Management of Drugs on Premises
Regional Protocols for Accommodation Providers

Strategies for Development and Implementation

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Draft for Wide Consultation

IMPORTANT:

Development: This is a draft document in its second stage of development. An initial draft was circulated to a small group of reviewers, and their feedback has been incorporated in to this draft. This version is being widely circulated and is a usable draft. Readers are actively encouraged to provide feedback which can be incorporated in to a final version in late 2007.

This draft version 2.07 was put on line in August 2007.

Caveat: The document explores legal issues in relation to the management of drug use in residential settings. While we believe the content to be accurate at the time of writing, we would always encourage agencies to seek additional legal advice from an independent source. No liability will be accepted for prosecution or damages arising from use of this briefing.

UK Variations: The document is relevant and usable in England and Wales. Due to significant differences in law and policing in Scotland, sections of the document cannot be applied there. However, the processes and issues described are still applicable.

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Feedback: Please send feedback on this draft to kfx@ixion.demon.co.uk

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Management of Drugs on Premises
Regional Protocols for Accommodation Providers

Section 1: Establishing Regional Protocols:

1 Introduction:

The management of drug use in housing settings is a complex and confusing area of work. A wide range of policy and practice responses exists, ranging from the lawful and safe to the downright dangerous. There are also a conflicting range of interests involved, including people seeking accommodation, the housing provider, the Police, the Local Authority and the wider community.

In response to this variance in provision and conflicting needs, a number of regional groups have attempted to develop "Regional Drug Management Protocols." These are typically developed by a group of key stake-holders, and become a template (or baseline) within which local accommodation providers can work.

The development of such protocols is not, in itself, an easy process. If done well, it can ensure that local accommodation provision is operated safely, lawfully and inclusively. But a badly developed and implemented protocol could have adverse effects, increasing exclusion and hampering the development of provision.

This document looks at the idea of Regional Drug Management Protocols, the benefits and drawbacks of such an approach, how they could be developed and what they could contain.

As Regional Drug Management Protocols will need to be developed locally, and be responsive to the specific local situation on the ground, this document cannot offer a "one-size fits all" solution to Regional Protocols. At best it can offer a starting point to the development of such a protocol.

2 The Context:

Accommodation providers, especially those working with people who have been sleeping rough, or staying in temporary accommodation, inevitably need to engage with drug use.

Levels of drug use amongst people who are homeless or vulnerably housed are very high, far exceeding the levels of drug use amongst the stably housed population. Research suggests that amongst homeless populations, 67% have lifetime use of heroin[1], compared to less than 1% of the general population of 16-24 year olds who report using the drug.[2]

[1] http://www.crisis.org.uk/pdf/HomeandDry.pdf

Most accommodation providers will have developed some sort of "drugs policy" which should shape how the organisation engages and works with drug users and responds to drug-related incidents.

Across any region, there is likely to be a range of different organisations, each working with a group of customers. And each organisation may well have developed its own policy and practice.

None of these organisations operates in isolation, and they need to engage with a number of external bodies. This may include other housing providers. It is also likely to include providers of other services, including drugs and mental health services, support agencies and referral agencies.

Significantly, the accommodation provider will also need to develop and maintain effective relationships with statutory bodies including the Local Authority and the Police.

In effect, each local accommodation provider needs to develop their internal policies and procedures with relation to drugs, and then mesh their policy and procedures with relevant external bodies.

Unfortunately, the result of this approach tends to be a significant amount of duplication of effort, and a wide variance in the quality of the end product.

3 The Role of Regional Drug Management Protocols:

A Regional Drug Management Protocol is an attempt to reduce the duplication of effort and increase the quality of the end product by producing a single standardised framework protocol within which all accommodation providers can work, and to which external agencies, including the Police, can sign up.

A Regional Protocol can have some useful functions:

- Signatories can be confident that, whilst working within a Regional Protocol, they are working in a way that is lawful and is endorsed by the Police and the Local Authority;
- Funders and purchasers can choose to fund organisations working within a Regional Protocol, thus ensuring that they are working with organisations adhering to locally-agreed practice;
- Mechanisms can easily be developed to facilitate the sharing of depersonalised information in line with the requirements of the Crime and Disorder Act where required;
- Referral agencies can be confident that they are referring accommodation-seekers in to accommodation which is safe and lawful;

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[2] British Crime Survey, 2005-06

- Policy and procedures that do not represent best practice can be challenged, and ultimately removed from local provision.

Regional Protocols can also play an important synergistic role in relation to other local protocols such as Homelessness strategies, Community Safety and Health strategies. Actively integrating the Regional Protocol in to other strategies adds value. For example, Regional Protocol that addresses the issue of needles and sharps bins well is likely to have an impact on public drug usage and unsafe discards – important aspects of a Community Safety strategy.

4 Key Stakeholders in Developing Regional Drug Protocols:

The development of Regional Drug Management Protocols can be a slow and arduous process. The larger the number of people involved in the process, the more "buy-in" there is likely to be from stake-holders, but the slower and more fraught the process is likely to be.

Key players who will need to be involved include:

- Local Authority
- Supporting People
- Police
- Accommodation Providers
- Drug service providers
- Drug Action Teams, or SMATs as applicable
- User representatives
- Crime and Disorder Reduction Partnerships

In some areas, an umbrella group of temporary housing providers exists, and this allows for representation of a large number of housing providers by one or two representatives.

Where no such group exists, a small number of housing providers will need to attend any development meetings, and developments will need to be cascaded back to wider population of housing providers.

Given the wide range of interests that will need to be represented, it is important that the group developing the Regional Protocol is representative but also chaired impartially.

Experience suggests that a 'prime-mover' will be required to take the process forward, and that the importance of the prime-mover as having the respect and sufficient approval amongst other stake holders cannot be understated.

