



**ASSOCIATION OF CHIEF POLICE OFFICERS OF ENGLAND, WALES AND
NORTHERN IRELAND**

SUBSTANCE MISUSE AND TESTING - POLICY AND GUIDANCE DOCUMENT

STATUS:

At its meeting on 6 September 2007 ACPO cabinet agreed to accept this policy and to recommend to Chief Constables that they adopt it for implementation as appropriate in their forces. This Guidance is fully within the public domain and subject to copyright.

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FOREWORD

Substance Misuse Compulsory Testing of Police Officers

Over the last 4 years the service has worked with the Home Office to secure compulsory powers to test police officers for substance misuse. The arrangements represent a significant advance on our current position providing the first comprehensive substance misuse testing regime for the police service.

The Home Secretary accepted the recommendations of the PABEW in October 2004, which enables:

- Pre-employment screening;
- Testing in the probationary period;
- Testing with cause; and
- Screening in specialist and safety critical posts

The testing will aim to detect the illicit use of Amphetamines, Ecstasy, Cannabis, Cocaine, Opiates (e.g., Morphine and Heroin), and Benzodiazepines.

In addition officers will be considered unfit for work in safety critical posts if they have more than 29mg of alcohol in blood (or equivalent in urine and breath) and as such officers in these roles will be liable for alcohol testing.

The relevant legislation / protocols were established on the 7th November 2005.

Following consultation with the Police Staff Council and the Trade Union side, this policy is also written to include police staff fulfilling the same criteria as set out for officers. Non-Home Office Forces will not be covered by the existing Regulations.

The safety of officers, staff and the public is the key driver and thus these additional powers will add further to the 'duty of care' placed on the police service.

It is therefore essential that forces introduce Compulsory Substance Misuse Testing at the earliest available opportunity.

The implementation is based on the assumption that forces have in place arrangements to facilitate and support self-reporting by officers and staff of substance misuse problems.

Regional representatives on the ACPO Counter Corruption Advisory Group (ACCAG) and the National Complaints and Discipline Group are briefed in more detail to enable them to give further advice and support.

Matters relating to medical issues and support for all officers and staff are within the remit of the Joint Advisory Group (JAG) of Health, Safety / Occupational Health Portfolio under the Workforce Development Business Area. If further information is needed, a referral should be made back to the JAG via the portfolio holder for 'A Healthier and Safer Workforce'.

1

SUBSTANCE MISUSE AND TESTING POLICY

- 1.1 The police service is committed to providing a safe, healthy and productive working environment. Alcohol and Drug misuse includes the use of illegal drugs, the misuse of prescribed drugs, non-prescribed preparations and the consumption of alcohol leading to impaired performance. The misuse of alcohol and drugs can lead to reduced efficiency, increased risk of accidents, increased sick leave, potential misconduct and criminality. This can have serious consequences for individuals, their families and the wider police service. It is for these reasons that the Association of Chief Police Officers (ACPO) have developed this policy.
- 1.2 The Association of Chief Police Officers does not approve of the excessive or inappropriate use of alcohol or the misuse of drugs, whether illegal or prescribed. Possessing and supplying illegal drugs are criminal offences. The Police Code of Conduct makes it clear that officers should present themselves as 'fit for duty'. Police Staff, whilst not having a national code of conduct, are governed by local codes and policies, which generally reflect the police codes. Both enable the organisation to take disciplinary or misconduct proceedings where appropriate. However, the Service recognises the difficulty of breaking a cycle of dependency and will offer help to those who volunteer that they may have a drink or drug misuse problem. Where officers or staff recognise that they need help, the primary aim of the service should be to support and assist that person as far as is possible.

2

GUIDANCE FOR APPLICATION OF THE POLICY

- 2.1 The aims of this policy are to create a climate where all police officers, police staff and members of the Special Constabulary recognise the need to create an environment where substance misuse is not tolerated and staff feel a genuine obligation towards openness and transparency when reporting such breaches of professional standards. This motivation arises from a desire to maintain the integrity of the police service and with the knowledge that such action will be universally acknowledged as right.
- 2.2 This policy is aimed at all members of the police service, and could also include volunteers in safety critical or vulnerable posts. The application of this policy is also intended to improve confidence in the police service amongst the community it serves.
- 2.3 When applying the policy, forces should carefully consider the issues of proportionality. Each case, whilst conforming to the policy and guidelines, must be considered on its individual merits.
- 2.4 For the effective introduction of local drug screening processes, the guidance covered in **appendix G**, will require local consultation with the staff associations / trades unions and must be published widely to the Force prior to introduction.

3

PURPOSE OF THE POLICY

- 3.1 The purpose of the policy is to ensure that: -

- All officers and staff are made aware of their responsibilities regarding alcohol and drug related problems.
- Officers and staff who have an alcohol or drug related problem are encouraged to seek help, in confidence, at an early stage, prior to any request of a sample.
- Officers and staff who volunteer an alcohol or drug related problem are dealt with sympathetically, fairly and consistently.
- That appropriate, effective and legitimate processes are in place to test officers and staff for substance misuse.

4

AIMS OF THE POLICY

4.1 In addition this policy aims to: -

- Increase awareness of the effects of alcohol and drugs and of the likely symptoms of misuse. This should include the provision of information for supervisors about dealing with people who have drug or alcohol related problems.
- Assist officers and staff to seek help in confidence at the earliest opportunity.
- Provide, wherever possible, a mechanism to assist officers and staff to return to full health.
- Ensure an effective testing regime is in place

4.2 The Police Service is committed to providing a citizen focused service, which responds to the needs of individuals and communities and inspires trust and confidence in the police.

4.3 The Service seeks to reassure all communities through a robust and transparent approach to professional standards issues. This key area of policy ensures that the Service acts appropriately in order to maintain the integrity of the organisation.

5.0 **HUMAN RIGHTS & RACE RELATIONS ACT CONSIDERATIONS**

5.1 **Human Rights**

5.11 This policy may impact on the rights of individuals with interference of an individual's rights under Articles 3, 5, 8 and 11 of the First Protocol of the European Convention on Human Rights, as embodied in the Human Rights Act 1998.

Article 3 - Prohibition of degrading treatment

Article 5 – Right to liberty and security

Article 8 - Right to respect for private and family life

Article 11 – Freedom of assembly and association

Article 11(2) Legitimate Restrictions only to protect: -

- I) National security
- ii) Public safety
- iii) Prevention of disorder
- iv) Health or morals
- v) Rights of others

5.12 Consideration has been given to the compatibility of this policy and related procedures with the Human Rights Act; with particular reference to the legal basis of its precepts: the legitimacy of its aims; the justification and proportionality of the actions intended by it; that it is the least intrusive and damaging option necessary to achieve the aims; and that it defines the need to document the relevant decision making processes and outcomes of this action.

5.2 Race Relations

5.2.1 This policy is relevant to the obligations placed upon the Police Service to;

- (a) Eliminate unlawful discrimination.
- (b) Promote equality of opportunity;
- (c) Promote good race relations between people of different racial groups.

