

# Substance Misuse Policy

## NHS GG&C Mental Health Service

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**Important Note:**

**The Intranet version of this document is the only version that is maintained.**

Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

## Revision/Amendment Information

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	May 2005		
2.0	Apr 2017	Updated version, Improved scope, refined aims. Updated terminology. Added definitions. Added Role of additional agencies. Removed repeated information. Updated disposal forms and communication flow.	Dr Beate Beck-Schwahn, Frank McGuigan, Charlie Sellar
2.1	Oct 2018	Section 7.1, page 5 - Added consent statement	Charlie Sellar
3.0	Dec 2020	Updated terminology.	Dr Beate Beck-Schwahn Steven McCulloch

## Contents

1.	Policy Statement.....	4
2.	Scope .....	4
3.	Aims .....	5
4.	Definitions.....	6
	4.1 Substance .....	6
	4.2 Drug .....	6
	4.3 Illicit drug .....	6
5.	Background .....	6
6.	General Principles .....	6
7.	Consent & Confidentiality.....	7
8.	Illicit Substances and the Admission Process .....	8
9.	Suspected Substance Misuse .....	9
10.	Confirmed Substance Misuse .....	9
11.	Disposal of Suspected or Confirmed Substances.....	10
12.	Exclusion of Visitors.....	10
13.	Legal Guidance .....	10
14.	Role of Other Agencies.....	11
15.	Supervision/Review of Incident/s De-brief .....	11
16.	References/Bibliography .....	12
17.	Appendix 1 - Scottish Legal Obligations .....	13
18.	Appendix 2 - Summary of Section 8 Misuse of Drugs Act 1971 .....	14
19.	Appendix 3 - Meaning of Drug Trafficking.....	16
20.	Appendix 4 - Communications Flow Diagram .....	17
21.	Appendix 5 - Disposal Process .....	18
22.	Appendix 6 - Sample Inpatient Destruction Form .....	19

## 1. Policy Statement

This policy seeks to address the fact that substance use can pose particular difficult clinical and managerial problems when presented on NHS Greater Glasgow & Clyde's (NHS GG&C) premises.

This Policy is not concerned with the moral or ethical judgement on the use of illegal drugs, but concerns usage by patients or visitors whilst on NHS GG&C property.

*Patients have a right to receive care in a safe environment, free of substance use. There is evidence that indicates **'the use of illicit and non-prescribed drugs and alcohol by psychiatric patients may exacerbate symptoms, trigger relapse into acute phases of illness and lead to self-harm or violence to others, sometimes with tragic consequences. Services have a responsibility to help those already using substances, prevent others from becoming involved and protect the safety of patients, visitors and staff'***

(Department of Health 2002).

## 2. Scope

This policy applies to all clinical staff working within NHS GG&C Mental Health & Associated Services (MHAS). This includes Adult and Older Adult Mental Health, Learning Disabilities, Primary Care Mental Health, Alcohol and Drug Recovery Services, Forensic & Specialist Services.

This policy includes the use of substances by visitors and carers whilst on NHS property. Scope of the policy also includes the use of alcohol and non-prescribed medication by patients whilst under our care as this may render them less responsive to treatment and may interact with prescribed medication.

This policy should be read and considered in conjunction with the following MHS Clinical Policies & Guidelines:

- MHS 03 – Adult Mental Health and Addiction Services shared Guidance and Specification for Interface Working
- MHS 06 – Confidentiality and Consent: Best Practice Guide
- MHS 07 - CRAFT Clinical Risks Screening and Management Policy
- MHS 19 - Mental Health Services Personal & Environmental Search Policy
- MHS 24 – Specified Person Policy
- GGC 10 - Policy for the Management of Violence and Aggression.

### 3. Aims

***The primary aims of this policy are to:***

- Provide an environment as free from substances that could be used problematically as possible. Action should be aimed at making wards drug and alcohol free rather than accepting that their presence is inevitable (Department of Health 2006)
- Provide a procedure to help control substance use on hospital premises, combined with therapeutic approaches and support (Health Advisory Service, 2001)
- Ensure all patients are treated with dignity and respect, taking into account individual needs, the needs of society and the needs of the organisation, and encouraging the individual patient to participate in their treatment programme