The driver behind the development of a protocol is important; on several occasions, the impetus behind the development of a protocol has come from Safer Communities, Crime and Disorder or other Police-led initiatives.

This can have an impact on the final protocol emerging from the process: it could

result in a protocol that primarily meets the demands of the police or Crime and Disorder partnerships, rather than the needs of accommodation providers.

Steering a course through the middle of this minefield of competing interests is a difficult task, and an impartial chair can be essential in ensuring balance in the end product.

5 The Spectrum of Regional Drug Management Protocols:

Different areas have adopted a range of approaches to the scope of Regional Protocols and the extent to which they are voluntary or mandatory for local providers.

5.1 Minimum Standards Protocol:

At one end of a spectrum, a protocol could cover the minimum legal standards to which an organisation would be expected to work. A minimum-legal framework Protocol would typically include:

- Requirements under Section 8 of the Misuse of Drugs Act 1971 to respond to the production or supply of any controlled drug, and the smoking of cannabis on site;
- Expectations in terms of the handling of controlled drugs found on site;
- Policy and practice around paraphernalia in terms of needles, syringes and other potential hazards;
- Addressing the organisations obligations under Health and Safety legislation and the Duty of Care owed to staff, service users, visitors and others.

Such a protocol would be a relatively short document, and there would be an expectation that, within this, organisations further develop and refine their policies and procedures to reflect the specific nature of that organisation.

A key benefit of such a protocol is that it won't, by its very nature, impose new and onerous restrictions on an organisation.

However, by restricting itself to the minimum legal standards, the Protocol could miss the opportunity to encourage good practice or direct organisations to an appropriate response.

5.2 Comprehensive Protocol:

At the other end of the spectrum, a Comprehensive Protocol would look at the main drug-related situations encountered by an organisation and outline an expected response for that organisation. This would be a far more extensive document than a Minimum Standards Protocol.

5.3 Legal Requirements or Additional Requirements:

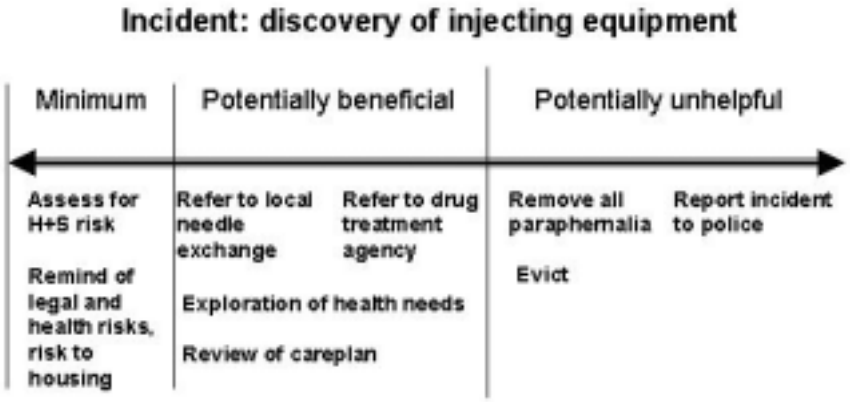
This is the single biggest area of contention when developing Regional Protocols. At various points the Protocol will impose requirements on accommodation providers.

Generally these requirements will reflect statutory obligations, for example in relation to Health and Safety.

However, many Regional Protocols impose additional duties and requirements on Housing Providers – and these requirements exceed those required on a statutory basis.

There are advantages and disadvantages to this. And it is virtually impossible to discuss these without making some value judgements. Additional measures could be construed as beneficial or unhelpful, and this is heavily influenced by the perspective of the observer.

The example below looks at how a spectrum of responses to a straightforward issue – the possession of injecting equipment – could impose a range of outcomes.



Different stakeholders contributing to a Protocol are likely to believe that the measure that they want to see included is beneficial, while other stake-holders may see this as unhelpful interference.

Minimum standards must be incorporated in to the Protocol. If all stakeholders agree that an intervention is beneficial, then it is probably a good idea to include it in the protocol. But if some stakeholders feel that a measure is not helpful to them, then it is probably better to leave it out of the protocol or include it as a possible, not a mandatory step.

Generally beneficial interventions that would often be encouraged within a protocol would include:

- Provision of advice and information on substance use and related risks
- Encouragement to attend treatment and support agencies
- Review and updating of assessments and careplans

Potentially unhelpful requirements may take several forms. Examples include:

- **A requirement to stop activities not included in the statutory requirements**. For example the legislation does not require an organisation to prevent someone possessing paraphernalia for injecting drugs. But a clause within the Protocol could impose a duty on the organisation to remove such paraphernalia.

- **A requirement to take action not required by statute.** For example, there is a legal obligation to prevent known supply taking place on site, but this does not equate with an obligation to bar someone from premises. A regional protocol could require someone be barred from premises for supply, and this would exceed the actions required in Law.
- **A requirement to share information with the Police or other external agencies where no statutory obligation exists.** With the exception of a handful of situations (e.g. Child protection, terrorism) there is rarely a statutory obligation for accommodation providers to share information with external agencies. But a requirement written in to many of the Regional Protocols reviewed to date create new and substantial obligations to share information with the police about drug-related incidents even where no legal obligation exists to do so.

5.4 Flexible or Directive:

The extent to which a protocol is to be flexible or directive is another complicating factor in the development process.

Directive Protocols:
A DIRECTIVE protocol will establish a required or expected course of action for a given situation.

Example 1 below, is an example of a Directive protocol from one Regional Drug Management Protocol in relation to knowledge of Supply of Class A drugs by a resident:

Example 1: directive clause
- Evidence of supplying (class A)
- ACTION: Notice to Quit or indefinite ban; Inform the police
- Factors to consider: No considerations relevant

In this situation, no flexibility is included; to work within the protocol, on any occasion where it is known that a Class A drug has been supplied, the person is to be evicted or barred and the police informed.

