Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Code: GR37
Issue number: 1

The management of illicit substances within CWP premises

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Responsible Committee/Sub Committee	Clinical Risk Review Committee
Document approved by & date:	Clinical Risk Review Committee – 9th April 2010
Document consultation:	Health and safety welfare group (HSWG) Acute care group (ACG)
Patient and Public Involvement (outline any PPI input into policy and associated impact on service users and carers)	PPI representation at Clinical Risk Review Sub Committee (CRRSC)
What type of document is this	Policy
Document applicable to (Identify by location and staff groups):	All staff
If new document, reason for development:	For the purpose of this policy the term 'controlled drug' relates to an 'unknown substance or illicit drug'.
Synopsis outlining document aims:	A controlled drug means a drug that is governed by statute law and can therefore be a criminal offence to be in possession or to pass on that drug to another. CWP does not encourage or condone the possession of a controlled drug.
Implementation Date:	October 2010
How will the implementation of this document be monitored and reviewed	
Document to be read In conjunction with:	CP6 Management of violence and aggression policy (incorporating verbal threat to staff and offensive weapons) GR1 Incident Reporting, Management and Review Policy CP12 Searching of Persons and environments MP1 Medicines Policy HR4.3 Substance misuse for staff CP23 Policy on dual diagnosis (continuum model for service users with mental health and substance misuse problems)
Financial resource implications of this document and how these are going to be addressed:	N/A
Is this document carried out wholly or in part by contractors, or organisations with which the Trust has a service level agreement, and if so state the relevant contractor	N/A

Document Change History (changes from previous issues of policy (if appropriate) :

Issue Number	Page	Changes made with rationale and impact on practice	Date

CONTENTS

1. Introduction / background

The NHS Security Management Service (NHSSMS) have issued guidance to all health care providers around the management of illicit substances with the aim of protecting all staff and service users and ensuring that health care premises are safe areas for purpose. *The Misuse of Drugs Act 1971 (MDA)* is the main piece of legislation governing the unlawful possession and supply of controlled drugs. This act, and other supporting legislation, states that it is an offence for an individual to have possession of, or to supply to another, a controlled drug, unless they are specifically permitted to do so by the act or consequential regulations.

Section 8 of the MDA creates further offences in relation to controlled drugs and their use and supply on premises. It is an offence for the occupier or manager of any premises knowingly to permit or allow the unlawful use or supply of controlled drugs on the premises they occupy or manage. Section 21 imposes the same duty on health bodies and on the directors and managers appointed by health bodies.

2. Content

For the purpose of this policy the term 'controlled drug' relates to an 'unknown substance or illicit drug'. A controlled drug means a drug that is governed by statute law and can therefore be a criminal offence to be in possession or to pass on that drug to another. CWP does not encourage or condone the possession of a controlled drug. It is important that such behaviour is challenged in a healthcare environment, when safe to do so. Consideration should always be given to notifying the police immediately that an offence is being committed or is suspected. The contents of this document outline the steps that must be followed when CWP suspect or know that a patient or visitor has on their possession an illicit substance.

2.1 The Law

The Misuse of Drugs Act 1971 (MDA) lists the drugs that are subject to control and classifies them into three distinct groups **(A, B and C)** according to their addictiveness and the dangers posed to human life by their misuse.

Class A - Drugs are the most addictive and physically dangerous drugs when misused and include heroin (diamorphine), cocaine, crack cocaine, LSD, fresh or prepared magic mushrooms, ecstasy, amphetamine (if prepared for injection) and methadone.

Class B - Drugs include cannabis, amphetamines and codeine.

Class C - Diazepam, temazepam and anabolic steroids.

A number of recreational drugs previously known as 'legal highs' became classified are now known as controlled substances. Gamma-butyrolactone (GBL) and 1,4-butanediol (1,4-BD), which are both converted into gamma-hydroxybutyrate (GHB) once ingested, are now Class C drugs, as is benzylpiperazine (BZP) and related piperazines, whose actions are similar to amphetamines. All synthetic cannabinoids are now controlled as Class B drugs alongside cannabis. These often take the form of herbal smoking products and have similar effects to cannabis (the most common is sold under the name 'Spice'). In addition, the 2009 legislation also classified 15 anabolic steroids and 2 growth promoters as class C drugs.