***These primary aims of this policy will be met by:***

1. Ensuring that NHS GG&C MHAS premises are not used for the supply, possession or use of illegal drugs or other substances.
2. Enable NHS GG&C to identify, and help any patients who have problems related to the use of drugs or alcohol. Offer in-depth and appropriate interventions/guidance to all patients who report substance use or are believed to be using substances or are at risk of misusing substances
3. Protect patients, public and other staff from detriment or risk through use of substances.
4. Prevent the use of illicit drugs, non-prescribed medication, substances with known psychotropic effects and alcohol on NHS GG&C premises
5. Prevent the use or supply of suspected illicit or illegal non- prescribed drugs.
6. Provide guidance to staff on the correct course of action if they suspect a patient is in possession of a substance whilst on NHS GG&C premises.
7. Ensure patients found to be in possession of a substance receive appropriate care.
8. Protect patient confidentiality whilst protecting the needs of the community, working within the Misuse of Drugs Act 1971 and assisting the Police in accordance with the Crime and Disorder Act 1998.
9. Confirm the responsibilities of staff regarding the confiscation of illegal drugs to protect both NHS GG&C as an employer, and individual staff members as employees of NHS GG&C, from potential legal liability under the Misuse of Drugs Act 1971.
10. Clarify action staff should take when substances are, or may be, present to protect themselves personally (e.g. from assault by an aggressive patient or visitor) and legally (from litigation by a patient or visitor).
11. Provide guidance on the appropriate action to take where substances are, or are suspected of being present on NHS GG&C premises.

12. Ensure staff have the knowledge, skills and attributes to work with patients who use substances, or are at risk of such use and to offer appropriate care to address identified needs promptly
13. Ensure that staff respond to substance use issues in a safe, effective and sensitive way with due regard to the patient's wellbeing

## **4. Definitions**

### **4.1 Substance**

A general term used in the context of the guideline to describe a matter with known or unknown effect on body and mind.

### **4.2 Drug**

A substance which alters the way in which the body or mind works. The term applies to drugs controlled under the Misuse of Drugs Act (1971), the Psychoactive Substances Act (2016), prescribed drugs, over the counter medication, solvents and other substances with known psychotropic effects.

### **4.3 Illicit drug**

Refers to drugs controlled under the Misuse of Drugs Act (1971)

## **5. Background**

- 5.1 Many people who misuse drugs are treated each year in Greater Glasgow & Clyde's hospitals, health centres and other premises, either as a direct result of substance misuse or for other reasons. Patients with co-existing mental health and substance misuse problems present many challenges for health care staff. It is acknowledged that, as a group, people with dual diagnosis are more difficult to manage and treat because of their complex needs.
- 5.2 This guidance presents information and care approaches to ensure safe and effective clinical care is delivered to people, and that the service is responding sensitively to the needs of families/carers. The policy covers the roles of multidisciplinary team members including nurses, pharmacists and medics. It also highlights the role of external agencies, particularly the police.
- 5.3 This policy covers patients in all services, but the interventions referred to are mainly aimed at those with a primary diagnosis of mental illness who also have problems with substance use. This includes patients with a dual diagnosis of mental illness and substance misuse disorder, and those without a diagnosis of substance misuse but whose substance use may worsen their mental illness and hamper treatment and recovery

## **6. General Principles**

- 6.1 Upon engagement with Mental Health Services, patients and their relatives/friends/carers should have the relevant policies and expectations of

the service clearly explained to them by staff, including information specific to substances prohibited on NHS GG&C premises. This should always be reinforced by written information in the form of an information leaflet. This information leaflet should clearly outline the NHS GG&C Service's policy statement on substance misuse.

- 6.2 Consideration must also be given to the support needs of relatives/friends and carers. Written information about support organisations and networks for families and friends of those with a substance use problem should be available in clinical areas.
- 6.3 Involving relatives, friends or carers can be beneficial as part of a planned package of care, and they should be viewed whenever possible as part of the treatment team. Feedback on progress from relatives/friends/carers may be sought at regular intervals to help inform clinical decision-making. The informed consent of the patient on the level of involvement from relatives/friends/carers should always be sought and recorded in the person's clinical notes.
- 6.4 The role of harm reduction and health improvement education is crucial, and should be considered from the perspective of both individual patients and their families.