5.2.2 The reason for this policy is to prevent crime, ensure public safety, ensure the integrity of the service and protect the rights and freedoms of others.

5.2.3 The policy contains a certification statement confirming that it has been drafted in accordance with the Human Rights Act and the principles underpinning it.

6. LEGALITY

6.1 Overview

6.1.1 Testing of Police officers became law under the Police (Amendment) Regulations 2005 (Statutory Instrument 2005 number 2834). This policy has links and interdependencies with a number of service policies and procedures, these include: -

- Dignity and Respect at Work Procedure
- Grievance Procedure
- Complaints and Discipline Procedures (Police Discipline) Regulations 1985 / 2004 and Police (Conduct) Regulations 1999
- Police Staff Misconduct Procedures
- Unsatisfactory Performance Procedures (Police Efficiency) Regulations 1999
- Health and Safety at Work Act 1974: - this clearly states that it is the responsibility not only of the 'employer', but also the 'employee', to protect themselves and others who may be affected by their action. It is a criminal offence to put yourself and others at risk. Police Officers are now specifically covered by the Police [Health & Safety] Act 1997.

6.2 Statutory Health and Safety Duties

6.2.1 Under the Health and Safety at Work Act there is a duty to ensure a safe place of work and safe systems of work. With regard to substance misuse, this would include having clear rules about coming to work under the influence of alcohol and / or drugs, whether prescribed, over the counter or controlled substances, and about alcohol consumption or drug taking while at work. This “duty of care” extends to both the individual officer or member of staff, and their colleagues.

6.2.2 To help comply with health and safety obligations and to tackle substance abuse misuse at work amongst police staff, forces should include certain statements in the contract of employment to cover:-

- Reporting to the relevant manager or Occupational Health professional the need to take any prescribed or over the counter medication during working hours that might impair their ability to do their job, or indicate as positive in the event of a drugs test.
- Coming to (or being at) work under the influence of alcohol, drugs or medication not reported to the relevant manager.
- The drinking of alcohol or taking of drugs while at work.
- Possession of drink or drugs while on duty, without reasonable or lawful explanation.

Force policies should be reviewed and rewritten to ensure that police officers are subject to the same conditions, where not already covered by Regulations.

6.3 Common Law

6.3.1 The police service has a duty of care to protect the health and safety of officers and staff, as well as members of the public who may be affected by their work. This would include:-

- Taking care to recruit suitably qualified and competent officers and staff.
- Taking care to ensure that they are fit to carry out their function safely and effectively.

6.3.2 Nothing in this policy will prevent the exercise of statutory duties in relation to the: -

- Road Traffic Act 1988
- Misuse of Drugs Act 1971

Or any other statutory provision relating to substance misuse.

6.4 Other issues

6.4.1 Employment Tribunal (ET) cases have suggested that misconduct and poor performance caused by alcohol misuse should be treated as an illness and the individual should be given the opportunity for treatment and rehabilitation (Strathclyde Regional Council & Syme).

6.4.2 The Corporate Manslaughter Bill (currently going through Parliament) will

mean that a police force could face prosecution if a member of staff, officer or member of the public is killed, and it can be shown that substance misuse was a contributory factor, the force was aware and there was a gross breach of duty.

6.4.3 Individual managers may also be liable to a charge of manslaughter if they were deemed to be responsible in management terms and were either reckless or wilful in their management; i.e. they knew about a substance misuse problem but took no action.

6.4.4 Forces could still be liable for civil litigation, in the event of death or serious injury where no criminal offences are disclosed.

7. STATEMENT OF POLICY

7.1 Application of policy

7.1.1 This policy applies to all members of the Police Service; police officers and police staff, irrespective of rank, grade or role. In some cases it may be applicable to volunteers, if they are in vulnerable or safety critical posts.

7.1.2 This policy is predominantly aimed at those with recurrent problems. It is not intended to apply when problems with conduct or work performance are created by incidents of alcohol or drug misuse where there is no evidence of a recurrent problem. In such circumstances action should be taken by managers through other channels, such as the use of the misconduct procedures. However, a single acute episode of drink or drug related incapacity may be an early indication of a long-standing issue, and appropriate steps should be taken to try and identify whether this is the case.

7.2 Provision of support

7.2.1 It is recognised that alcohol and drug related problems:-

- May develop for a variety of reasons.
- May develop over a lengthy period of time.
- May have a significant impact upon an individual's life and the ability to carry out work safely and effectively.
- Can be successfully treated.
- Should, as far as possible, be treated in a similar way to other ill health problems.

7.2.2 Accordingly, individuals suffering from such problems are encouraged to seek help and treatment in overcoming them, in which case individual Forces should provide:

- The opportunity for referral through the Occupational Health Unit to appropriate treatment agencies in conjunction with the individual's own General Practitioner and with the individual's consent.

- Appropriate time off work to attend such treatment as is recommended by the Occupational Health Unit or General Practitioner
- Recognition of any periods of treatment as periods of sickness absence, as with any other form of ill health.
- Appropriate modification to duties in consultation with the Occupational Health Unit during any period of treatment and for an agreed interval thereafter, subject to operational requirement and feasibility.
- Other appropriate support that may be recommended by the Occupational Health Unit or other appropriate agency.
- Maintain a level of confidentiality determined between Occupational Health Senior Management and the individual, except where there may be a significant risk of self-harm or harm to others.
- Where it is identified that stress is a contributory factor to the person's substance misuse, appropriate control measures to reduce stress in the work place.

7.2.3 The aim will be to provide support with a view to achieving a full recovery, thereby allowing a return to work to undertake the normal range of duties.

7.3 Alcohol and Legal Drug Misuse

7.3.1 Where an individual seeks help directly from the Occupational Health Unit, without the knowledge of their line manager, the matter will be treated confidentially unless, in the opinion of the Occupational Health Unit, maintaining confidentiality could put either the individual, or others, at significant risk. In cases where disclosure is identified as being necessary to prevent harm, written consent will be sought from the individual at the outset. If it is refused, the Occupational Health professional should make a written record of their decision making process, before making the disclosure. They may wish to seek advice from the appropriate professional body, prior to breaking confidence, provided that this will not result in too long a delay. A system should be put in place that ensures only relevant people are made aware of the individual's condition. Information should be disseminated on a 'need to know' basis.

7.3.2 Examples include those who drive vehicles, or handle machinery or firearms, and also those who make judgements, which may put others at risk. In these circumstances, the Occupational Health Unit will firstly encourage the individual to inform their manager of the situation, and give sufficient time for this, and will then make a formal written report to the line manager advising of any potential risk.

7.4 Supporting an officer or member of staff who volunteers a problem

7.4.1 See **appendix A**

7.5 Roles and responsibilities

7.5.1 See **appendix B**

7.5.2 **Appendix C** provides guidance on management decision making.