2.2 Unlawful possession of a controlled

Unlawful possession of a controlled drug Section 5, Misuse of Drugs Act 1971, states:

- 'It is an offence for a person to have a controlled drug in their possession without lawful authority.'

Possession means the smallest measurable trace of a controlled drug within a person's possession or control i.e. upon their person or within their belongings.

The offence requires:

- That the person knew the substance was a controlled drug;

- That they knew it was in their possession or control;
- That they have no lawful authority to possess the drug.

In simple terms, unless the law specifically states that you can have a controlled drug in your possession (e.g. it has been prescribed to you), you are committing an offence.

Unlawful possession of a controlled drug (Class A or B) and unlawful supply of a controlled drug (Class A, B or C) are indictable offences. Unlawful possession of a Class C drug is a summary only offence. The penalties imposed for possession or supplies depend on the class and quantity of drug involved.

It should be noted that controlled drugs are not only those commonly thought of as 'illegal' or 'recreational', such as cannabis and heroin, but also prescription drugs – for example, temazepam and dihydrocodeine. Under the Misuse of Drugs Act 1971 it is an offence to be in possession of a prescription drug which has not been lawfully prescribed by a medical practitioner or to supply such a drug without lawful consent It is likely that, in the course of their duties, Local Security Management Specialists, security officers and members of healthcare staff may:

- Have reason to suspect that someone is in unlawful possession of and/or unlawfully using a controlled drug;
- Have knowledge of an unlawful controlled drug being found;
- Be involved in searching those suspected of being in possession of an unlawful controlled drug;
- Be involved with searches of premises or individuals undertaken by 'sniffer dogs' and their handlers;
- Suspect or know of the unlawful supply of controlled drugs;
- Be required to dispose of or destroy a controlled drug that has not been lawfully prescribed.

2.3 Suspicion of a patient having unlawful possession of an illicit drug

If there is a suspicion that a patient has unlawful possession of a controlled drug or drugs and/or is using such a drug(s), the line manager/responsible manager – should be informed and they should:

- Inform relevant people, such as clinical lead / responsible clinician or on-call manager as soon as practicable;
- Consider notifying the local police;
- In the absence of direct evidence, take care to avoid wrongly accusing the patient of possession or use; any discussion with the patient should take place in the presence of another staff witness;
- If it is deemed appropriate and safe to do so, advise the patient that drugs are not to be held or used unlawfully on the premises and if such drug use is proved or unlawful drugs found, the police will be notified immediately;
- Record the incident using the health body's incident reporting system;
- If the drug is surrendered, the written record should include a complete the unknown drug confiscation form (see MP1 Medicines Policy) and the designated pharmacist should be contacted immediately.

2.4 Knowledge of a patient having unlawful possession of a controlled drug

If it is known that a patient has unlawful possession of a controlled drug and/or is using an illegal drug(s), the staff member should:

- Inform the relevant people, such as your line manger/bleep holder as soon as practicable;
- Consider notifying the police if there are known risks with patient;
- Consider informing the patient, if it is deemed appropriate and safe to do so, that they are suspected of committing an offence under the Misuse of Drugs Act 1971 and that drugs are not to be unlawfully held or used on NHS premises;
- Ask the patient to voluntarily surrender the drug (staff must **always** ensure that a staff witness is present when any drugs are surrendered);
- Record the incident using CWP's incident reporting system.