## **7. Consent & Confidentiality**

- 7.1 Health professionals must ensure that before they commence any treatment or intervention that they discuss:
  - The prognosis.
  - The various treatment options and their benefits (including the option of not to treat).
  - The individual circumstances and preferences of the patient (Montgomery).
  - The risks associated with the intervention (consider significant risks, risks which are less severe but which occur frequently and risks which this patient may attach significance to (Montgomery)).
  - The alternatives available.
  - Additional procedures, including those which may become evident at a later stage.
- 7.2 When sharing information with relatives, friends and or carers, general rules of sharing information and maintenance of confidentiality should always apply and all inpatients are asked to notify staff of their wish for information to be shared with family/carers etc. on admission – with the completion of a relevant consent form at this time.
- 7.3 Regard should always be taken to the latest available guidance from professional bodies, such as the Nursing and Midwifery Council or General Medical Council, or from national publications such as the NHS Code of Confidentiality.
- 7.4 Staff should be aware of the exceptions to the confidentiality provisions of the Data Protection Act 1998, which allow confidential information to be shared

for the purposes of preventing or detecting a crime, and for the apprehension or prosecution of offenders.

- 7.5 There are a number of statutes and circumstances that require disclosure of information to the police. While there is no general legal requirement upon care staff to assist police, it is important to note that health care/medical staff have not been granted immunities. Wherever possible senior managers should be involved in the decision to disclose information to Police Scotland. Advice should be sought in the first instance from the Lead Nurse/Locality Manager.
- 7.6 For the NHS, the Caldecott Guardian can also advise on the disclosure of confidential information. For the NHS Greater Glasgow & Clyde Mental Health & Associated Services this is **Dr Emilia Crichton**, Interim Director of Public Health.

## 8. Illicit Substances and the Admission Process

- 8.1 Understandably in the instance of confirmed drug misuse, there is an emphasis on appropriate procedure re confiscation & disposal of any illicit substance, may need to involve police, legal issues applying to staff and informing senior clinicians/managers and reviewing clinical input. This includes the question of discharge. Although these procedures are not intended to be punitive in nature, how they are experienced by those involved depends greatly on how they are carried out, as well as on staff approach. This may present a threat to any established therapeutic relationships. In reviewing the clinical care needs it could be worth emphasising the need for extra effort on behalf of clinicians to maintain therapeutic relations and consider whether the situation offers an opportunity for a motivational intervention.
- 8.2 During the admission process, an explanation must be given by the admitting staff that drugs not prescribed by the ward doctor are not allowed on the ward. This should be backed up by written information, ideally as part of the ward information leaflet. This information is also clearly documented within the inpatient agreement which all patients are asked to agree/sign on admission. The same principles apply for community resource centers and day hospitals.
- 8.3 This policy applies to any visitor, who will be asked to leave the premises should they be considered under the influence of illicit substances, or bringing illicit substances onto the premises. Consideration should be given to contacting the police should the person refuse to leave the premises when requested.
- 8.4 Searching is a sensitive, but important part of risk management/reduction and can be a significant contributor to creating and maintaining a safe environment. When a search of the person and/or their property is being planned, then staff should refer to the MHS 22- Personal & Environmental Search Policy.
- 8.5 The completion of a clinical risk assessment and management plan is an integral component of the admission assessment, and will aid the identification of risk factors associated with substance use.
- 8.6 When prohibited substances are discovered or handed over by the patient it needs to be made clear that under no circumstances will the substance ever

be returned? This will be recorded in the clinical record. The substance will be disposed of at the earliest opportunity.

## **9. Suspected Substance Misuse**

- 9.1 If a nurse/team member suspects that a patient is using substances, they should discuss their concerns immediately with the nurse in charge of the ward/area. A senior member of staff (in the first instance the senior charge nurse or Senior Nurse Manager/page holder) should be notified and the concern documented in the patient record. A revised plan of care should be formulated as soon as possible, which should include a review of risks and outlines the management of suspected substance misuse.
- 9.2 Changes to the plan of care should be made with the involvement of the patient concerned and their carers/family if practicable.
- 9.3 It should further be established whether immediate medical attention is required and consideration given to increased clinical observation as part of the reviewed care plan.
- 9.4 Screening for substance misuse can be a helpful part of a routine admission/assessment option and can be offered compassionately as part of a robust mental health assessment. Urinalysis for drug screening can help identify problematic drug use and encourage brief psychosocial interventions and/or engagement with addictions services.