This would mean, for example, that if person A bought a £10 bag of heroin and it was known that they shared it with person B, it would be required under the protocol to evict/bar, and inform the Police.

Flexible Protocols:
A flexible protocol will not direct an organisation to a specific outcome, but will outline the factors that should be considered, and the courses of action that may be appropriate.

Where there is a specific course of action that is mandated by Law, the Protocol will make this explicit – and will, at various points, therefore be directive. But for the

most part the Protocol will allow an organisation space to consider what responses will be appropriate.

Example two below illustrates a flexible response to supply:

Example 2: Flexible Clause

- Evidence of supplying (class A)
- ACTION: organisation will need to act to ensure that supply stops, and as far as is possible does not recur
    - The organisation should assess the context, gravity and history of the situation and respond appropriately and proportionately
    - Responses could include written warnings, Notice to Quit, temporary or permanent exclusion, Police involvement
- Factors to consider: The nature of the supply, quantities involved, previous episodes of supply, previous actions taken, vulnerability of residents involved.

5.5 Mandatory or Voluntary:

While there is no LEGAL requirement for an organisation to sign up to a Protocol, it is feasible for a Regional Protocol to be a mandatory document. For example, it may be a matter of local policy that organisations are required to sign up to the Protocol, and that funding, receipt of Supporting People monies, endorsement etc are dependent on such a sign up.

Alternatively, a Protocol could be merely voluntary, and organisations supported and encouraged to sign up to it but without sanctions attached. With a well-planned, well-developed Protocol that doesn't place onerous requirements on the providers, a voluntary process may well be adequate. However, in situations where poor practice persists, the "stick" of a mandatory approach may be needed.

5.6 Summation:

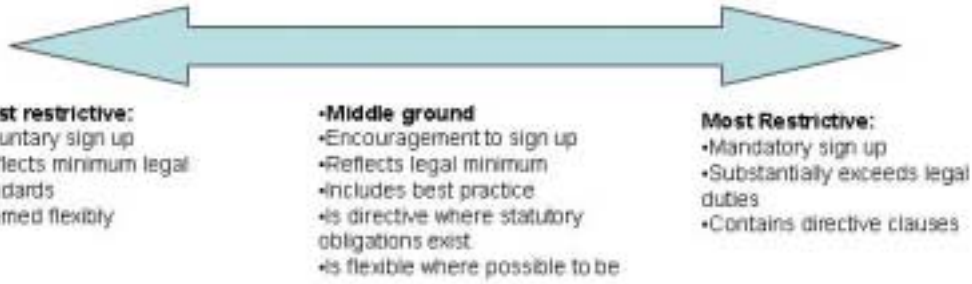
By putting together the variables above, it will be clear that the resulting Regional Drug Management Protocol could range significantly in scope and content.

In its most "light" incarnation, it would take the form of a minimum-standards document, which would be flexible rather than directive, would not impose any duties beyond the statutory minimum, and to which signing up would be voluntary.

At the other end of the spectrum, a Protocol could be far more comprehensive, be directive, imposing duties that exceed the statutory minimum and to which signing up is mandatory.

It is not the place of this document to assert which of these models is the most appropriate.

There are advantages and drawbacks to each. Instead, it is worth exploring some of the pitfalls – especially of the comprehensive and directive model, and strategies for avoiding these perils.



6 Hallmarks of a good Regional Drug Management Protocol:

1: The protocol will reflect the current, up-to-date, legal position

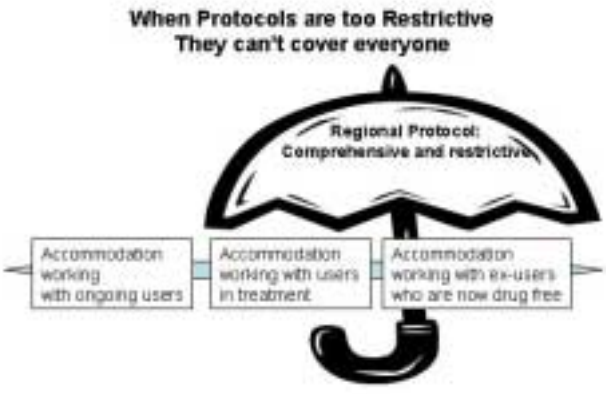
This may sound like an obvious starting point, but, surprisingly, some protocols do not accurately reflect the current legal position, and make erroneous statements as to what is, and is not legal.

Examples:

- Section 8(d) of the MDA was not extended by S.38 of the Police and Criminal Justice Act 2003;
- An up-to-date protocol will reflect the Antisocial Behaviour Act 2003

2: The protocol will reflect the wide range of current and potential accommodation provision.

Within any region, there will need to be a range of housing provision, for people with a range of drug related needs. This could range from open-access services working with ongoing users, to abstinence-based services for ex-users who are now drug free. In between these two poles, a wide range of other provision, including housing for users currently engaged in treatment and those who are using non-problematically will be needed.



A good Regional Drug Management Protocol will not preclude the development of housing provision for any of these groups. Some protocols, written (for example) with the needs of abstinent former-users in mind, may be less suitable or relevant for a provider working with on-going users.

3: The protocol will not restrict organisations from working in a way that is lawful.

Organisations may well want to develop responses to situations that reflect the culture of the organisation and the needs of their clients. Provided that such ways of working are lawful, the Protocol should not preclude these methods of working.

The most pertinent example of this is the scope, within the current legislation, to work with ongoing use on site. It is feasible and lawful for an organisation to work with ongoing use of drugs (other than cannabis) on site thanks to the space afforded by Section 8(d) of the Misuse of Drugs Act 1971.

However, a Protocol could impose restrictions on such a way of working, even though the legislation imposes no such restriction.

While any individual organisation can choose to impose restrictions on behaviour or activity that are not required by law, these additional prohibitions should not be imposed by a Regional Drug Management Protocol.