2.5 On receipt of a suspected illegal substance

Staff must on receipt of any suspected illegal substance:

- Inform the nurse in charge or line manager;
- One of the above plus another staff witness should place the item in a bag/envelope labelled with the following details: Found by or in possession of ward and date;
- The bag/envelope should be sealed. Both members of staff should sign over the seal;
- Enter 'unknown substance' and 'patient name' on the patients own page of the CD record book as for patients own CD, and store in the CD cupboard until collected;
- The relevant consultant should be informed at the earliest opportunity;
- Fill in the 'Unknown Drugs Confiscation Form' (see MP1 Medicines Policy) and the Trust's GR1 Incident Reporting, Management and Review Policy;
- A designated pharmacist should be contacted immediately;
- Reasonable action is required to ensure that a member of the police attends to remove the confiscated drug to avoid possible committing an offence of unlawful possession.

2.6 The designated pharmacist

- The designated practitioner will complete the drug confiscation form with the details of receipt of the unknown substance. The designated pharmacist will then sign the same form for the substance for disposal;
- The designated pharmacist will complete appropriate records;
- The designated pharmacist will contact the police to arrange collection of the unknown item.

2.7 The police

Although it will only be on rare occasions that the police will want to use CWP illicit drug reports as intelligence it is important that all information is treated as highly confidential. CWP staff must always act on the advice given by the police when it is reported. Any problems or issues arising associated with this policy please contact CWP security services manager.

Merseyside Police: (Paul Johnson – or his successor) - Tel 07801-741781
Chester Police: Tel 01244-350222 or #6217

Please obtain an incident number.

Central Cheshire: Contact on-site police.
East Cheshire: DC Carter – or his successor, on Tel 01244-613437

2.8 Unlawful supply of a controlled drug

Section 4, Misuse of Drugs Act 1971, states:
'It is an offence to unlawfully supply a controlled drug to another, or to be involved (concerned) in the supply, or offer to supply a controlled drug to another, or involved (concerned) in the making of an offer'.

In simple terms, it is an offence to be involved in any way in giving a controlled drug to another person without lawful authority

2.9 Patient is suspected of dealing controlled drugs

If it is suspected that an individual is in possession of controlled drugs, whether lawfully or not, with the intention of supplying the drugs to someone else, the police must be contacted immediately. The member of staff should not discuss the drugs with the individual or request that they are surrendered.

If the patient has surrendered the suspected illegal substance and is also suspected of dealing the Intelligence Report must be completed in conjunction with the Unknown Drug Confiscation form. The police must be contacted immediately and informed of the confiscated drugs. A Trust incident form must also be completed.

2.10 Hospital visitor / member of public

If the individual concerned is a visitor who has unlawful possession of a controlled drug(s) or is using this drug(s), the responsible manager should, in addition to the above actions, take the necessary action to ensure that the police have been contacted and the visitor is removed and barred from the premises. Physical interventions by staff should only be undertaken as a last resort and there is a risk to others and only if it is considered safe to do so.

2.11 Searching of Visitors (please refer to CP12 Searching of persons and environments)
Prior to undertaking any planned search CWP staff must be aware that:

- Staff do not have any right in law to search any visitor / individual or their property (except for staff working in mental health or learning disability settings, who may be able to instigate such searches subject to specific criteria outlined in the policy CP12) and consideration should be given to report to the police for advice;
- Any risk to staff the search must not be carried out and the individual not allowed to visit and must be asked to leave CWP property and police contacted;
- The incident must be discussed with the patients care team to agree a plan of action for future visits;
- If a search of an **individual's property** is deemed appropriate or necessary, in order to minimise risks to staff and patients following suspicion that the individual is in unlawful possession of a controlled drug, staff can **only** conduct **a voluntary search of the individual's property**. A staff witness must be present when the search takes place. The individual **must** be informed that staff have no right in law to conduct the search, that no force can be used and that they can refuse to allow the search;
- The individual must be told why the search has been requested (i.e. what the suspicion is based on) and what its objective is;
- Ensure that health and safety procedures are adhered to by staff during any voluntary search of the individual's property to protect them from direct contact with any drug or harm from any associated paraphernalia;
- Be aware that if a search is carried out, a written record should be made as soon as practicable afterwards, including details of any controlled drug(s) found.

2.12 Defences to unlawful possession
It is strongly advised that illegal drugs are always passed to the police for destruction. This will help to avoid any future allegations of misappropriation by the staff member involved.