7.6 Drug screening: protocols for testing procedures

7.6.1 Scope of testing

7.6.2 The extent of testing by any force should be proportionate to the problem. A testing regime should not be of a scale that implies a lack of trust in the professionalism of the police, or of a nature that might undermine the existing sense of responsibility to alert senior officers to signs that a colleague might have a substance misuse problem.

7.6.3 Testing may be carried out in the following circumstances:

- Testing with cause (that is, where there is a reasonable suspicion of substance misuse);
- Pre-recruitment screening and testing in the probationary period; and
- Screening of officers and staff in vulnerable or safety critical posts

7.6.4 The intention of a testing regime should be preventive. Testing regimes should be designed to:

- Minimise the chances of substance misusers entering the police service in the first place.
- Deter officers and staff from substance misuse through the application of a policy that makes detection a real possibility.
- Encourage those with a substance misuse problem to identify themselves, so that they may be supported in seeking treatment.
- Screen officers and staff in safety critical posts, to minimise any risk of operations being prejudiced by impaired judgement.
- Protect officers and staff in posts in which they may be vulnerable to malicious allegations of substance misuse.

7.6.5 Forces have the power to test officers if they have cause to suspect that they are misusing controlled drugs. Testing of police staff 'with cause' would have to form part of their contract of employment. For "cause" to be established, the test of "reasonable suspicion" must be satisfied. It should be made clear to the officer or staff member that testing "with cause" may either prove or disprove intelligence or allegations made. A single and unsubstantiated allegation, particularly if made by a member of the public who may have malicious intent, would not normally amount to reasonable suspicion.

7.6.6 Officers and staff (of all ranks) working in the following fields will be liable to be tested:-

SAFETY CRITICAL POSTS

(These are police officer posts currently designated by the Secretary of State, and as such are not subject to Chief Officers' discretion. Testing of Police Staff within safety critical or vulnerable posts would have to form part of their contract of employment and the definition of such posts be subject of local agreement. A suitable basis for discussion would be 'Any post in which impairment would pose a greater risk of harm to officers, staff or the

public’.

- **Firearms officers.** All officers authorised to use firearms, or directly supervising such officers.
- **Drivers and motorcyclists who have received the appropriate training from their force to use the police exemptions under the Road Traffic Regulation Act 1984.** All officers or staff who have received the appropriate training from their force to use the police exemptions under the Road Traffic Regulation Act 1984, and holding posts in which they may be called upon to use those exemptions.
- **POLSA teams.** All officers or staff who are members or supervisors of Police Search Advisor teams.

HEALTH AND SAFETY

- **Police divers**

VULNERABLE POSTS

In the nature of their duties, many police officers and staff, and particularly those working under cover, will have close associations with criminals. Those whose duties bring them into contact with drugs or drug dealers are particularly vulnerable to malicious allegations that they are themselves drug users. A liability for such officers and staff to be tested enables it to be demonstrated that they remain “clean”.

In some forces it is possible to define the posts concerned – for example drugs squad officers and test purchase officers. However, not all forces have single function crime squads, so it is necessary to define vulnerable posts on a force by force basis. It would be beneficial if this were done in consultation locally with staff associations and trade unions. As such, the posts to which the liability to be tested attaches are:

Posts identified by the Chief Officer within each force as being vulnerable because of a specific responsibility for dealing with drugs.

7.6.7 **Substances to be tested for:**

7.6.8 Testing covers the illicit use of the following substances:

- Amphetamines (including ecstasy)
- Cannabis
- Cocaine
- Opiates (e.g. morphine and heroin)
- Benzodiazepines

7.6.9 There may be legitimate reasons for a drug being present in a specimen. For example, the presence of morphine may indicate heroin abuse, or the use of a legitimate medicine (e.g. a painkiller or an anti-diarrhoea preparation). Officers required to take a test should be asked to declare all medications they are taking, and it should be fully explained to them why this is necessary. The content of such declarations is confidential to the

occupational health service of the force, and to the medical officer reviewing the result of a test.

7.6.10 See **Appendix G** for further procedural details.

7.7 Alcohol screening: protocols for testing procedures

7.7.1 Alcohol is a substance that can be misused, and which can impair judgement. Misuse of alcohol can lead to offences such as being drunk and disorderly, or drink /drive offences under the Road Traffic Act. The level of alcohol which needs to be present to result in impairment to those working in safety critical areas, is significantly lower than that regarded as the legal limit for driving. The regulations reflect this lower threshold for officers and staff whilst at work

7.7.2 Officers and staff have a responsibility to present themselves fit for duty. The Police Code of Conduct requires that officers must be sober whilst on duty, nor should they behave in a way that is likely to discredit the service. An officer whose judgement is impaired by alcohol is unlikely to be fit for duty. It is for a senior officer to determine whether an officer has presented himself or herself for work whilst unfit through alcohol consumption and deal with it appropriately. In deciding the course of action to be taken, due consideration should be given to all of the circumstances to ensure a proportional response.

Whilst there is no national code of conduct applicable to police staff, most forces have a Code of Conduct closely reflecting that for police officers. There is therefore an expectation that police staff will present themselves as fit for work and not impaired through alcohol misuse. Where necessary, forces should consider amending force policy or contracts of employment to reflect this expectation.

7.7.3 As with drugs, self-declaration of a drink problem is a matter that should be managed through the occupational health service, rather than being regarded as a disciplinary matter.

7.7.4 In respect of the safety critical posts (as defined in para 7.6.6), and in these areas only, there is a power to conduct tests with cause, if it appears that an officer or member of staff is under the influence of alcohol. Those working in these areas should be liable also to random testing should risk of impairment appear to warrant this, on a scale to be agreed with the local staff side.

7.7.5 See **appendices F and G** for further procedural details

8.0 IMPLICATIONS OF THE POLICY

8.1 Financial Implications / Best Value

8.1.1 The aim of the policy / process is to help ensure the integrity of the organisation and its resources. There are financial implications for providing adequate screening regimes and occupational health provision.

8.2 Staffing / Training

8.2.1 Additional training will be required for supervisors, managers and the staff involved in screening. Adequate marketing / publishing of the policy is required for its effective implementation, and dissemination amongst all officers and staff.

8.2.2 In addition to this policy, there is further information available to assist managers and supervisors of police staff through the ACAS advisory booklet ' Health and Employment' ref B/11. Further details can be found on the ACAS website.

8.3 Bureaucracy

8.3.1 The policy aims to facilitate this important process. Analysis and justification will be required, but police personnel should recognise the need to keep bureaucracy to a minimum. The recording of the decision making process and testing regime is extremely important.

8.4 Risks

8.4.1 Effective and timely implementation of this policy is required to ensure the service is in an appropriate position in terms of substance misuse management.

9.0 CONSULTATION

9.1 Consultation has taken place with:

- ACPO Professional Standards Committee
- ACPO Workforce Development Business Area
- Police Federation
- Superintendents' Association
- FSS
- IPCC
- Police Staff Council
- Association of Local Authority Medical Advisors (ALAMA)
- Occupational Health National Adviser to the Police Service (OHNAPS)

10.0 DISTRIBUTION / PUBLICATION

10.1 This policy does not contain any information about police procedures or tactics that make it unsuitable for public disclosure under the principles of the Freedom of Information Act.

