice: *Putting notices up and informing service-users of the rules is a good start. Make it clear that, as an organisation, you will act on the suspicion of use or supply, and make it clear what the sanctions are. Then enforce this consistently.*

"If I find drugs in the building, how should I dispose of them?"

Good Practice: *You can either take them straight to the police station for disposal or dispose of them on the premises - for example, down the toilet. If you dispose of drugs on the premises, the policy should say how this is done. At least two workers should be present, preferably one of whom is a senior worker. A note should be made in the logbook. Drugs should not be stored on premises for later disposal.*

"I know or suspect that people have been using or dealing on the premises. I have told these people to leave the premises, and they have done. Should I also inform the police?"

Law: You are not legally obliged to inform the police if you know or suspect that clients are in possession of, using or supplying controlled drugs.

Good Practice: *Ideally, policy in this area should be agreed between the organisation and the police. Such an agreement could clarify what action would be taken in different circumstances. It would not be legally binding. However, until national guidelines are produced, it is perhaps better to have in-house guidelines and policy approved by local police forces and by national organisations.*

"The police are demanding to see our day-book for a list of people we know or suspect are using drugs. Do I have to show it to them?"

Law: In certain circumstances, the police can obtain Crown Court warrants to seize such documents. It is then essential to co-operate with the police. It is a serious offence to obstruct the police particularly if a warrant is issued under the Misuse of Drugs Act.

Good Practice: *Keep a written record of names, dates and events involving any legal matters and consult a solicitor or other legal advisor at the earliest opportunity.*

It is not desirable to store sensitive or incriminating information in highly accessible locations such as daybooks, or in reception areas.

"Can police enter premises without a warrant?"

Law: The police can enter premises without a warrant in many situations, including the following:

- 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 an arrestable offence or certain public order offences
- to protect life or stop serious damage to property

Other laws give police specific powers to enter premises.

Good Practice: *If the police come on to premises, whether lawfully or not, obstructing them may have both legal and practical ramifications. It is important to maintain good working relationships with the police. However, it is unlikely that there is a criminal law obligation to assist them. Keep a written record of names, dates and events involving any legal matters and consult a solicitor or other legal advisor at the earliest opportunity.*

APPENDIX 1

Drug Terms and Drug Legislation

The term "drug" is wide-ranging and imprecise. The following notes are intended to clarify terms within the paper. In addition, this section highlights the importance of precise wording when drawing up policies.

Drug: 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. Drug policies and responses will, in turn, need to respond differently to these different groups.

Drug Legislation

Drug law is complex, and is covered in The Misuse of Drugs Act (1971) and The Misuse of Drugs Regulations (1985), The Intoxicating Substances (Supply) Act (1985), and The Medicines Act (1968) governing 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) and licensing laws all have an impact on drugs offences.

The Misuse of Drugs Act (1971)

The Misuse of Drugs Act (MDA) divides drugs into a series of Classes and Schedules. The Classes determine criminal penalties and the Schedules determine whether a restricted drug may be prescribed or not, and imposes duties relating to the manufacture, storage and distribution of drugs.

Drugs Controlled under The Misuse of Drugs Act (1971)

The possession of drugs covered in Schedules 1, 2 and 3 of the MDA is tightly regulated and constitutes an offence unless one has a license to be in possession.

Under the Misuse of Drugs Act, drugs are divided into three Classes, A, B and C.

CLASS A
(Class B drugs which are prepared for injection are classed as Class A).

Includes: Opium, LSD, Ecstasy, Heroin, Morphine, Magic Mushrooms, Cocaine, Methadone, Dipipanone, Phenylcyclidine, and Pethidine.

CLASS B
Includes: Codeine, Amphetamine, Methylamphetamine, Cannabis, Barbiturates and Dihydrocodeine.

CLASS C
Includes: most of the Benzodiazapines, Buprenorphine, Diethylpropion, Mazindol, Pemoline, Phentermine.

The Misuse of Drugs Regulations creates 5 Schedules, governing possession and supply of the drugs controlled under the Misuse of Drugs Act.

The regulations also govern prescribing, safe custody, importation, exportation, production and record keeping.

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

These drugs are currently no considered to have any medical use and are not available on prescription. Unlicensed possession is an offence.