There is a specific defence to unlawful possession (this does not apply to unlawful supply) under Section 5(4) of the Misuse of Drugs Act. Individuals found to be in unlawful possession of a controlled drug have a defence if it can be proved that:

'*knowing or suspecting the drug to be a controlled drug, they took possession of it for the purpose of preventing another person from committing or continuing to commit an offence in connection with that drug and as soon as possible after taking possession they took all reasonable steps open to them to destroy the drug* ***or*** *deliver it into the custody of a person lawfully entitled to take custody of it'*

or

'*knowing or suspecting it to be a controlled drug, they took possession of it for the purpose of delivering it into the custody of a person lawfully entitled to take custody of it and as soon as possible after taking possession of it they took steps as were reasonably open to them to deliver it into the custody of such a person'.*

CWP staff can take possession of a controlled drug (or what you suspect to be a controlled drug) in two ways and have a defence to unlawful possession:

- If your sole purpose in taking possession was to prevent someone from committing an offence **and**, once you have done this, you immediately either destroy the drug or immediately make arrangements to take it to a person with lawful authority to have it e.g. a police officer and/or
- If you have found a drug and taken possession of it with the sole purpose of taking it to someone with lawful authority to have it and you do this with immediate effect. Please note: **you cannot destroy the drug** in this situation, i.e. on finding.

2.13 Physical & environmental deterrence and prevention

A variety of physical security measures can be used to *deter* and *prevent* such unlawful activity on healthcare premises, including:

- Regular supervision of all areas likely to be at risk, such as toilets, car parks and stairwells;
- Installing CCTV or mirrors in such high-risk areas;
- Ensuring that access controls are fitted to areas that are infrequently used by staff, such as basements and boiler or plant rooms;
- Banning those found supplying or suspected of supplying drugs (advice on available legal remedies should be sought from the NHS SMS's Legal Protection Unit) displaying notices that state clearly the health body's stance on such activity and the procedures that are in place to deal with it;
- Calling the police to remove banned individuals from the premises;
- Informing the police about people known or suspected to be supplying;
- Use of blue (ultraviolet) lighting in all toilets (public and staff) to help both deter/prevent and detect drug misuse.

2.14 Destruction and disposal of controlled drugs (Please refer to the MP1 Medicines Policy)

For the purposes of regulation 26 of the *Misuse of Drugs Regulations (1985)*, a controlled drug may be considered to have been destroyed if it has been: '*dissipated or denatured to the extent that it is incapable of being retrieved, reconstituted and used and it is the responsibility of the person carrying out the destruction to ensure this criteria is met'*.

3. Duties and responsibilities

The Local Security Management Specialists (LSMS)

The LSMS must ensure:

- That all CWP staff likely to encounter the situations described in this chapter are fully aware of the local procedures, based on this policy, that should be followed if the possession or supply of such drugs occurs within their working environment;
- Raise awareness of drug misuse and what staff can do to address this issue and to encourage reporting of such incidents. It is, however, important that staff should only intervene directly with an individual involved in drug misuse if it is necessary and safe to do so;
- The police are fully aware of the trust's procedures for dealing with illegal drugs and their disposal, so that the risk of misunderstanding is reduced and clarity of roles is enhanced;
- The memorandum of understanding between the NHS SMS and the Association of Chief Police Officers should be taken into account and the LSMS should liaise with their local police to develop robust working practices.

Designated pharmacist

The designated pharmacist will complete appropriate records as per MP1 Medicines Policy and in accordance with the law.

The designated pharmacist will contact the Police to arrange collection of the unknown item.

The designated pharmacist will notify the LSMS of all illicit drug incidents as soon as possible.

CWP Staff

CWP staff will be responsible for familiarising themselves with the contents of this document in accordance with trust policy.

CWP staff will record all incidents of suspected or known illicit drug use onto the Trust DATIX system.