4: The protocol will not advocate courses of action that are illegal

A surprisingly large number of regional protocols advocate courses of action that are not robustly lawful, such as the removal of paraphernalia from residents' rooms, the searching of residents' rooms, and the storage of prescribed controlled drugs.

Where a course of action is prohibited by law, it is beyond the gift of the Protocol to make the unlawful legal. While the risk of prosecution is of course unlikely if following a regionally-agreed protocol, the existence of such a Protocol would not represent a cast-iron defence if a prosecution took place. Further, an organisation may find that their insurance is jeopardised by operating in a way known to be illegal.

5: The Protocol will be compatible with other relevant legislation

While a key area of concern is, clearly, legislation relating to the Misuse of Drugs Act 1971, the Protocol would also need to have due regard for other relevant legislation. These would include (but are not limited to):

Relevant housing legislation: Regional Protocols should not advocate a course of action that is incompatible with existing housing legislation.

The arbitrary exclusion of a person from accommodation where they are entitled to reside – for example where they have a licence and this has not been lawfully ended – will not be lawful. So a policy in a hostel, where residents stay on licence, which

provided for people to be summarily evicted from the property for a non-critical drug-related episode could be unlawful. It will be important that careful consideration is given to the circumstances in which summary eviction takes place.

Data Protection Act 1984: This has important ramifications regarding what information is recorded about residents, with whom it is shared and under what circumstances. The sharing of information with external agencies, including the Police, without the client's informed consent may in some circumstances not be compatible with the Data Protection Act.

Regional Protocols must be compatible with the Data Protection Act and should not advocate information sharing outside the terms of the Act.

Human Rights Act: Where applicable, the Human Rights Act is relevant in the management of drug use on premises. The most relevant will be Article 8: Right to Respect for Private and Family Life. This could impinge on organisations seeking to search residents' rooms or property, or sharing of information without consent or where not justified.

The Regional Protocol should be compatible with the Human Rights Act.

Health and Safety at Work Act 1974, and The 1999 Regulations: Procedures and policy should be in place to ensure that drug-related risks are risk assessed, and that suitable safeguards are put in place to address identified risks; the most significant of these as regards drug use will be policy and procedures around needles and other sharps, provision for their safe disposal and procedures around handling.

The Regional Protocol should clearly direct organisations where policy and practice will be required under the Health and Safety at Work Act and should not preclude actions or procedures that may be required to fulfil health and safety requirements.

Civil Law obligations: as well as obligations created by statute, organisations should also have due consideration for the scope for civil litigation that emerges from poor policy and work practice. Organisations should have regard for the Duty of Care that they owe their staff, residents, visitors and the wider public.

Other Civil law areas of concern include advice-giving to clients, trespass against client's goods or properties, assault of clients, and the risk of defamation through, for example making and publishing unproven and untrue statements about a resident.

7 Process for Developing a Regional Drug Management Protocol:

The process of developing a regional drugs protocol is not a fast one, and can take a year or two from initial development to complete implementation. This process can be delayed by poor group formation and process, so some initial strategic thinking can pay dividends later on.

1) Group membership is identified, including Chair. Group members should have sufficient seniority to ensure buy-in and agreement from their own organisations.
2) Group receive an initial briefing session, to ensure that group are all up to speed with the current legal framework, models and scope of protocol
3) Group agree type and scope of the protocol, and areas that it needs to cover
4) Protocol statements and procedures developed and agreed by group
5) Draft protocol reviewed by external agencies – including statutory and voluntary sector stakeholders
6) Comments received are reviewed and incorporated where appropriate
7) Final version of Protocol developed, agreed by key parties
8) Local agencies invited to launch event, can sign up to protocol
9) Training rolled out to signatory agencies
10) Review of protocol on annual basis.

Once a final version of the Protocol is agreed and rolled out, a number of additional steps are invariably essential:

- Where the Protocol impacts on internal processes such as record keeping, sharps handling or drugs procedures, these will need to be amended in line with the Protocol
- Staff handbooks may need to be revised
- Tenants handbooks, posters, contracts may need to be revised
- Licence agreements will need to be reviewed.

8: Things that might go wrong:

1 Senior Local Authority officials won't sign off on the Protocol:

Often, a Regional Protocol is developed by a small working group, and then passed up, to the Director of Housing, or another senior person for a final sign-off. Unfortunately, this is often the first time that the relevant worker has seen the document, they've not been part of the discussions that led up to it and so they don't sign off on it or insist on additional clauses being added.

If sign-off is going to be required, then either the working group should be given authority to proceed on the basis that the agreed document will be signed off. If this isn't possible, the senior signatories should be involved at stages 1,2, and 6 of the Process for developing the protocol, to reduce the risk that it grinds to a halt at the very end.

2 The Protocol ends up serving the Crime and Disorder Reduction Partnerships Agenda alone

Housing providers do have an important role in contributing to Crime and Disorder Reduction partnerships. But the Regional Drug Management Protocol will need to balance the needs of accommodation providers with the needs of the wider community. This is a judicious balancing act, best achieved by clarity of aims at the starts and careful chairing to steer a course between the conflicting demands.

DATs and CDRPs are currently in the process of merging, and in many areas have already done so. This may make it more difficult to ensure that the resultant protocol is as effective in representing the needs of accommodation providers as it is in reflecting the agenda of the CDRP/DAT.

It should be stressed that, while all stakeholders will want to see crime and disorder addressed in the locality, this cannot simply be achieved by excluding people from provision. The development of well-planned, well-run housing can reduce issues such as public use of drugs, discarding of equipment, street-drinking, and other forms of "antisocial behaviour." As such engaging with and retaining drug users in appropriate housing should be viewed as an essential strand of a CDRP.

Any information that is shared by these bodies should be in the form of depersonalised data and the Crime and Disorder legislation does not create an obligation to share information about specific incidents of drug related behaviour.