## **10. Confirmed Substance Misuse**

- 10.1 Discharge or transfer may not always be possible or appropriate despite use of substances on health service premises being confirmed.
- 10.2 In such cases treatment and care plans should be re assessed with a view to any necessary added vigilance and supervision required. Discharge or transfer decisions should not be taken lightly and should always be informed by clinical risk assessment.
- 10.3 If discharge or transfer is being considered every step should be taken in advance of the final decision with regard to continuing care and support necessary to maintain the individual after discharge/transfer. This must include medical review which should always be sought before any decision to discharge is made. It may also be useful to highlight that if the patient declines to await medical review - and that nursing staff have no immediate concerns – the patient should be asked to agree/sign the 'Against Medical Advice Discharge Form' – with further community follow up at the earliest opportunity – and updated CRAFT risk assessment, All disciplines that would be involved in providing support on discharge should be included in both the decision making process and any resulting interventions. The following should be considered as part of a review:
  - 10.4 The individual's mental and physical state and social circumstances

- 10.5 The seriousness and the extent of the problem, including potential evidence of possession or trafficking or other offences
- 10.6 The risk of harm to self or others including child protection concerns and adult protection issues
- 10.7 Importance of engagement with person centred visiting and leave during stay in in-patients.
- 10.8 Planned follow up arrangements following transfer/discharge.
- 10.9 Legal status – e.g. if the patient is restricted (CPSA -59, MHSA –72), then the Scottish Government would have to be advised of the incident and subsequent management plan

## **11. Disposal of Suspected or Confirmed Substances**

- 11.1 The communications flow diagram Appendix 4 should be followed if substances are found or supply suspected.
- 11.2 The process for the disposal of suspected or confirmed substances is outlined in the algorithm attached in Appendix 5 of this guideline
- 11.3 Forms that require to be completed by nursing and pharmacy staff as part of the disposal procedure are appended to this guideline Appendix 6.

## **12. Exclusion of Visitors**

- 12.1 In the context of suspected or confirmed substance misuse, visitors may be excluded from the premises if by their actions and behavior they are endangering the care or safety of patients and/or staff. This could include substance misuse on the premises or suspected or confirmed supplying of drugs, alcohol or other prohibited substances.
- 12.2 Any decisions to exclude visitors should be taken following full discussion with the clinical team. The rationale for the decision should be clearly documented in the patient record of the patient who had been receiving that visitor.
- 12.3 The clinical team must involve local police if illicit drug use/supplying is suspected or confirmed.

## **13. Legal Guidance**

- 13.1 Section 5(4) of the Misuse of Drugs Act 1971 provides circumstances for a defence for staff who take possession of an individual's illegal drugs. . Section 11 of the Psychoactive Substances Act 2016 provides for exceptions to offences as detailed under schedule 2 including "Healthcare related activities".
- 13.2 With all drugs, it is a legal defense for staff who receives suspected illicit drugs into their possession to prevent another person committing a crime, or for the purpose of delivering it into lawful custody. Staff must be able to prove that as soon as possible after taking possession, all such steps were taken

as necessary to deliver the drugs into lawful custody, or destroy them, as appropriate to the circumstances.

13.3 In a community setting police advice should be sought immediately if the patient is found in possession of a suspected/confirmed illicit substance.

13.4 Under the Misuse of Drugs Act 1971, those in charge of premises have a duty to inform the police if they believe that anyone is committing an offence on their premises.

13.5 Managers could be liable to prosecution if they knowingly allow such activity to take place. This is well documented in the wintercomfort case, when, in 1999, two day centre managers were convicted of knowingly permitting the supply of a class A drug on their premises, despite the courts acknowledging that they had not been involved in or benefited from the drug dealing that took place.

## **14. Role of Other Agencies**

Involvement of specialist services or other support agencies should be considered in the management of substance use. Where it is felt to be necessary to involve other agencies, the patient's consent to invite these services to a joint care planning process should be obtained and recorded in the care plan.

Involvement of Alcohol and Drug Recovery services should always be considered for the management of patients with alcohol and substance misuse problems in order to provide the best possible care. Services can be accessed via the ADRS or Addiction Liaison Services. For referral information please see [MHS 03 - Adult Mental Health and Addictions Services Shared Guidance and Specification for Interface Working](#)

As highlighted in 13.4 the police services have to be involved if it is believed that an offence is committed on our premises. This refers to the suspected or confirmed supply and consumption of illicit drugs under the Misuse of Drugs Act 1971 on NHS GG&C's premises.