4. References

NHS Security Management Service – SA7 Misuse of Drugs

The Misuse of Drugs Act 1971

Appendix 1 - Recognition of drugs (alphabetically)

It can be extremely difficult to differentiate between controlled drugs, non-controlled drugs and other harmless substances. Other factors, such as apparent drunkenness without the smell of intoxicants, may lead to a suspicion that controlled drugs are being used or possessed.

The appearance and names of drugs are constantly changing. The following images and accompanying notes are designed to help you to identify some of the controlled drugs and drugs paraphernalia that you may encounter in the workplace. The list is by no means exhaustive;

Alkyl nitrite	**Appearance -** Yellow liquid in small bottles. **Method -** Vapours inhaled from bottle or poured onto material and placed over the mouth. **Effects -** Instant effect, which only lasts for two to five minutes, giving a 'rush'; blood vessels dilate and heartbeat increases. **Signs and Symptoms -** Bottles, pungent smell, flushed face and neck, dizziness and headache. **Street names -** Poppers, KIX, ram, snapper, liquid gold, TNT, thrust, stag, stud, locker room, hardware. **Risks -** Dermatitis, swelling and pain in nasal passages, pressure in eyes, reduced blood pressure, vomiting. **Other notes -** An antidote for industrial cyanide poisoning.
Amphetamine	**Appearance -** White or grey powder, or blue, pink, black, black and white or yellow tablets/capsules. Also in ampoules containing clear liquid. **Method -** Taken orally, sniffed or injected after being dissolved in water. **Effects -** Increased alertness, pulse rate and blood pressure, and feeling of high energy. **Signs and Symptoms -** Enlarged pupils, insomnia, loss of appetite and weight, irritability, depression, injecting equipment. **Street names -** Amphet, billy, speed, sulph, whizz, uppers. **Risks -** Delirium, panic, hallucinations, paranoia, loss of body weight, psychological dependence, depression, lethargy, toxic reactions, heart failure, blood clots. **Other notes -** Amphetamine sulphate is made in illegal laboratories. Original street name: purple heart.
Cannabis bong/hookah	**Appearance -** Green dried leaves and plant material, or brown resin. **Method -** Smoked in herbal or resin form with or without tobacco by drawing smoke through water to cool it. **Effects -** Euphoria, relaxation, hallucinations, hilarity and increased appetite. **Look out for -** Increased appetite, glazed eyes with large pupils, 'hookah', 'bong' or 'toot' equipment. **Street names -** Bush, grass, home-grown, gear, ganja, marijuana, weed, skunk, joint, toot, bong, blunt, blast. **Risks -** Psychological dependency, accidents, paranoia. Poor performance at work, Damage to lungs. **Other notes -** Active constituent: Tetrahydrocannabinol (THC).

Cannabis herbal	**Appearance -** Green dried leaves and plant material. **Method -** Smoked with or without tobacco, hand-rolled into a 'joint' or 'reefer'. Smoked in a pipe and 'hookah' or 'toot'. Taken orally in food. **Effects -** Euphoria, relaxation, hallucinations, hilarity and increased appetite. **Look out for -** Increased appetite, glazed eyes with large pupils, distinctive sweet herbal smell, cigarette papers. **Street names =** Bush, grass, home-grown, gear, ganja, marijuana, weed, skunk, joint, toot, spliff. **Risks -** Psychological dependency, accidents, paranoia, anxiety, psychotic reactions associated with use of high strength cannabis (such as skunk). Poor performance at work. **Other notes -** Active constituent: Tetrahydrocannabinol (THC).
Cannabis plant	**Appearance -** Bushy 'indoor type' plant with spiky leaves. **Method -** Smoked, hand-rolled into a 'joint', or smoked in a pipe or 'hookah'. Taken orally in food. Oil extract 'striped' down a cigarette and smoked. **Effects -** Euphoria, relaxation, hallucinations, hilarity and increased appetite. **Look out for -** Increased appetite, glazed eyes with large pupils, distinctive sweet herbal smell, cigarette papers. **Street names -** Bush, grass, home-grown, gear, ganja, marijuana, weed, skunk, joint, toot, spliff. **Risks -** Psychological dependency, accidents, paranoia. Poor performance at work. **Other notes -** Active constituent: Tetrahydrocannabinol (THC).
Cannabis resin	**Appearance -** Compressed brown, black or yellow-brown plant material. **Method -** Smoked with or without tobacco, hand-rolled into a 'joint' or 'reefer'. Smoked in a pipe and 'hookah' or 'toot'. Taken orally in food. **Effects -** Euphoria, relaxation, hallucinations, hilarity and increased appetite. **Look out for** Increased appetite, glazed eyes with large pupils, distinctive sweet herbal smell, cigarette papers. **Street names** Gear, ganja, marijuana, solid, joint, spliff. **Risks -** Psychological dependency, accidents, paranoia. **Other notes** Active constituent: Tetrahydrocannabinol (THC).
Cocaine	**Appearance -** White, slightly crystalline powder. **Method -** Sniffed, smoked or, in extreme cases, injected after being dissolved in water. **Effects -** Increased alertness and pulse rate, increased blood pressure, false sense of high energy and euphoria. **Look out for -** Nervousness, irritability, loss of appetite and weight, prolonged periods of sleep. **Street names -** Coke, blow, C, candy, snow, dust, charlie. **Risks -** Psychological dependency, nasal tissue damage, HIV from needles, blood clots, loss of sex drive. **Other notes -** Derived from the Andean Coca shrub of South America.