3 The Protocol ends up serving the Police's Agenda, not that of housing providers

A significant number of Regional Protocols produced to date lean very heavily towards a policing rather than a housing agenda. In some protocols, this has meant that all drug related episodes, suspected or known, are expected to be reported to the police. While such information sharing may be intended for "intelligence

gathering" reasons only, it still substantially extends the obligations placed on housing providers beyond what is legally required.

Other protocols have adopted less extreme positions, but have, for example stipulated that all episodes of supply involving Class A drugs should be reported to the police – again not required by the existing legislation.

If balance is to be achieved between policing and housing agendas, several factors will be decisive. The willingness of both groups to identify common ground is essential: there will be times when police involvement is warranted and justified, and times when it is not. Acceptance of this principle is a huge step.

The ability of a Chair to help work through points of difference and agree consensus is important. But equally important is having a working group who understand the issues and are willing to stand their ground at points where there is pressure to adopt positions that are not legally required or justified. Too often, it appears that housing providers have been told that a certain course of action is obligatory, when this is not in fact the case.

Lastly, running sample scenarios against protocols is a useful way of checking that correct outcome is achieved, not an unforeseen or an unwanted one.

4: The process has stalled

The development process can be slow and may grind to a halt. There are several ways to get things moving again:

- Revisit group composition: is it too large? If so reduce numbers to make it more manageable and productive
- Review Chair: are they keeping the process moving, avoiding getting bogged down and acting as a prime-mover? If not time to review the Chair's capacity for the job.
- Stuck on a contentious point? Try leaving it for a while, and come back to it. It may resolve itself. If not, try resolving it as follows:
    - Is it a point where there is a mandatory course of action, stipulated by law or other statutory requirements? If so then it must be adopted and those who feel unhappy about this will need to accept that it is not a matter for discussion.

Example 1:
Contentious clause: "If supply is known to be taking place on site and other measures have failed to prevent this, then the organisation will need to involve the police."

As organisations are obliged to use "all reasonable means readily available" to prevent supply, the organisation would be obliged to involve the police if other strategies are inappropriate or haven't worked.

As such, while organisations may have misgivings about doing so, it is a course of action that must be stipulated at this point.

- Is it a case where there is scope for introducing a flexible wording, so that decision making can be left in the hands of the organisation. If so adjust wording of the contentious clause to allow for this flexibility.

Example 2:

Inflexible: "where supply of class A drugs is known to be taking place, the police must be informed."

Flexible: "where it is known that supply of Class A drugs is taking place, workers should consider if police involvement is warranted.

Where supply is significant, ongoing, or other measures have not succeeded in stopping it, it is likely police assistance will be required.

It may be useful to discuss situations with the police informally, to gauge what level of response is required.

- Is there scope for consensus building? Typically, even with a contentious clause there is still some scope for consensus, usually at the extremes. By using these points for consensus, it should be easier to agree a way forward.

Example 3: Establishing Consensus through mapping the edges:

The contentious point: a proposed wording for the protocol says "*where a person is known to have supplied a class A drug to another on site, the person should be given a notice to quit and the Police should be informed*."

The issue: under what circumstances should the police be involved in supply of Class A drugs?

Mapping the edges: the group discuss a scenario where they become aware that Resident A has given resident B some of his methadone. B had been ripped off when he was buying heroin, and so had no money or drugs and was experiencing withdrawal.

The group discuss if police involvement and eviction was appropriate if this was a first incident.

The group discuss another situation in which resident C, who has had previous warnings for supply, is known to be selling crack on site.

Through discussion of the two scenarios, (hopefully) the group agree that in some situations police involvement will be required, and in others it will not be if other measures work.

Section 2:

Elements within a Regional Protocol:

2.1 Drugs Policy

Relevant legislation

- Health and Safety at Work Act 1974
- Civil obligations

Obligations:

- While not a legal requirement, every accommodation provider should have a drugs policy in place; failure to do so increases risk of prosecution for drug-related incidents, and the risk of harm to staff or residents.
- The regional protocol should make it clear that each organisation is expected to develop its own drugs policy within the scope of the Regional Protocol.

Best practice

- The organisations has developed a drugs policy
- The drugs policy covers the likely drug-related incidents that the organisation will encounter, based on their client profile and experience
- The policy has been developed in-house, involving a range of staff and service user input
- The policy has been reviewed externally
- The policy has been endorsed by the Police if possible, though this may not always prove possible
- The Drugs Policy is compatible with the Regional Protocol
- The Drugs Policy is reviewed regularly and after serious incidents
- All staff are inducted in to and have training in relation to the drugs policy

Undesirable – Regional Protocols should not:

- Take the place of an in-house Drugs Policy

2.2 Client Assessment

Relevant legislation

- Health and Safety at Work Act 1974
- Civil obligations

Obligations:

- An initial assessment of a client and their needs will be essential so that any risks can be managed, and needs can be addressed

Best practice

- A basic assessment will take place before accommodation is offered or as soon as possible thereafter; this basic assessment should include:
  - The presence, nature and extent of drug use
  - Risk of overdose
  - Current injecting behaviour
  - Mental health and wellbeing
  - Physical health and well-being
  - Current engagement with agencies
- This initial assessment may need to be updated as additional information is revealed or the client's situation changes

- The assessment is confidential and will not be shared without the client's informed consent
- A care-plan will be developed in light of this assessment
- The assessment and care-plan will be reviewed periodically

Undesirable – Regional Protocols should not:

- Require initial assessments to be pooled or shared without client's informed consent
- Make engagement with treatment a mandatory requirement before an offer of housing is made

2.3 Possession by residents

Relevant legislation

- Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- Health and Safety at Work Act 1974

Obligations:

- Organisations must not encourage or incite service users to be in possession of controlled drugs
- Organisations must have due regard for Health and Safety, assess the extent to which residents' possession of drugs poses a Health and Safety risk to users of the building
- Organisations must be vigilant as regards offences under Section 8 of the MDA. Where the form or quantity of drugs suggests an offence under Section 8 further action must be taken.
- If illicit drugs are confiscated or surrendered they should not be returned to the resident.