## **15. Supervision/Review of Incident/s De-brief**

15.1 Supervision is essential for helping all staff deal with the issues that can arise from working with people who have substance use or dependence problems. There should be a system in place for reflective practice and mechanisms for reviewing critical incidents.

15.2 In the case where materials found on the service user are going to be kept as evidence, staff must have the opportunity to discuss this and have the opportunity to de-brief and generally receive support from their manager.

15.3 In situations where staff are concerned about intimidation or reprisals following an incident concerning illicit drugs, police advice and involvement should be sought in order to provide an additional tier of support.

## 16. References/Bibliography

Psychoactive Substance Act 2016

Available at:

[http://www.legislation.gov.uk/ukpga/2016/2/pdfs/ukpga\\_20160002\\_en.pdf](http://www.legislation.gov.uk/ukpga/2016/2/pdfs/ukpga_20160002_en.pdf)

Misuse of Drugs Act 1971

Available at: <http://www.legislation.gov.uk/ukpga/1971/38/introduction>

Drug Trafficking Act 1994

Available at: <http://www.legislation.gov.uk/ukpga/1994/37/contents>.

NHS Quality Improvement Scotland (2005) *Clinical Governance & Risk Management: Achieving Safe, Effective, Patient-Focused Care and Services – National Standards*. Edinburgh: NHS Quality Improvement Scotland 2005.

Available at [http://www.nhshealthquality.org/nhsqis/files/CGRM\\_CSF\\_Oct05.pdf](http://www.nhshealthquality.org/nhsqis/files/CGRM_CSF_Oct05.pdf) .  
SACDM and SACAM (2003) *Mind the Gaps:*

*Meeting the Needs of People with Co-occurring Substance Misuse and Mental Health Problems.*

Report of the joint working group. Edinburgh: Scottish Executive.

## 17. Appendix 1 - Scottish Legal Obligations

Scottish Executive Health Department, May 2002

### *Legal Obligations to Disclose Information -Hunter v. Mann*

A doctor was prosecuted and convicted for refusing to release information about one of his patients in the case of *Hunter v. Mann* (1974) 10.8.767. The doctor had been asked by a patient to treat the patient's girlfriend who had been in a car accident. The doctor advised both parties to inform the police, but did not raise the matter of whether he might disclose their identity if approached. He was contacted later by the police in connection with a stolen car which had been involved in an accident in which both driver and passenger had run away. The doctor refused to release the information about his patients on the basis that this would be a breach of professional confidence. Section 168(2) of the Road Traffic Act 1972 (now Section 172 of the Road Traffic Act 1988) stated that 'any person shall if required give any information which it is in his power to give and may lead to the identification of the driver'. The doctor was prosecuted and convicted under this section in the Magistrates Court. His appeal was dismissed by the appeal Court on the basis that he was not being asked to disclose any confidential information but merely information which might lead to identification.

### *Legal Obligations to Disclose Information -W v. Egdell*

Disclosure can be justified if it is considered to be necessary in the public interest. *W v. Egdell* (1989) 1 All ER1089, involved a patient was detained in a secure hospital without limit of time following the knifing of five people and the wounding of two others. Ten years later he applied to a Mental Health Review Tribunal to be discharged or transferred. This application was opposed by the Secretary of State. The solicitors on the part of W instructed Edgell, a consultant psychiatrist, with a view to preparing a report which could be used in support of the application. In fact, the report strongly opposed the application, and expressed concerns at the patient's likely release or transfer. The consultant psychiatrist assumed that W's solicitors would place the report before the tribunal. This was never done, as the solicitors withdrew the application, but Edgell, on learning that a report had not been disclosed contacted the medical director of the hospital and eventually forwarded to them a copy of the report in order that W's further treatment could be assessed. The hospital then forwarded a copy to the Secretary of State, who in turn sent it on to the Tribunal. On discovering the disclosure of the report W issued a writ against Edgell seeking an injunction restraining the use of the report and damages for breach of confidence. This application was refused on the basis that the duty of confidentiality to the patient was subordinate to the public duty to allow the proper assessment of W's mental condition. On appeal, the Court of Appeal came down in favour of the disclosure of the report given the number and nature of the killings and the need to provide those responsible for W's treatment and management with the fullest relevant information concerning his condition.