Crack cocaine	**Appearance -** White or dark cream 'rock' crystals in various sizes. **Method -** Smoked in pipes or, in extreme cases, injected after being dissolved in water. **Effects -** Increased alertness and pulse rate, increased blood pressure, false sense of high energy and euphoria. **Look out for -** Nervousness, irritability, loss of appetite and weight, prolonged periods of sleep. **Street names -** Crack, rock, freebase, base. **Risks -** Psychological dependency, nasal tissue damage, HIV and hepatitis from needles, blood clots, loss of sex drive, lung damage. **Other notes -** Cocaine is dissolved in water, mixed with a reagent and heated to form crack cocaine crystals.
Ecstasy	**Appearance -** Various coloured and shaped tablets, with or without indented motifs. **Method -** Taken orally. **Effects -** Increase in energy and heightened perception of colour and sound. Some mild hallucinogenic effects. **Look out for -** Lack of coordination, anxious or confused state, paranoia, insomnia. **Street names -** Space biscuits, disco biscuits, pink smarties, china whites, M25s, triple X, love doves, Es, dove, M&Ms, MDMA, shamrocks. **Risks -** Anxiety, panic and confusion, lack of sleep, depression, lethargy, blood clots in lungs. **Other notes** Hallucinogenic amphetamine – MDMA.
GHB and rohypnol (date-rape drugs)	**Appearance -** Colorless, odorless liquid. Sold in small bottles or by the capful, occasionally in tablet form. Rohypnol is often coloured blue. **Method -** Taken orally in small quantities. Used as an adulterant to spike drinks, for sedative effect. **Effects -** Induces sleep, relaxation and intoxication, usually for two to eight hours. Often accompanied by 'blackouts' and memory loss, dizziness, disorientation and nausea. **Look out for -** Sleepiness, loss of memory, dizziness and disorientation. **Street names -** Date-rape drug, R2, rib, roofenol, roofies, blue juice, forget pill, liquid ecstasy, heaven. **Risks -** Associated with rape. Loss of memory. Can produce physical and psychological dependence with frequent use. **Other notes -** Powerful prescription sedative
Heroin (injected)	**Appearance -** White powder in its pure form, but can vary through grey to brown. **Method -** Can be taken orally, but usually sniffed, smoked or injected after being mixed with liquid. **Effects -** Feeling of well-being and drowsiness, some nausea and vomiting. **Look out for -** Burnt pieces of foil or burnt spoons. Paper wraps, torn magazines and home-made tubes, injection marks and equipment. **Street names -** Smack, H, horse, gear, skag, brown, stuff. **Risks -** Often 'cut' (mixed) with unknown substances making it hard to judge doses accurately and leading to overdoses. Highly addictive; unpleasant withdrawal. Needle infections (HIV and hepatitis). **Other notes** An opiate – diacetylmorphine.