10.2 The Policy will be published on the ACPO Intranet site and circulated to all forces for information / dissemination.

11.0 REVIEW

11.1.1 This policy will be first reviewed in September 2008 and every 3 years thereafter. The reviews may be completed more frequently if issues are identified. The review will take each of the template headings in turn and determine whether anything in relation to that heading should change. The initial review will also consider any areas of potential expansion, the type of testing and the range of testing, in line with any changes in the regulations.

11.1.2 The review will also look at: -

- Changes to general principles underpinning the policy
- Changes to legislation or Human Rights or Race Relations case law
- Issues from the monitoring and evaluation process
- Relevance of policy objectives
- Challenges to the policy by events / incidents / staff
- Adverse affects
- Identified inefficiencies in relation to the policy's implementation
- Policy / procedure communication
- The number of occasions forces have had cause to use or refer to the policy, and the value of the policy in assisting them with their enquiry.
- Whether there are any corrective measures that need to be put in place in order to deal with identified shortcomings?

11.1.3 **Records required**

In order to monitor and review the policy, forces are requested to maintain the following information:-

- The number of requests made
- The number of tests conducted
- The results of tests
- The type of test conducted
- The reason for the test e.g. Safety Critical role etc
- The job title of the participants
- The ethnicity of participants
- The gender of participants

Every effort must be made to maintain confidentiality. In certain circumstances it may be possible to identify the identity of the person being tested by the combination of data collected. This should be borne in mind, particularly when dealing with FOI requests.

APPENDIX A

SUPPORTING AN OFFICER OR MEMBER OF STAFF WHO VOLUNTEERS A PROBLEM

1. Identification by the Individual

- 1.1 An individual may choose to seek help on a completely voluntary basis, prior to a request for a screening sample. If an officer or member of staff believes that he / she has an alcohol or drug related problem they should seek specialist advice as soon as possible. The Occupational Health Unit will initiate such help if requested. If an employee voluntarily requests assistance with an alcohol or drug related problem from the Occupational Health Unit prior to managers being aware of poor work performance, wherever possible the matter will be treated in confidence. If time off is needed for treatment or medical appointments, this should be facilitated without disclosing to the Line Manager the exact nature of the problem, unless with the agreement of the person concerned, or because failing to do so may put others at risk.

2. Identification by the Manager

- 2.1 Managers have an important role to play in identifying problems at work. Deterioration in work performance and/or changes in patterns of behaviour may be noticed by a manager with or without there being any obvious signs of alcohol or drug misuse. In these circumstances the Occupational Health Unit will provide advice and assistance for managers if required. However, it should always be borne in mind that changes in behaviour are not exclusively as a result of alcohol or drug misuse. Training will be of great importance in assisting managers to understand the issue, and deal with it appropriately.

3. Identification by a Colleague

- 3.1 It may be that a change in an individual's pattern of behaviour is identified by a colleague or by a supervisor. In this case it is their responsibility to draw the matter to the attention of the individual's manager. Colleagues should not, even for the best of motives, 'cover up' for a fellow member of staff whose work or behaviour is suffering as a result of an alcohol or drug related problem. Familiarisation training would be of benefit to assist officers and staff.

4. Programme of Treatment

- 4.1 When an individual agrees to undergo the programme of treatment recommended by the Occupational Health Unit, by the General Practitioner or by a specialist agency, the Occupational Health Unit will have to determine whether or not the individual is able to continue in their existing role, during the period of treatment. An assessment of the risks associated with the role should be made in consultation with a senior manager. Whenever possible, this should be done without disclosing the reason for the enquiry. Depending on the treatment arrangements, the individual's manager will also have to be informed that they may be absent from the workplace. Again, it should not be necessary to disclose the reasons why. A 'treatment contract' drawn up between the individual and Occupational

Health covering issues of disclosure is recommended. If a generic contract is to be used, it should be following consultation with the force Medical Advisor, Occupational Health professionals, Professional Standards, Legal Services, staff associations and trade unions. There should be scope for individual needs to be addressed, within the generic contract

- 4.2 When an individual successfully completes a programme of treatment the Occupational Health Unit will, confirm the fact to the manager in writing, if disclosure has previously been made to them.
- 4.3 When an individual does not complete a programme of treatment successfully, either because the treatment agency discontinues the programme due to lack of progress, or because the individual him / herself discontinues, the Occupational Health Unit will, accordingly, advise the manager who will then interview the individual and determine what further action should be taken. This issue can be covered in the 'treatment contract' which may include the information that failing to complete treatment may result in referral to Professional Standards, although this decision should be made on a case by case basis

Each force needs to make a policy decision around how to manage disclosure and the assessment of risk. This process should be achieved by discussions involving the force Medical Advisor, Professional Standards department , staff associations and trade unions.

APPENDIX B

ROLES AND RESPONSIBILITIES

1. The Member of Staff

- 1.1 Officers or staff who have an alcohol or drug related problem, or who suspect that they may have, should seek assistance as soon as possible. They may wish to approach their manager, a Personnel Officer, the Occupational Health Unit or a specialist agency. Whichever source of help is chosen, the matter will be dealt with in a confidential and sympathetic manner.
- 1.2 When an individual is prescribed drugs which have possible adverse side effects and they are involved in work of a hazardous nature, they must notify their line manager or Occupational Health immediately in order that a risk assessment can be carried out and if necessary alternative work arranged. It is not necessarily the case that they must disclose the type of drugs or the condition for which they are being taken. The key area of risk is the nature of the adverse side effect.
- 1.3 Non-prescription medication may also have adverse side effects, such as drowsiness. Individuals should ensure, when taking such medication, that they are aware of any side effects and that they discuss the matter with their line manager so that, where necessary, work of a non-hazardous nature may be arranged.

2. The Colleague

- 2.1 When an officer or member of staff suspects that a colleague may have an alcohol or drug related problem they should, initially, encourage that person to seek assistance. If this concern persists they should discuss the matter in confidence with a line manager, a Personnel Officer or the Occupational Health Unit.

3. The Manager

- 3.1 All supervisors and managers have a responsibility to be aware of the content of this policy. They should be alert to early indicators of a potential problem. Appendix D provides some guidance on this.
- 3.2 If approached, managers should offer advice, support and guidance in a sympathetic and confidential manner. If it is a self-referral by an officer or staff member, they should encourage them to seek specialist help, through the Occupational Health Unit, their General Practitioner or direct from a specialist agency. If it is an approach about concern for a colleague, the officer or staff member making the referral should be able to expect that it will be treated with respect and in confidence.

4. The Occupational Health Unit

- 4.1 The Occupational Health Unit will deal with any referrals made by the manager, or from the individual him / herself. They may refer the individual to a specialist agency. They will also provide a point of contact and liaison between the individual, the line manager, the General Practitioner and any specialist agency.