## 18. Appendix 2 - Summary of Section 8 Misuse of Drugs Act 1971

MHS 13 – Substance Misuse Policy Scottish Executive Health Department, May 2002

### *Summary of Section 8 of the Misuse of Drugs Act 1971*

'It is an offence if the occupier or person concerned in the management of any premises knowingly permit or suffer any of the following activities to take place on those premises:

- a) Producing or attempting to produce a controlled drug
- b) Supplying or attempting to supply a controlled drug, or offering to do so
- c) Preparing opium for smoking
- d) Smoking cannabis, cannabis resin or prepared opium'

### *Definition of 'person concerned in management'*

According to one authority, 'management' imports the notion of control over the running of the affairs of an enterprise, venture or business. In order to be concerned in the management, it is enough to share, or assist in, the running of the premises.

### *Definition of 'premises'*

The word 'premises' is not defined in the Misuse of Drugs Act and the courts have experienced difficulties in apply the word to actual situations. A definition of premises is contained in Section 23 of the Police and Criminal Evidence Act 1984. It includes 'any place and, in particular, any vehicle, vessel, aircraft, hovercraft, tent or movable structure'. It also includes any offshore installation as defined in Section 1 of the Mineral Workings (Offshore Installations) Act 1971.

A further useful definition of the word is to be found in Section 12 of the Criminal Law Act 1977. This states that 'premises' means any building, any part of a building under separate occupation, any land ancillary to a building, the site comprising any building or buildings together with any land ancillary thereto. Clause 187 of the Draft Criminal Code Bill contains an identical definition.

Based on these definitions, it would be argued that a hospital manager, knowing that a patient is smoking cannabis inside a marquee in hospital grounds, will be guilty of an offence contrary to Section 8 (d). Unfortunately, the courts have yet to rule on this point. Similarly, the legal position is unclear if a hospital manager knowingly allows passengers to smoke cannabis in a hospital minibus.

### *Definition of 'knowingly permit' and 'suffer'*

The words 'permit' and 'suffer' mean the same thing. Both words clearly imply knowledge of the relevant activity. (See Thomas (1976) 63 Cr.App.R.65).

In addition to the statutory obligations placed on managers by Section 8 of the Act, managers are encouraged to contact police in cases where drug trafficking offences

have been committed on hospital premises. 'Drug trafficking offences' are defined in Section 1 of the Drug Trafficking Act 1994, and include:

- Production
- Supply, and possession with intent to supply
- Importation and exportation of controlled drugs