SCHEDULE 2
A Home Office licence is required for import, export, production, supply and possession:

Includes: Heroin, Morphine, Pethidine, Methadone, Quinalbarbitone, Amphetamine and Cocaine.

These drugs are considered to have medical uses, and are prescribed to people. The person to whom they were prescribed can legally possess them. Their possession by anyone else represents an offence.

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.

These drugs are treated much in the same way as section 2 drugs, except some requirements such as storage and record-keeping are less stringent.

SCHEDULE 4
Authority is required for production and supply, but no authority is required for their possession, import or export.

Includes: the Benzodiazapines (except Temazepam), Pemoline and 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.

Possession and Supply

The Misuse of Drugs Act creates the offences of **Possession** and **Supply**.

The possession of many drugs is illegal, as governed by the Schedule of drugs described above. **Possession** may mean direct physical possession of a drug by one individual. People sharing a drug would usually be defined as having **Joint Possession**. The charge of **Past Possession** can be laid if someone admits to the police that they have possessed the drug in the past, even if drugs are not found.

Occasionally, cases of **control** of a drug can arise when someone not physically in possession of a drug is nevertheless controlling it. In such cases, if control can be proved, the controlling individual will be in possession.

Possession with intent to supply

Frequently, people found in physical possession of drugs are charged with possession with intent to supply another, which is a drug trafficking offence. In such cases, police infer from a number of factors that the drugs were not for personal use. Factors could include the quantity of drugs, their packaging and other circumstance of arrest.

Supply of illegal drugs under the Misuse of Drugs Act constitutes a serious offence. Supply means simply handing over control of a drug from one person to another. Both the selling of drugs at cost or for profit and the giving away of drugs counts as supply.

Defences to Possession

Under criminal law, knowledge is usually a crucial ingredient for a successful conviction. You must know, for example, that you are in possession of a cannabis plant (as opposed to any other plant) to be convicted.

It is a defence to the charge of possession if the drug was being taken to an authorised person or if the person in possession was intending to destroy the drug in order to stop another person from using or controlling the drug.

Incitement

Section 19 of the Misuse of Drugs Act creates the offence of incitement. It states:

'It is an offence for a person to incite another to commit an offence under any provision of this Act.'

Over The Counter Medicines (OTCs)

Many medicines can be readily purchased without prescription. A small number of these medicines are misused to achieve intoxication. Some are addictive. However, they can be legally bought, stored and used without prescription, and are widely used to treat a large number of minor conditions.

For a more detailed consideration of commonly misused OTCs, readers should consult the ISDD booklet on OTCs in their Drug Notes Series.

Prescription Only Medicines (POMs)

Medicines not available over the counter are generally available by prescription only. Drugs are prescribed to a named patient. However, with the exception of the drugs specified in the Misuse of Drugs Act, Schedules 1, 2, and 3, no offence is committed if a person other than the named patient is found in possession of these drugs.

Significantly, in the context of social care, some medicines used outside a medical setting, notably Benzodiazapines such as Valium (but not Temazepam), can be in a person's possession even if they have not been prescribed the drug themselves. The same applies to anabolic steroids. The unlicensed supply of drugs specified under Schedules 4 and 5 is an offence.

"Legal Highs"

Some drugs have little or no restriction on their possession. Drugs such as, Khat/Qat, Ephedra, Amyl/Butyl Nitrites and Ketamine are not covered by the Misuse of Drugs Act, and their possession is not an offence, though the supply of some of them by unlicensed suppliers will be an offence under the Medicines Act.

Nicotine: Found in tobacco, nicotine is probably the most prevalent drug within direct-access services.

Nicotine is not a controlled drug under the Misuse of Drugs Act, and so is not covered by Section 8 of that Act. The extent of most policies regarding tobacco is to establish (and sometimes enforce) smoking and non-smoking areas. It is highly desirable that more consideration is given to providing smoke-free arenas for the wellbeing of workers, volunteers and other service-users.

Alcohol: Alcohol is widely used both by people who are homeless and in wider society. Like nicotine, alcohol is not covered by the Misuse of Drugs Act. Unlike nicotine, however, alcohol has a number of effects, such as reducing inhibitions and increasing violent behaviour that make it a key management issue in direct-access services.

Volatile Substances: Volatile substances are products that contain chemicals that, when deliberately inhaled, cause intoxication. Products include certain glues, butane gas, lighter fluid, some paints, cleaning products and hairsprays and other aerosols, some correction fluids and a range of other products.