Heroin (smoked)	**Appearance -** White powder in its pure form, but can vary through grey to brown. **Method -** Can be taken orally, but usually sniffed, smoked or injected after being mixed with liquid. **Effects -** Feeling of well-being and drowsiness, some nausea and vomiting. **Look out for -** Burnt pieces of foil or burnt spoons. Paper wraps, torn magazines and home-made tubes, injection marks and equipment. **Street names -** Smack, 'H', horse, gear, skag, brown, stuff. **Risks -** Often 'cut' (mixed) with unknown substances making it hard to judge doses accurately and leading to overdoses. Highly addictive; unpleasant withdrawal. Needle infections (HIV and hepatitis). **Other notes -** An opiate – diacetylmorphine.
Ketamine	**Appearance -** Clear liquid, white powder, or tablets. **Method -** Usually 'snorted' but can be smoked with tobacco or marijuana. Larger doses can be injected. **Effects -** Hallucinations, visual distortions, loss of sense of time and identity. Effects last between half an hour and three hours. **Look out for -** White powder or tablets. **Street names -** Vitamin K, super K, special K, K, green. **Risks -** Respiratory failure, unconsciousness. Long-term effect unknown. **Other notes** Ketamine was developed in the early 1960s as a veterinary anaesthetic. Often substituted for or mixed with ecstasy.
LSD	**Appearance -** Tablet or capsule, but more commonly impregnated into paper 'tabs'bearing various designs. **Method -** Taken orally; 'tab' usually placed on tongue. **Effects -** Hallucinations and heightened awareness of colours, sound and light. **Look out for -** Glazed eyes, over-excitement and irrational behaviour. Flashbacks confusion and hallucinations. **Street names -** Acid, blotter, brop, L, Lucy, stars, tab, trip. **Risks** Impaired judgement leading to accidents, panic, and paranoia. Irrational and dangerous behaviour, disturbing behaviour. **Other notes -** Lysergic acid diethylamide, man-made – often in illegal laboratories.
Methadone	**Appearance -** Green syrup-like liquid. Occasionally small white tablets. **Method -** Taken orally or injected. **Effects -** Similar to those of heroin. Feeling of well-being, dilated pupils, reduced body temperature, blood pressure and heart rate. **Look out for -** Often used legally. Otherwise, green liquid or tablets and injecting equipment. **Street names -** Dolly, meth. **Risks -** A dangerous prescription drug which should be taken under medical supervision. Used to control the withdrawal effects of heroin. Addictive, increased sweating and constipation, sexual problems. **Other notes -** Powerful physical/psychological dependency.

Methyl amphetamine	**Appearance -** Clear rock-like crystals in various sizes. **Method -** Smoked in a pipe; crystals are heated until they turn into a gas and then inhaled. **Effects -** Increased alertness, pulse rate and blood pressure, and feeling of high energy. **Look out for -** Similar signs to amphetamine, but more intense. **Street names -** Ice, crystals, crystal meth. **Risks -** Dizziness and loss of co-ordination, collapse and toxic psychosis. Highly addictive; severe withdrawal symptoms. **Other notes -** Made from methyl amphetamine hydrochloride.
Opium	**Appearance -** Brown or black resin from the opium poppy. **Method -** Smoked in pipes, burned on silver paper and inhaled, or in joints. **Effects -** Hallucinations, heightened awareness, calmness and relaxation, constipation. **Look out for -** Glazed eyes, relaxed behaviour, slurred speech and unsteadiness on feet. **Street names -** Poppies. **Risks -** Highly addictive, similar risks to heroin and cocaine. **Other notes -** Raw opium is generally not seen outside Asia and the Orient, but forms the basis of opiate drugs such as morphine and heroin

Appendix 2 – Training needs analysis

Training

For all Trust training please refer to policy HR6 Trust wide policy on learning and development requirements http://www.cwp.nhs.uk/GuidancePolicies/Policies/Humanresources/Pages/default.aspx