- 4.2 The Occupational Health Unit will also encourage the early identification of problems by raising awareness of drug and alcohol related problems and providing guidance to managers and staff.
- 4.3 There are, however, some circumstances in which the interests of the proper administration of justice may over-ride an absolute confidentiality. In particular, the Criminal Procedure and Investigations Act 1996 and the Code of Practice issued under it agreed between ACPO and the Crown Prosecution Service place a personal responsibility on the individual Officer or member of staff to declare any matter that may affect their credibility as a witness in a court case. In some circumstances substance misuse on the part of an Officer or member of staff acting as a witness may have to be revealed to the Crown Prosecution Service, as the damage to the credibility of the officer as a witness may be a factor to be considered in a decision whether to proceed with a prosecution.
- 4.4 The personal responsibility under the Criminal Procedure and Investigations Act should be drawn to the attention of an officer / member of staff, by the Occupational Health Service (or if the disclosure is made to them, their manager), at the time at which any self-declaration of a substance misuse problem is made. The need to make a declaration to CPS will not arise in every case; each should be considered on its own facts and merits. Any declaration to CPS should be properly managed, with appropriate support provided to the officer or member of staff. This matter could be dealt with within the treatment contract as a separate paragraph to be read by the individual, or as an information sheet presented to them at the time of disclosure. Officers and staff who fail to discharge their responsibilities under CPIA may place prosecutions, and therefore the organisation and public at risk, so appropriate means should be negotiated locally to ensure that this does not happen.

5. The Human Resources Department

- 5.1 The Human Resources Department will support officers, staff and managers in the practical application of this policy by offering advice to managers who are dealing with work performance problems, advise on reasonable targets and timescales, and advise on the misconduct process. The Human Resources Department will also be responsible for reviewing the policy as necessary.

6. Trade union / Staff associations

- 6.1 Staff associations and trades union representatives should encourage officers and staff to seek assistance in accordance with the provisions of this policy. Should an officer or member of staff request it, a representative may attend discussions with the manager.

APPENDIX C

ILLEGAL DRUG MISUSE – DECISION MAKING GUIDANCE

1. Overview

1.1 It would be incongruous for the police to deal leniently with the criminality of its own staff. However, if a disproportionately severe disciplinary action for any incident of substance misuse is taken, there is a risk of driving the issue 'underground'. If that happens, it would make dealing with substance misuse all the more difficult, as individuals, colleagues and even some managers, would be reluctant to take any action that might harm a colleague.

1.2 In trying to achieve the balance between support and law enforcement, the following issues have to be considered:

2. Trigger for referral

2.1 If an individual presents themselves and seeks help from the Occupational Health Unit, then support may be more appropriate than if the illegal substance abuse is revealed through the individual's action or by a third party. Between these two examples lie a spectrum of referral routes and each case should be judged accordingly.

3. Nature of Abuse

3.1 The early revelation of a problem may be more easily and supportively addressed than a history of acute abuse of addictive drugs or a history of repeated lapses into substance abuse.

4. Honesty and Openness

4.1 The abuser often hides substance abuse. Where an officer or member of police staff is dishonest about their continued use of an illegal substance, then a misconduct investigation will normally follow. This policy is not designed to stigmatise those who have successfully conquered an addiction, and each case should be judged on its own merits.

5. Attendant Circumstances

5.1 The possession of controlled drugs remains an offence under the Misuse of Drugs Act, the purchase of controlled drugs from an illegal supplier is therefore aiding and abetting the commission of the offence of supplying. The fact that a member of the police service is engaged in assisting criminal activity cannot be ignored, but the response to it must be judged on a case by case basis'. The purchase of controlled drugs from someone who knows the individual is a police officer or staff member, leaves the individual particularly vulnerable to blackmail, or pressure to engage in corruption. An intelligence debrief should wherever possible be conducted when an officer or staff member self declares, and the means by which this is facilitated should be subject of a discussion within the force. However, the issue of breach of medical confidentiality makes it entirely inappropriate for this to be carried out by medical professionals, unless they perceive there to be a significant risk of harm to either individuals or the organisation. If the individual is not prepared to volunteer information about their drug associations, then this issue cannot be forced. If an

information report is submitted, it should be dealt with in accordance with current intelligence handling procedures.

5.2 Even though cases of substance misuse might initially be dealt with sympathetically and in confidence, in an organisation with the security and law enforcement roles of the Police Service, it is not possible to ignore previous substance abuse when assessing suitability for some roles. Individuals will have to accept that such history may debar them from certain posts in the future because of security and/or health and safety reason. However, each case should be judged on its own merits. If an officer or member of staff is known to have successfully completed a treatment programme and there has been a period in which they have been drug or alcohol free this should be taken into consideration and where the post is a vulnerable or safety critical one, a comprehensive risk assessment should be done.

APPENDIX D

POSSIBLE SIGNS OF SUBSTANCE MISUSE

1. Overview

- 1.1 Alcohol and /or other substance misuse may manifest itself as specific acute symptoms and signs attributable to the actions of alcohol or the substance itself. These only last for, at most, a few hours after taking the substance. If the misuse becomes a regular occurrence or develops into addiction, then non-specific changes in behaviour normally develop over a period of time. Listed below are some commonly used drugs, and the acute observable symptoms and signs. It must be noted however that the regulations limit drug testing to Amphetamines (including ecstasy), Cannabis, Cocaine, Opiates and Benzodiazepines only. Careful consideration should be given to the legality of testing for other drugs not currently covered by the regulations. Some examples of acute observable symptoms and signs are:-

2. Cannabis

- 2.1 The potential abnormal observations on someone who has recently taken cannabis are:

- Distinctive smell
- Poor co-ordination and balance
- Impaired perception of time and distance
- Reddening of whites of eyes
- Poor attention span
- Relaxed inhibitions
- Possibly dilated pupils

- 2.2 Observed symptoms and signs start almost immediately on taking cannabis and can last up to 6 hours.

3. Opiates

- 3.1 These include Codeine, Heroin, Methadone, Morphine and Opium. Potential abnormal observations of someone who has recently taken opiates include:

- Very small pupils
- Slow speech and reflexes
- Sleepy
- Facial itching
- Dry mouth
- Possibly euphoria

- 3.2 Observed symptoms and signs start within a few seconds of taking opiates and last up to 8 hours (24 hours with Methadone). It should be noted that regular users may not display any of the above signs.

4. Central Nervous System Stimulants

4.1 These include Cocaine and Amphetamines. Potential abnormal observations of someone who has recently taken these include:-

- Dilated pupils
- Restless and anxious
- Difficulty keeping quiet
- Easily irritated
- Eyelid tremors
- Euphoria

4.2 Observed symptoms and signs start almost immediately on taking CNS stimulants and last about 90 minutes with Cocaine and 6 hours with Amphetamines.