Best practice

- Organisations will respond to all episodes of possession or suspected possession of controlled drugs by residents
- They will assess each episode in terms of gravity, risk and legal concerns
- In all circumstances where residents are found to be in unlawful possession of drugs, residents will be offered the chance to surrender drugs, and be reminded of the legal ramifications of possession;
- As appropriate, residents will be referred to advice or support agencies;
- Where the quantity or form of the drug possessed suggests supply may be taking place, further action will be taken in line with the organisation's responsibility under Section 8.
- Removal of substances without the residents knowledge or involvement could put the resident at risk of withdrawal and may create a more volatile situation; this course of action is strongly discouraged wherever it can be avoided.
- Where possession puts the resident or others at serious risk of harm, further action will need to be taken to reduce or remove the risk

Undesirable - Regional Protocols should not:

- Direct workers to remove suspected controlled drugs from a person's room without their knowledge and consent unless there are serious and pressing safety concerns to do so;
- Require workers to confiscate drugs from residents
- Require agencies to automatically evict or exclude residents known or suspected to be in possession of controlled drugs for personal use (N.B. this course of action may be required in those premises working with people currently abstinent, and where abstinence is a condition or residency, but this should be specified within the project's own policy, not the Regional Protocol);
- Automatically mean that people found in possession of controlled drugs for personal use are reported to the police;

2.4 Possession by staff

Relevant legislation

- Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- Health and Safety at Work Act 1974

Obligations:

- Organisations must not store or return illicit substances to residents
- Organisations do not have the authority to store and supply prescribed controlled drugs to their residents and should not do so
- Organisations which store other medicines for their residents must ensure that they are trained and competent to do so and comply with best-practice guidance in this area

Best practice

- Organisations will assess the ability of residents to store and manage their own medicines
- Organisations will put in place measures to assist users to manage their own medication including joint working with prescribers and dispensers, safe-storage facilities, life-skills and support
- Organisations will generally only temporarily take possession of prescribed controlled drugs for the shortest period of time possible, where there is a serious risk to client safety.
- Residents who do not have the capacity to manage their own medication, and need to be prescribed controlled drugs, will need housing and provision which can lawfully hold and dispense their medication

Undesirable - Regional Protocols should not:

- Require workers to store medication (including controlled drugs) for their residents

2.5 Destruction and Disposal of Controlled Drugs

Relevant legislation

- Misuse of Drugs Act 1971 (s 5(4) a and b)
- Misuse of Drugs Regulations 2001
- Health and Safety at Work Act 1974
- Environmental Protection (Duty of Care) regulations 1991

Obligations:

- Organisations must ensure that any drugs that are found abandoned or surrendered from residents are destroyed or disposed of lawfully
- Organisations must not supply these drugs to a person not authorised to possess them
- Destruction must not be contrary to the Environmental Protection Regulations

Best practice

- Drugs that have been removed from a person's possession may be destroyed or handed in to someone authorised to possess them;
- Drugs that have been found abandoned should be passed on to someone authorised to possess them
- Schedule 1 Controlled Drugs should be destroyed where appropriate, or passed on to the Police
- Controlled drugs in Schedules 2-5 should be passed on to a GP, Pharmacist, Police or returned to a named patient, authorised to possess the drugs, where the organisation are satisfied that it is safe and appropriate to do so
- Destruction should meet the requirements of the Environmental Protection Regulations 2001, and so disposal via the sink will not normally be appropriate
- Only very small quantities of drugs should be considered for in-house disposal
- Protocols for the safe storage and transfer of substances from the accommodation to the police/pharmacy should be in place. This should include where drugs are stored, who has access to them, record keeping, transportation, and receipts and confidentiality.

Undesirable - Regional Protocols should not:

- Encourage organisations to store substances on site than longer than absolutely necessary;
- Preclude methods of disposal that are lawful and safe
- Encourage methods of disposal that are unlawful or unsafe
- Prevent organisations discarding small amounts of surrendered drugs on site
- Require organisations to breach client confidentiality when handing in drugs

2.6 Use of illicit controlled drugs by residents

Relevant legislation

- Misuse of Drugs Act 1971, especially Section 8(d)
- Health and Safety at Work Act 1974
- Antisocial Behaviour Act 2003

Obligations:

- Organisations must not encourage or incite service users to use controlled drugs on or off site
- Organisations must use reasonable means to stop the smoking of cannabis on site where it is known that this is taking place[MDA 1971, s8(d)]
- Organisations must have due regard for Health and Safety, assess the extent to which residents use of drugs poses a Health and Safety risk to users of the building

Best practice

- Organisations will respond to all episodes of use or suspected use of controlled drugs by residents
- They will assess each episode in terms of gravity, risk and legal concerns; this will include risk of overdose, levels of intoxication, hazards arising from drug paraphernalia and impact on other residents
- When responding, workers should make sure that worker safety, safety of residents and user safety are prioritised. This may mean for example that a resident in the act of injecting should be permitted to finish, if to attempt to stop the process could increase risk to the resident.
- Where use of cannabis is known to be taking place, organisations will need to pursue an enforcement route, using warnings and other sanctions. Organisations could seek to negotiate a "Cannabis Protocol" with the Police to increase the range of options available when responding to the use of cannabis.
- Where use of any controlled drug is known to be taking place, residents will be referred to advice or support agencies as appropriate.
- Where use puts the resident or others at serious risk of harm, further action will need to be taken to reduce or remove the risk;
- Use of Class A drugs and antisocial behaviour on or near the premises will need to be addressed rapidly and effectively, or an organisation could face closure under the Antisocial Behaviour Act 2003.
- In housing settings where abstinence is a condition of residency, action may need to be taken to terminate the resident's stay.
- All actions will be recorded.