## 19. Appendix 3 - Meaning of Drug Trafficking

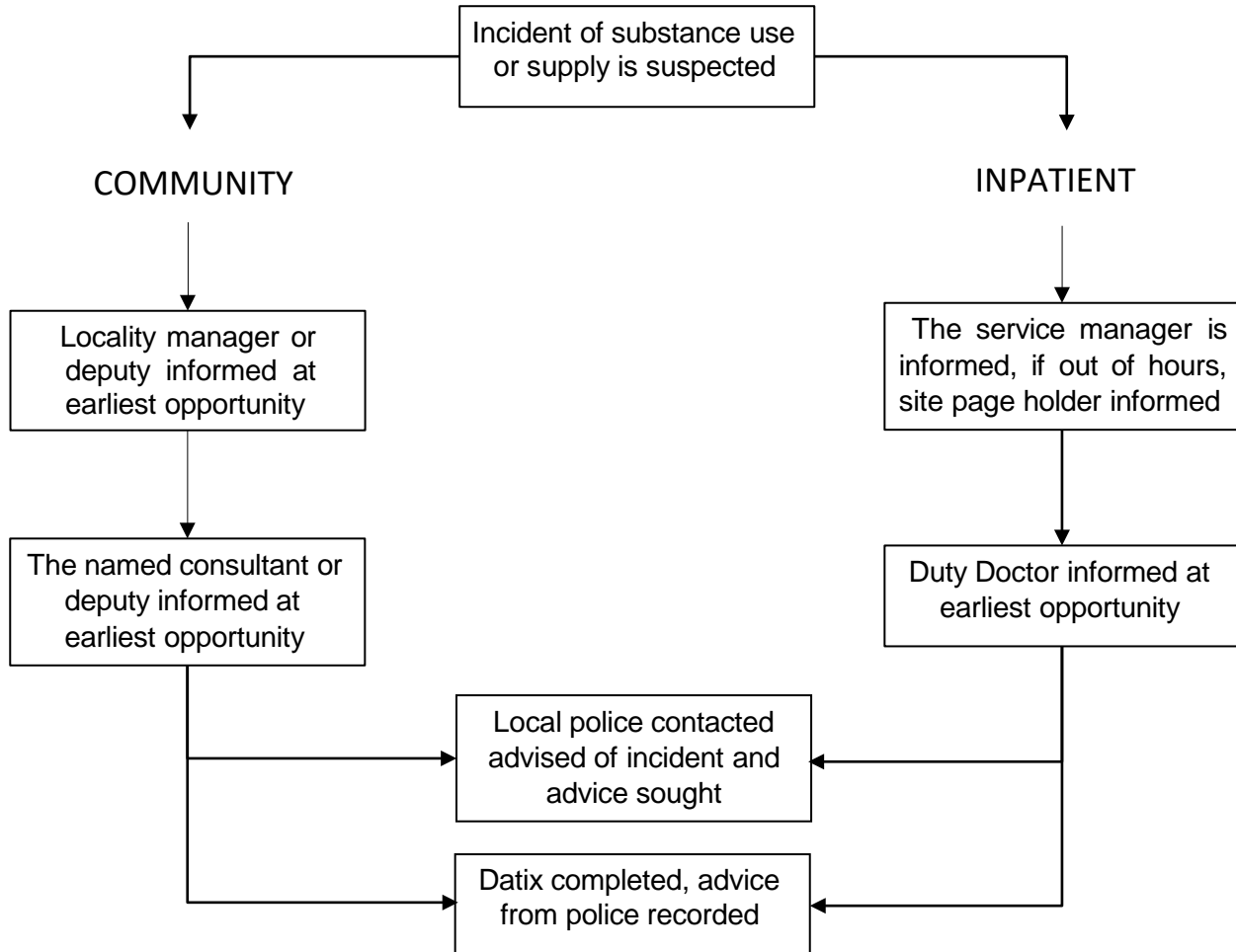
Scottish Executive Health Department, May 2002

### Meaning of Drug Trafficking

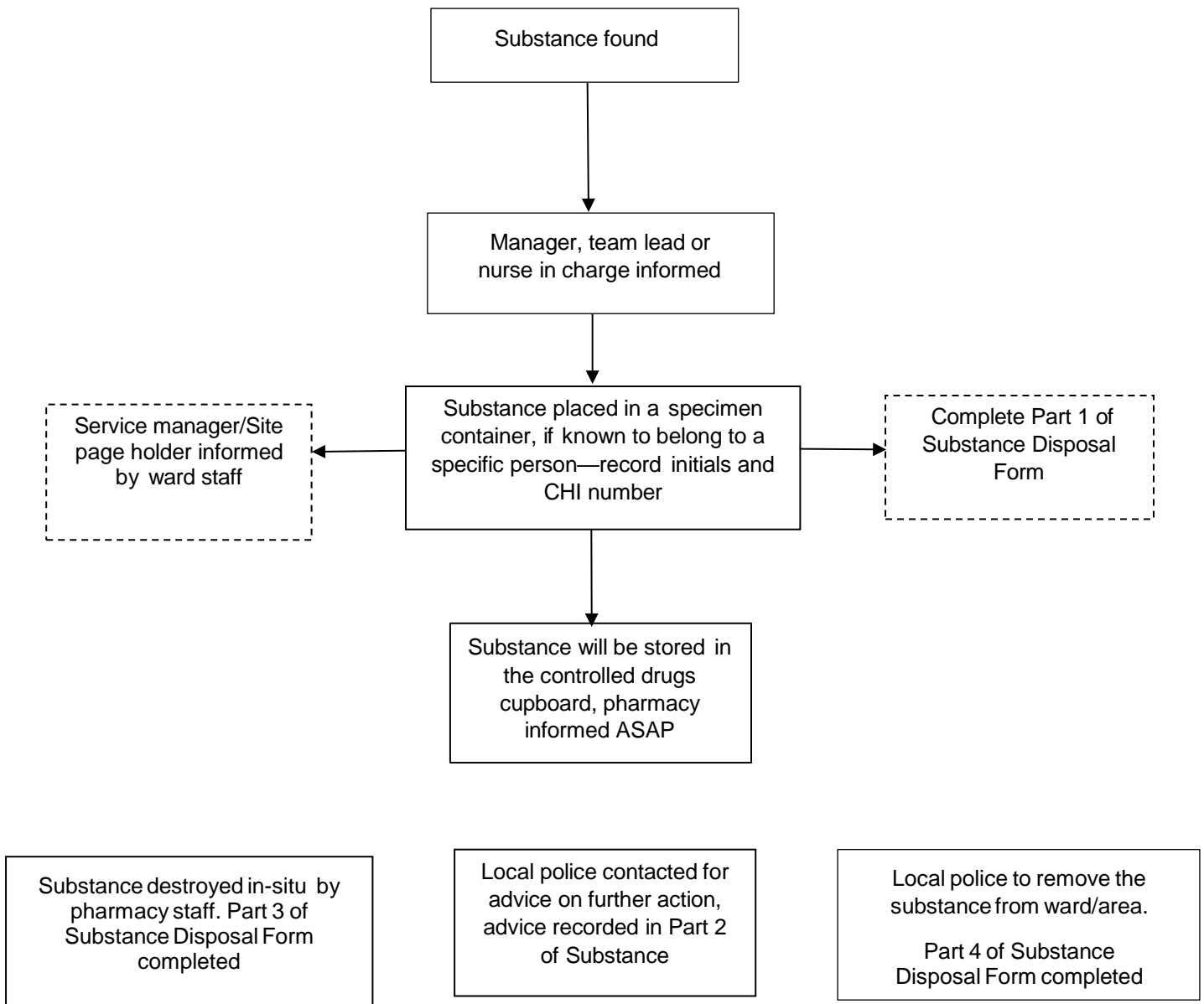
In Section 1 (3) of the Drug Trafficking Act 1994 'drug trafficking offence' means any of the following:

- a) An offence under Section 4(2) or (3) or 5(3) of the Misuse of Drugs Act 1971 (production, supply and possession for supply of controlled drugs)
- b) An offence under Section 20 of that Act (assisting in or inducing commission outside United Kingdom of offence punishable under a corresponding law)
- c) An offence under:
  - Section 50(2) or (3) of the Customs and Excise Management Act 1979 (improper importation)
  - Section 68(2) of that Act (exportation)
  - Section 170 of that Act (fraudulent evasion)
- d) An offence under Section 12 of the Criminal Justice (international Co-operation) Act 1990 (manufacture or supply of substance specified in Schedule 2 to that Act)
- e) An offence under Section 19 of that Act (using ship for illicit traffic in controlled drugs)
- f) An offence under Section 49, 50 or 51 of this Act or Section 14 of the Criminal Justice (International Co-operation) Act 1990 (which makes, in relation to Scotland and Northern Ireland, provision corresponding to Section 49 of this Act)
- g) An offence under Section 1 of the Criminal Law Act 1977 of conspiracy to commit any of the offences in a) to f) above
- h) An offence under Section 1 of the Criminal Attempts Act 1981 of attempting to commit any of those offences
- i) An offence of inciting another person to commit any of those offences, whether under Section 19 of the Misuse of Drugs Act or at common law and includes aiding and abetting, counselling or procuring the commission of any of the offences in a) to f) above.


## 20. Appendix 4 - Communications Flow Diagram



## 21. Appendix 5 - Disposal Process



## 22. Appendix 6 - Sample Inpatient Destruction Form

NHS Greater Glasgow & Clyde - Mental Health Services			
<b>Substance Disposal Form</b>			
Name (if known)		CHI No.	
<b>Part 1 – Demographics &amp; Substance</b>			
Hospital/Site		Date found	
Ward/Area		Time found	
Found by		Designation	
Reported to		Designation	
<b>Substance Found</b>			
Form		Location	
Colour			
Quantity			
<b>Part 2 - Police Contact</b>			
Police Station		Date & time contacted	
Name of Officer		Badge number	
Advice given		Recorded by	
		Designation	
<b>Part 3 – Destruction by Pharmacy</b>			
I, ....., confirm that I have destroyed the substance in an authorised manner.			
<input type="checkbox"/>			
Pharmacy signature		Date	
Witnessed by		Time	
<input type="checkbox"/>			
<b>Part 4 – Collection by Police (if required)</b>			
Name of Officer & Badge No		Date & time	
Signature			
Witness name & designation		Date & time	
Signature			
White Copy – Ward/Patient      Pink – Pharmacy Department      Blue – Police (if required)			