5. Central Nervous System Depressants

5.1 These include Alcohol and Benzodiazepines (anti-anxiety medication like Valium and sleeping pills like Mogadon). Potential abnormal observations of someone who has recently taken these include:

- Abnormal sized pupils
- Drowsiness
- Thick, slurred, slow speech
- Slow, sluggish reactions
- Poor co-ordination
- Watery eyes

5.2 Observed symptoms and signs start within about 30 minutes of taking CNS depressants and last up to 14 hours.

6. Hallucinogens

6.1 These include LSD, Ecstasy and "Magic Mushrooms". Potential abnormal observations of someone who has recently taken these include:

- Hallucinations
- Synesthesia (sensations may be transposed from one sensory mode into another, e.g. sounds may be interpreted as sights or odours)
- Dazed appearance
- Poor balance
- Distorted time and distance perception
- Nausea and sweating
- Paranoia
- 'Goose bumps'

6.2 Observed symptoms and signs start within 20 to 60 minutes and last 3 to 12 hours according to the substance taken. It should be noted that 'magic mushrooms' and LSD are not included in the regulations

7. Inhalants

7.1 These will include Petrol, Glue, Solvents, Aerosols and Paint. Potential abnormal observations of someone who has recently taken these include:

- Smell or residue around the face
- Dizziness or light headed
- Bloodshot, watery eyes
- Confusion
- Flushed, sweaty appearance
- Slow, slurred speech (often non-communicative)
- Distorted time and distance perception
- May complain of intense headache

7.2 Observed symptoms and signs start almost immediately and last from a few seconds to 2 or more hours according to the substance and quantity inhaled.

It should be noted that inhalants are not included in the regulations.

8. **Anabolic Steroids**

8.1 Anabolic steroids are abused by athletes and body builders to increase muscle bulk. As well as their anabolic (muscle building) action, they also have androgenic (masculinising) actions. There are no immediate acute symptoms or signs of taking anabolic steroids, but over a period of time they cause:

- Much more rapid weight (muscle) gain than usual
- Increased greasiness of skin and hair
- Increased spots or 'acne'
- An increase in aggressive behaviour

It should be noted that anabolic steroids are not included in the regulations.

8.2 All of the above are specific to the substance taken and, apart from anabolic steroids, are of limited duration.

8.3 Someone who is regularly misusing alcohol and / or other substances may show typical persistent patterns of behaviour that develop over a period of time.

9. **Poor Attendance**

9.1 All aspects of attendance tend to be affected including:

- Frequent, short term sickness absence, especially in relation to other leave (weekends/rest days, bank holiday, etc.)
- Poor time keeping; late in to work, late returning from lunch, late for appointments, early leaving work.
- Unexplained absences or disappearing from the workplace.

10.1 **Poor Work Performance**

10.1 The main areas of work performance affected by substance misuse are:

- Lack of concentration and poor memory
- Frequent mistakes and errors of judgement
- Unreliability and difficulty meeting deadlines

11. **Frequent Accidents**

11.1 Substance misusers tend to suffer more accidents than normal.

Other warning signs to look out for are:

- Smelling of alcohol, or something to disguise the smell of alcohol or cannabis, such as mints or strong after-shave.
- Hand tremor, slurred speech, facial flushing, especially after a weekend or rest day, a prolonged lunch break or unexplained absence from the workplace.
- Poor relationships with colleagues, possibly to the avoidance of company altogether.
- Always short of money and may attempt to borrow money from colleagues.
- Tendency to blame others for shortcomings at work and to over-react to real or imagined criticism.
- Moodiness, apathy, depression, irritability.
- General neglect of appearance including cleanliness and personal hygiene.

11.2 If an officer / member of staff displays any of the above behavioural changes, it must not be automatically assumed that this is proof of a substance misuse problem. Many of the signs and symptoms above could be indicative of other illnesses and conditions.

Appendix E

DRUGS SCREENING: PROTOCOL FOR TESTING

1. Recruits and serving officers

- 1.1 There are some differences that may apply to the procedures used for testing potential recruits and serving officers. If a potential recruit does not wish to submit to a test, he or she may withdraw from the recruitment process. An officer is obliged to submit to a test, if so required, and may, as a consequence, have to declare information about medications that he or she is taking. These declarations may have the effect of disclosing personal information that the officer is entitled to expect will be treated in confidence by Occupational Health. By contrast, all aspects of the collection and on-site screening of samples from potential recruits, including the taking of information about medications, may be undertaken as a part of the human resources function.

2. Conducting the test

- 2.1 There must be a secure chain of custody through collection, analysis and medical review. Laboratory analysis should be undertaken by an independent agency. Collection of samples, and initial on-site screening, may be undertaken by an independent agency, or by suitably qualified staff of the force. It is preferable that this function is not carried out by staff from Occupational Health, as they have a primary function in supporting officers and staff.
- 2.2 For the purpose of the physical administration of the test, the suitably qualified person may be a member of the staff of the independent agency, a trained officer or member of staff of the force, or (in exceptional cases) a member of the occupational health service of the force. However, forces should bear in mind the issue of Medical Confidentiality. Best practice will be that testing and medical interviews (other than pre recruitment testing) are carried out by external, independent bodies. The Occupational Health Unit in a force has competing priorities, and an obligation to disclose other issues that are not material to the substance misuse test, but which may come to light during the medical review. Using them to conduct tests and reviews places them in an exceptionally difficult position, could call into question their ability to maintain confidentiality and could lead to a breakdown of trust between the unit and the workforce. Where completion of the paperwork by an Officer or member of staff involves disclosure of medication being taken, only occupational health staff should see that paperwork. It follows that where the paperwork is not completed by the Officer or member of staff personally (i.e. it is completed in response to questions put to the officer, and then signed by the officer), that task should be undertaken by occupational health staff only. It is important that information about medications taken prior to the test is recorded at the time of specimen collection, and not at any later stage. The testing procedure should be agreed locally by all relevant parties, including staff associations and trade unions.

3. On-site screening and laboratory testing

- 3.1 Any test that may be relied upon in disciplinary / misconduct proceedings should be conducted through laboratory analysis, not on-site testing. On-site testing, using portable testing kits, may be used to screen out persons tested. However, if there is a positive indication at any screening stage, the residual specimen of urine or saliva (remaining after the screening test) should go forward to full laboratory analysis and medical review. Where testing is carried out with cause, the specimen may be submitted directly to the laboratory, without conducting a screening test.

4. Split samples

- 4.1 Provision should always be made to allow the donor of the urine or saliva an opportunity to have an independent analysis of the specimen to challenge the outcome of a laboratory analysis. A split sample (at the time of collection) provides an effective means of providing this opportunity.

5. Material to be tested

- 5.1 Either saliva or urine may be tested. Saliva testing may be regarded as the least personally intrusive option. The testing of blood and hair samples will not form part of routine testing. The Home Office Circular 45/2005 states ‘the testing of blood samples should not form a part of routine testing, where there is no necessary ground for suspecting misuse as the procedures are disproportionately intrusive’. This could be interpreted as enabling blood samples to be tested for ‘with cause’ cases. However, this interpretation is not supported by the Home Office. Blood tests are not mentioned in the Regulations. Forces should therefore give careful consideration to the legality of carrying out blood tests.