Volatile substances are not covered by the Misuse of Drugs Act in England and Wales, but are controlled under the Intoxicating Substances Supply Act (1995). This makes it an offence for a retailer to supply or offer to supply to a young person under the age of 18 a substance which the supplier knows or has reason to believe, will be used "to achieve intoxication".

Scottish Common Law classifies as criminal, willful and reckless actions that cause real injury to another person. Hence, under Scottish Common Law it is an offence for anyone to supply volatile substances to another person knowing that they are going to inhale them.

APPENDIX 2

References and Further Reading

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Carlen, P. *Jigsaw: a political criminology of youth homelessness*. (Open University Press, 1996)

Flemen, K. *Smoke and Whispers – Drugs and Youth Homelessness in Central London*. (Turning Point, 1997)

Hammersley, R. & Pearl, S. *Show me the way to go home – Young people, homelessness and drugs*. (Druglink, Jan/Feb 1997)

The Hostel Directory, (The Resource Information Service, 1998)

Grant, L. *Hip to be Homeless*. (The Guardian, February 15th 1997)

Klee, H & Reid, P. *Drugs and Youth Homelessness – reducing the risk*. (Drugs, Education, Prevention and policy, Vol. 5, no. 3, 1998)

NHS Health Advisory Service. *The Substance of Young Needs: Children and Young People Substance Misuse Services*. (HMSO, 1996)

The NDP Newsletter No. 10 (National Day Centres Project, October 1997)

Oxfordshire Health Authority. *The Newby Report*. (1995)

Ramsay, M & Percy, A. *Drug misuse declared: results of the 1994 British Crime Survey*. (HMSO, 1996)

The Social Exclusion Unit. *Rough Sleeping Report*. (HMSO, 1998)

Tackling Drugs to Build a Better Britain. (HMSO, 1998)

APPENDIX 3

Useful Contacts

Release

Release, the national drugs and legal charity, provides a range of services to meeting the health, welfare and legal needs of drug users and those that live and work with them. The organisation was founded in 1967 in response to the growing number of young people who were coming into contact with illegal drugs.

With the voluntary support of many young professionals, Release established the first ever national Drugs Helpline and has maintained a pivotal role in the drugs and legal advice field.

388 Old Street, London EC1V 9LT
Tel: 0171 729 5255
Helpline: 0171 729 9904
Fax: 0171 729 2599
E-mail: info@release.co.uk
www.release.co.uk

Organisation specialising in training, publications and support on legal matters relating to drugs.

The Camelot Foundation

The Camelot Foundation, an independent charitable trust launched by the Camelot plc in November 1996, focuses specifically on voluntary organisations that support disabled and disadvantaged people and enables them to play a fuller role in society. Together with providing funding – almost £7million to date – The Camelot Foundation works collaboratively with small and large organisations across Britain and offers input and partnership. The Inclusion initiative is an example of such an undertaking.

One Derry Street, London W8 5HY
Tel: 0171 937 5594
Fax: 0171 937 0574

Institute for the Study of Drug Dependence (ISDD)
32-36 Loman Street, London SE1 0EE
Tel: 0171 928 1211
Fax: 0171 928 1771
E-mail: services@isdd.co.uk
www.isdd.co.uk

Comprehensive library and database of research on drugs and drug issues.

National Homeless Alliance
5-15 Cromer Street, London WC1H 8LS
Tel: 0171 833 2071
Fax: 0171 278 6685
E-mail: NHA@home-all.org.uk

National membership body for organisations and individuals providing services and support to homeless people, providing advice, support and specialist training.

National Drugs Helpline
Tel: 0800 77 66 00

Confidential telephone Helpline, open 24 hours a day.

Shelter
88 Old Street, London EC1V 9HU
Tel: 0171 505 2000
Helpline: 0808 800 4444
Fax: 0171 505 2167
www.shelter.org.uk

Training and support to those who offer housing advice or with an interest in housing.

Standing Conference on Drug Abuse (SCODA)
32-36 Loman Street, London SE1 0EE
Tel: 0171 928 9500
Fax: 0171 928 3343
E-mail: info@scoda.demon.co.uk

Specialist advice on local drug services and best practice information on drug treatment and care, prevention and education.