Appendix 3 - Equality and diversity/human rights impact assessment

	IS IT RELEVANT?		HOW RELEVANT IS IT?	
	Does the policy include anything that … Eliminates discrimination and/or Promotes equal opportunities (Answer yes, no or N/A for each category listed)	Is there evidence to believe that groups could be treated different- if so, which groups within each category(e.g. under 16 year olds in age category)	How much evidence do you have 1. None or a little 2. Some 3. Substantial	Is there public concern that the policy is discriminatory[1] (Answer yes, no or N/A for each category listed)
Race	NO	NO	N/A	N/A
Gender	NO	NO	N/A	N/A
Disability	NO	NO	N/A	N/A
Age	NO	NO	N/A	N/A
Sexual orientation	NO	NO	N/A	N/A
Religion or beliefs	NO	NO	N/A	N/A

Now evaluate your answers by using the criteria provided and <u>underline</u> which describes your policy

Relevance	Rationale	Monitoring[2]
High relevance	If there is substantial evidence that indicates that groups could be treated differently because of the policy	You need to start monitoring the impact of this policy within a year of it being introduced
Medium relevance	If there is some evidence that indicates that groups could be treated differently because of the policy	You need to start monitoring the impact of this policy within 2 years of it being introduced:
<u>Low relevance</u>	If there is little/no evidence that indicates that groups could be treated differently because of the policy	Impact monitored at least every 3 years

[1] Could be gauged from surveys, audit data, complaints etc,

[2] Policy Reviews Group working with Equality & Diversity/Human Rights Group must monitor the impact of policies through the following channels: results from the national service user survey, the national mental health and ethnicity census, complaints data, PALS feedback, individual systems within clinical services through which ward and community staff liaise with service users and carers i.e. ward meetings, modern matron meetings

[4] This assent will be reviewed by the Equality and Diversity/Human Rights group

Human Rights
When developing any policies, policy writers should ask themselves 'does the policy engage/restrict anyone's Human Rights?'

<table>
<tr><td>What is the Convention of Human Rights?</td><td>There are 16 basic rights in the Human Rights Act, all taken from the European Convention on Human Rights. There are 3 types of rights detailed as follows:
<table>
<tr><td>Absolute- <u>cannot opt out of these rights under any circumstance</u>- cannot be balanced against any public interest</td><td>– Right to life
– Prohibition of torture
– Prohibition of slavery and forced labour
– No punishment without law
– Right to free elections
– Right to marry
– Abolition of the death penalty</td></tr>
<tr><td>Limited- these rights are subject to predetermined exceptions</td><td>– Right to liberty and security
– Right to a fair trial</td></tr>
<tr><td>Qualified- these rights can be challenged in order to protect the rights of other people</td><td>– Respect for private and family life
– Right to Freedom of thought, conscience and religion
– Freedom of expression
– Freedom of assembly and association
– Prohibition of discrimination
– Protection of property
– Right to education</td></tr>
</table></td></tr>
<tr><td>Where can I get more information about this?</td><td>More details can be found at the Department of Constitutional Affairs (DCA)
http://www.dca.gov.uk/peoples-rights/human-rights/publications.htm
<u>Publications</u>
DCA (Oct 2006) Human rights: human lives – a handbook for public authorities, crown copyright
DCA (Oct 2006) Making sense of human rights – a short introduction, crown copyright
DCA (Oct 2006) A Guide to the Human Rights Act 1998, crown copyright</td></tr>
<tr><td>What should I do if I suspect my policy affects anyone's Human Rights?</td><td>You should forward for discussion at the Trustwide Equality and Diversity and Human Rights Group within the Trust- contact Director of Operations, executive lead for Equality & Diversity and Human Rights</td></tr>
</table>

Please tick one of the following

The above has been considered and to the best of my knowledge my policy **<u>does not affect</u>** any of the human rights listed	✓
The above has been considered and my policy does affect a human right article(s) but this has been discussed and 'qualified' at Trust Equality and Diversity and Human Rights Group	