TESTING PROCEDURES

6. Self declaration

- 6.1 Officers or members of staff with substance misuse problems should be encouraged to identify themselves, and should be assisted in seeking treatment. Information about self referral and means of treatment (such as advice lines) should be made available in the workplace through posters, leaflets and intranet sites). However, self-declaration cannot be used to avoid the consequences of a positive test. Any such declaration must be made before an officer or member of staff is notified of any requirement to take a test. A self-declaration made after an officer / member of staff is notified of the requirement to take a test cannot be used to frustrate the consequences of a positive test result’.

7. Safety critical posts

- 7.1 The scale of testing should be risk based. Where the numbers involved are relatively small, forces may wish, in the first instance, to test all officers in this category. If the assessment of risk is low, then any sample of officers selected for testing should be random.
- 7.2 Scale of testing should be determined at force level, having regard to perceived risk and cost. “Scale” encompasses size of sample and

frequency of testing. If initial testing produces a nil or low number of positive results, then the scale of testing need not be large. On the other hand, a higher proportion of positive results would indicate a larger scale of future testing. "Risk" encompasses the risk inherent in the consequences of impairment of judgement or performance, and the risk of incidence of misuse. In safety critical posts the former risk will usually be high, even if the latter risk is low.

8. Vulnerable posts

- 8.1 Testing should be routine. If a high degree of risk is assessed, universal testing covering all officers in the vulnerable category might be appropriate. If the assessment of risk is low, then a sample of officers to be tested should be selected at random, in proportion to the perceived risk.

9. Consultation and monitoring

- 9.1 The scale of testing adopted, and the identification of vulnerable posts, should be the subject of consultation with the local staff associations and trade unions. All random samples should be monitored by ethnicity and gender, to ensure that no unintended bias arises from the sampling technique.

10. Immediate consequences of positive test results on serving police officer or member of staff at the on-site screening stage

- 10.1 Only a suitably qualified person should carry out on-site drug screening tests. The person being tested should be advised that any positive screening test results provide a provisional indication only, and will be subject to further laboratory analysis and medical review, either of which could result in the final result being negative.
- 10.2 In the event of a positive on-site screening test result, there may be a risk in continuing to deploy the officer or member of staff on the full range of police duties. An immediate assessment of the risk needs to be made, in consultation with a senior manager, and if necessary the individual may have to be re-deployed. At this stage there is no final result, as this can only be provided by laboratory analysis, so the language used to describe the outcome of an on-site test is very important. In particular, the manager should not be told that "a test has been failed" as this is not the case.
- 10.3 It is for the manager to assess the risk in relation to the duties due to be undertaken by the officer, but there would be a presumption of removal from duties involving contact with the public. Formal suspension would be appropriate only if a positive result was confirmed following laboratory test and medical review.
- 10.4 Difficulties arise, inevitably, for both the officer or member of staff and management from a positive result at the screening stage. A confirmed result, either positive or negative, will not be available until the completion of laboratory analysis and medical review, a process that is likely to take two or three days. In some cases the turnaround period may be for longer. However, any difficulties arising from this delay are outweighed by the benefit of screening, in giving an instant confirmation of a negative result.

11. Handling confirmed positive results

- 11.1 A positive laboratory analysis will be subject to medical review, as explained more fully in the Annex. Medical review involves a specially trained medical practitioner reviewing the test result and the medical history of the individual to determine if there is a legitimate explanation for the presence of a drug in the sample.
- 11.2 Test results following laboratory analysis and medical review should be returned to the occupational health service of the force concerned. Where the result is negative, the officer or member of staff and the senior manager should be informed without delay. It is particularly important that a confirmed negative result after an initial on-site positive screening result is communicated to the officer and management without delay.
- 11.3 A positive result from a test administered as a part of the pre-employment process should be notified to human resources, so that the candidate may be rejected.
- 11.4 A positive result from a person who had self-declared a substance misuse problem prior to being tested should be reviewed by Occupational Health to assess whether the result was consistent with rehabilitation treatment being undertaken. If the result suggested that an agreed programme of rehabilitation was not being followed, then reference to professional standards should be considered. Again, confidentiality and organisational risk will have to be taken into account before this course of action is taken. The inclusion of a suitable clause in the treatment contract would cover this point adequately.
- 11.5 All other positive results should be referred to professional standards for action. It is for professional standards to notify both the officer and the line manager of the result, and of any immediate action, including suspension from duty where appropriate.
- 11.6 Any claim by the officer or member of staff concerned that there was a reason (other than a medical reason) for the positive result should be dealt with by professional standards or through formal disciplinary proceedings. Such claims would include any claim that a positive test was a result of the officer having consumed unknowingly a “spiked” drink. Appeals should be handled through normal appeals process.

12. Liability

- 12.1 An officer or member of staff who has misused controlled drugs suffers a double jeopardy. He or she is at risk of disciplinary proceedings that might lead to dismissal, and, if there is additional evidence of current possession or supply of a controlled drug, may also be at risk of criminal prosecution. Because of this double jeopardy, and whether or not criminal proceedings are contemplated, cautioning and interviewing should be to the standards required under the Police and Criminal Evidence Act (PACE). However, the presence of metabolites of controlled drugs, or alcohol, in a sample does not constitute the commission of a criminal offence in itself..
- 12.2 The penalty for refusal to take a test is no less than the penalty for failing a test. The liability to take a test is established in Police Regulations, thus a failure to take a test when required to do so is a failure to obey a lawful

order. There is no substantive criminal offence of having an unlawful substance in the body, only a presumption that the offence of “possession” must have been committed beforehand. Such a presumption may be rebutted by medical evidence that the positive test resulted from use of a lawful medication. The presumption of possession that would arise from a positive, medically confirmed test result should be treated as discreditable conduct. The maximum penalty for both failure to obey a lawful order and discreditable conduct is the same.

Appendix F

ALCOHOL SCREENING: PROTOCOL FOR TESTING

1. Overview

- 1.1 There is a presumption that a person is unfit to work in a safety critical post (as defined in paragraph 7.6.6.) if they have more than 29 mg% in blood (39 mg% in urine, 13 micrograms% in breath). This compares with a limit of 80 mg% in blood for driving.
- 1.2 Where testing is carried out, it should be conducted using breath testing equipment capable of making measurements at the 13 micrograms% level (equivalent to the 29 mg% blood level). Officers or members of staff should never be tested on apparatus held in a custody suite, unless the suite is cleared of all other users.
- 1.3 Each "breath test" should consist of two consecutive breath specimen tests from the officer or member of staff, with the final result being declared as the lower of the two results.
- 1.4 If a supervising officer or member of staff smells alcohol on the breath of an officer or member of staff liable to alcohol testing, a breath alcohol test can be administered after a wait of 15 minutes. (This is to deal with the eventuality that at the time the suspicion of excess drinking is aroused, a proportion of the alcohol consumed may still be in the stomach. Alcohol must be absorbed into the body to register in a breath alcohol test.)
- 1.5 It should always be open to an officer or member of staff to declare that they suspect they might have inadvertently exceeded the limit. Any such declaration should be made before the officer or member of staff is notified of any requirement to take a test. Such declarations should not result in the officer or member of staff being penalised, provided there is no pattern of continuing excess. A declaration may be particularly appropriate in circumstances of an unexpected change of duty, for example being allocated to driving duties involving possible use of the police exemptions under the Road Traffic Act, due to a staff shortage.