Undesirable - Regional Protocols should not:

- Place a blanket prohibition on working with managed use on site.
- Direct workers to stop people in the process of using where to do so could increase risk to workers or users;
- Direct agencies to exclude or evict residents for use on site;
- Require organisations to automatically report episodes of use to the Police;
- Expose users to risk by directing organisations to exclude them from accommodation after use, when intoxicated or at risk of overdose;

2.7 Supply of Controlled Drugs by Residents

Relevant legislation

- Misuse of Drugs Act 1971
- Antisocial Behaviour Act 2003

Obligations:

- Organisations must take reasonable means readily available to address and stop supply of controlled drugs taking place where they know that this is taking place;

Best practice

- Organisations will make it clear to all residents that the supply of CDs on site cannot and will not be tolerated and that action will be taken where supply is known or suspected
- Organisations will investigate each episode of suspected or known supply;
- Organisations will respond according to the context, gravity and history of the episode
- Where episodes are low level, it may be feasible to deal with them in-house
- Where an organisation is uncertain how to proceed, Police advice and guidance should be sought
- For more serious episodes, or ongoing episodes, it is likely that Police input will be required
- All knowledge and actions will be recorded appropriately

Undesirable - Regional Protocols should not:

- Direct workers to report all episodes of supply to the Police
- Direct that people involved in supply should face automatic eviction or exclusion
- Use the word “dealing” in place of the word “supply.”

2.8 Paraphernalia

Relevant legislation

- Misuse of Drugs Act 1971
- Misuse of Drugs Regulations 2001
- Health and Safety at Work Act 1974
- Waste Handling Regulations

Obligations:

- Organisations must not distribute items of paraphernalia for the consumption of controlled drugs unless this is done within an approved scheme for the distribution of such items.
- All organisations must develop clear policy and practice for the handling and safe disposal of hazardrous, discarded drugs paraphernalia.
- Organisations who wish to transport used drugs paraphernalia must comply with the requirements to register with the Environment Agency as a Waste Carrier and fulfil their duty of care.
- Where injectors may come on site, organisations must ensure that there is some provision for the safe disposal of used injecting equipment.
- Where paraphernalia suggests supply may be taking place, organisations must act in line with their Section 8 obligations.
- Where paraphernalia suggests cannabis smoking is taking place, organisations must act in line with their Section 8 obligations.

Best practice

- Organisations working with ongoing injectors should ensure that individuals have access to sharps bins on a personal basis, and sharps boxes should also be located in communal areas (e.g. toilets).
- Organisations allow injectors to keep unused injecting paraphernalia on site.
- Where the presence of paraphernalia suggests drug activity is taking place, organisations should discuss the issue with the resident and respond in an appropriate and proportionate manner.

Undesirable - Regional Protocols should not:

- Oblige workers to remove paraphernalia that can be legally possessed;
- Remove paraphernalia that is associated with harm-reduction interventions;
- Discourage injectors from storing adequate amounts of clean injecting equipment;
- Preclude the use of sharps boxes;
- Remove paraphernalia without the client's knowledge unless there is an overwhelming health and safety reason to do so;
- Breach confidentiality solely for possession of paraphernalia, unless there are additional and substantial factors present (e.g. supply, injury etc)

2.9 Overdose

Relevant legislation

- Civil obligations as regards the Duty of Care owed to residents
- Health and Safety at Work Act 1974

Obligations:

- Organisations should ensure that they are able to fulfil the duty of care that they owe their residents in the event of an overdose.
- Organisations should ensure that any staff expected to respond to episodes of overdose have appropriate training and resources, so that they can respond safely.
- Organisations maintain proper records of all suspected overdoses

Best practice

- On admission, residents are assessed as to level of overdose risk
- Residents are offered accommodation in line with the level of overdose risk (e.g. residents with a high level of overdose risk housed in accommodation with 24 hour staffing)
- Staff and residents have training around overdose risk and management
- In-house protocol exists on management of overdose including:
  - Assessing risk
  - Responding to suspected overdose, First aid
  - Emergency service protocols
- Building is risk-assessed in terms of overdose management (e.g. how doors open, lock etc)
- Policy does not increase risk of undetected overdose (e.g. doesn't require that people have no company when using, automatic police involvement for use on site).

Undesirable - Regional Protocols should not:

- Impose rules that increase risk of undetected overdose (e.g. no use on site)
- Mandate that police be required to attend all overdoses

2.10 Information sharing and Confidentiality

Relevant legislation

- Misuse of Drugs Act 1971
- Data Protection Act 1998
- Human Rights Act 1998
- Children Act 1989
- Crime and Disorder Act 1998
- Police and Criminal Evidence Act 1984

Other legislation relating to Policing; Civil obligations

Obligations:

- Organisations must ensure that they protect a client's right to privacy and confidentiality in line with the Data Protection Act, and the Human Rights Act
- Organisations must comply with the requirements of the Misuse of Drugs Act 1971, especially Section 8 of this Act, and this may at some points require an organisation to breach confidentiality in order to comply with the MDA.
- Organisations working within the terms of the Children Act will need to share information with external agencies where there are concerns regarding child safety
- Some organisations will be obligated to provide depersonalised statistics under the Crime and Disorder Act

Best practice

- Organisations will draw up a clear confidentiality policy which is explained to all residents at admission
- Residents should be asked to give their informed consent before any information is shared with external agencies; this should include specifying agencies with whom information can and cannot be shared, and any information which the resident wishes to restrict sharing. The resident should be able to amend or withdraw consent at any time.
- Residents should have the limits of confidentiality explained to them, and that some information may be shared without their consent or knowledge, including where there is considered to be serious risk to the user or someone else, where the organisation becomes aware of serious offending behaviour, where sharing information is required to prevent activities prohibited under Section 8 and in other similar situations
- External organisations such as the Police will not request information informally which would require an organisation to breach residents' rights to privacy; where there is a policing need for such information, requests will be made through formal channels, demonstrating the overwhelming need for this information
- Organisations and the Police will recognise that documents such as Client records are Excluded Materials and will respect the protection that such documents enjoy

Undesirable - Regional Protocols should not:

- Require organisations to disclose or share information contrary to key legislation
- Require organisations to maintain any records in a way which would conflict with the Data Protection Act

2.11 Antisocial Behaviour

Relevant legislation

- Antisocial Behaviour Act 2003
- Crime and Disorder Act 1998
- Civil obligations

Obligations:

- Organisations risk closure of properties that are associated with antisocial behaviour and class A drug activity
- Some organisations will be obligated to provide depersonalised statistics under the Crime and Disorder Act
- Organisations may owe a Duty of Care to their neighbours and could breach this by failing to address antisocial behaviour

Best practice

- Organisations should explain to residents what is meant by antisocial behaviour, and why the organisation cannot and will not tolerate it
- The licence or tenancy agreement, and any resident handbooks should include clauses around antisocial behaviour
- Where a resident acts in an antisocial way, the organisation should use supportive and enforcement approaches to address this behaviour
- The organisation should maintain links with the police and the Local Authority to enable them to address and respond to Antisocial Behaviour effectively
- Responses should help residents change their behaviour rather than simply excluding them
- Where properties are the subject of a closure order, the needs of vulnerable individuals made homeless as a result of the closure order are assessed and they areappropriately rehoused.

Undesirable - Regional Protocols should not:

- Impose blanket exclusions on individuals who have been evicted or excluded as a result of antisocial behaviour
- Endorse measures that result in reduced access to harm reduction services as a result of Antisocial Behaviour Orders

2.12 Community Relations

Relevant legislation

- Civil obligations

Obligations:

- Organisations may owe a Duty of Care to their neighbours and could breach this by failing to address antisocial behaviour

Best practice

- Organisations should endeavour to maintain good relationships with the local community
- A steering group including members of the local community can provide representation to local residents
- Strategies for contacting the organisation and raising concerns are well publicised
- Concerns and complaints from local residents are documented and responded to in a timely manner
- Both the local residents and the accommodation provider can feed in to and air concerns via the local Crime and Disorder Reduction Partnership
- The organisation further engages with the local community via open days and similar

Undesirable - Regional Protocols should not:

- Ignore the needs of local residents, or their concerns
- Undermine the need to house drug users, or to breach their rights to privacy and confidentiality, in order to appease local residents

2.13 Health and Safety/Risk Assessment

Relevant legislation

- Health and Safety at Work Act 1974
- Civil obligations

Obligations:

- To undertake a workplace risk assessment
- To ensure that identified risks are addressed
- To ensure that staff training and provision is in place to allow for safe working practices
- To regularly review the risk assessment, on a periodic basis and after incidents

Best practice

- The provision is risk assessed from the perspective of staff, service users, and visitors
- Risk assessment includes: managing difficult and dangerous behaviour, needles and other sharps, blood and other body fluid spills, managing intoxication, managing overdose
- Health and Safety policies are developed, rolled out to all relevant parties
- Sign-off takes place to confirm policies have been rolled out
- Periodic inspection takes place to ensure policies are being followed

Undesirable – Regional Protocols should not:

- Prohibit courses of action that may be required as part of a Health and Safety plan (e.g. provision of sharps bins)
- Make it harder to assess risk by forcing users to downplay or conceal their drug use
- Tie mandatory requirements under Health and Safety legislation to voluntary requirements such as information sharing with external bodies. E.g. a worker finds used, hazardrous equipment in a room: the organisation MUST ensure that they are removed and handled in a safe way as part of their Health and Safety obligations. Any further considerations as to how this information is shared with (for example) the Police are NOT part of the Health and Safety protocol.

2.14 Staff Training

Relevant legislation

- Health and Safety at Work Act 1974
- Civil obligations

Obligations:

- To make sure that staff have received training to allow them to work safely as regards identified risk

Best practice

- Staff training takes place on a regular and ongoing basis
- Drugs training for staff enables them to be competent to work at least to Tier 2, and includes:
    - Drugs awareness, drugs legislation, Reducing drug deaths, understanding drug interventions, drug-related harm reduction, dual diagnosis
- Further training includes sharps handling, managing difficult and dangerous behaviour, therapeutic interventions such as Motivational Interviewing
- Training takes place on an in-house basis and alongside other professionals
- Staff have a Training and Needs Assessment which is regularly reviewed

Further Information, Resources, Contacts

KFx	**www.ixion.demon.co.uk** kfx@ixion.demon.co.uk
Cymorth Cymru	**http://www.cymorthcymru.org.uk/** info@cymorthcymru.org.uk
Drugs and Housing	**www.drugsandhousing.co.uk**
Homelesslink	**http://www.homeless.org.uk/** Info@homelesslink.org.uk
Shelter	**http://england.shelter.org.uk/home/index.cfm** **http://www.sheltercymru.org.uk/shelter/home/**
SITRA	**http://www.sitra.org.uk/** post@sitra.org

Sample Drugs Policy: Flemen, K: KFx: 2006

Drugs Legislation: Flemen, K: KFx: 2006

Tackling Drug use in Rented Housing: DTLR: Robinson & Flemen: 2002

Safe as Houses: McKeown, S: Shelter: 2006

Clean Break: Integrated housing and care pathway for homeless drug users: Research Summary: HomelessLink: 2007

Drug Services for Homeless People - a good practice handbook: Randall: Drugscope/Homeless Directorate:

Home and dry? Homelessness and substance use in London: Jane Fountain and Samantha Howes. Crisis 2002