APPENDIX G

GUIDANCE ON AND OVERVIEW OF TESTING PROCEDURES

1. **Overview of Drug Testing Procedures**
- 1.1 The outcome of a drug test is expressed as “Positive” or “Negative”.
- 1.2 The purpose of drug testing is to establish whether the donor of the specimen has consumed a controlled drug at some time prior to the collection of the specimen. The identification of a drug in a specimen is not the complete picture as there may be legitimate reasons for the drug being present.
- 1.3 For example, the presence of morphine in a urine specimen may indicate that the donor is a heroin misuser (heroin is converted to morphine in the human body) but equally it may indicate only that the donor had legitimately taken an anti-diarrhoea preparation, which contained morphine as its active ingredient.
- 1.4 Drug testing involves three integrated stages; collection, analysis and medical review.
- 1.5 All final drug positive test results should arise from analysis conducted in an accredited laboratory. On-site screening tests may be used to screen out negative results, but a positive indication at the screening stage must go forward to full laboratory analysis and medical review.
- 1.6 The first stage of the drug testing procedure is the collection of the specimen. The collection of a specimen from a donor is straightforward, but it must be conducted in such a way as to maintain the Chain-of-Custody of the specimen, with full documentation at all stages. The collector must be properly trained, with the standards applying being those that would apply to any other procedure in which it is important to maintain the integrity of an exhibit. The suitably qualified person may be a member of staff from an independent agency, a trained officer or member of staff from the force or in exceptional circumstances only, a member of the occupational health staff. Best practice advice is that it should be an external independent person, as using in house staff may lead to compromise of the Occupational Health Unit or issues over the confidentiality of the process as outlined at Appendix E para 2, 2.1.
It is at this stage that the donor should be invited to submit details of any medication currently being, or recently taken. This can be by interview, or by completion of a confidential questionnaire. If by interview, it should be conducted by a member of the Occupational Health Staff. If a questionnaire, it should be completed by the donor, and then enveloped and signature sealed. The envelope should be retained in a secure location (preferably within the Occupational Health Unit) until such time as the result of the test is known. In the event of the test revealing the presence of drugs, the sealed envelope containing the documentation should be forwarded to the Medical Review Officer. If the donor states they have not taken any medication, this should also be recorded.
- 1.7 Analysis is the process of seeking to detect drugs in the collected

specimen. If no drugs are found in the specimen, the drug testing procedure is complete at that stage, and the force will be advised of the "Negative" outcome.

- 1.8 If the analysis identifies one or more drugs in the specimen, further work is required. The positive analytical results need to be interpreted in the light of any factors that may provide a legitimate explanation for the presence of the drugs (e.g. medications taken by the specimen donor in the days before the test). This process is referred to as "Medical Review" and is conducted by a medical practitioner (the "Medical Review Officer"), in case there is a need for a medical discussion with the donor. The medical practitioner reviews the evidence, including the information on the donor's questionnaire and arrives at an opinion as to the origins of the drugs identified. If their presence can be explained by the use of prescribed or proprietary medication the force will be advised of a "Negative" outcome.
- 1.9 If the presence of drugs in the specimen cannot be accounted for in this way, the force will be advised of a "Positive" outcome. The "Positive" outcome reported will include the details of the drug(s) identified. In any case where there is any doubt, the overriding principle of the medical review process is to give the benefit of that doubt to the specimen donor.
- 1.10 In summary, the outcome of a comprehensive drug testing procedure involves three integrated stages: collection, analysis and medical review. A "Negative" result for a specimen indicates that no illicit drug use has been identified. A "Positive" result indicates that there is evidence of illicit drug use that cannot be explained by any of the legitimate medications used by the donor

2. Chain-of-Custody Collection

- 2.1 The general principles of Chain-of-Custody collection can be summarised as follows:
- ◆ to ensure that the donor understands the procedure.
 - ◆ to document medications taken by the donor.
 - ◆ to maintain the chain-of-custody.
 - ◆ to avoid cheating by the donor (specimen dilution, adulteration, substitution etc).
 - ◆ to allow the donor to provide a specimen in appropriate circumstances (e.g. privacy for urine collection).
 - ◆ to adopt procedures that allow the donor to have access to the specimen for independent analysis (e.g. splitting the specimen).
 - ◆ to allow the donor to observe the whole procedure by which the specimen is packaged ready for transport to the laboratory.
 - ◆ to ensure that the specimen is untouched at any stage, thereby avoiding contamination.
 - ◆ to ensure that the specimen is sent to the laboratory in tamper-evident

packaging.

- 2.2 The collection process is facilitated by the use of a special Chain-of-Custody collection kit. The documentation is usually provided by a multi-part, duplicating Chain-of-Custody form. The documentation is completed by, or in the presence of the donor, who will sign to confirm that the urine or saliva specimen is theirs. The sample will be sealed in the presence of the donor. Any information provided about medication will be confidential to the testing laboratory, a medical review officer, and the occupational health unit.
- 2.3 The urine testing kit usually contains two containers and, after collection, the specimen is divided between the two and these are both labelled and sealed with tamper evident security seals in preparation for dispatch to the laboratory for analysis. Both specimen containers remain together. One container, the “A” sample, is used at the laboratory for drug analysis whilst the second is stored at the laboratory under secure conditions, on behalf of the donor, as a back up in case he/she wishes to challenge a positive laboratory result. The donor has the right to challenge the results of a drug test using the second part of the split specimen. In the case of a challenge, the sealed “B” sample will be sent to an independent accredited laboratory of the donor’s choice. The donor is required to meet the cost of the transfer and subsequent analysis, but these costs will be reimbursed in the event that the test on the “B” sample is negative.
- 2.4 The top copy of the Chain-of-Custody form is forwarded with the specimen to the analysis laboratory while copies of the form go to the donor, the collector and to the responsible manager in the Force. A further copy of the form, bearing the details of recent medications goes to the Medical Review Officer.
- 2.5 The general principles of Chain-of-Custody saliva and urine collection are the same. The major difference is that a saliva specimen does not have to be provided in privacy, which reduces the measures that need to be adopted to minimise the risk of “cheating”. A further difference is that the small volume of the sample means that specimens are not always split, so an alternative approach may be taken to providing the donor with an opportunity to have an independent specimen analysis.

3. Principles of Laboratory Drug Analysis

3.1 Sample reception

- 3.1.1 On arrival at the laboratory the specimens and their packaging are examined to check that the security seals on the containers are intact, and that there are no other signs of tampering. Further checks establish that the Chain-of-Custody paperwork has been fully completed. Once these sample integrity checks have been done, one of the specimens (the “A” sample) is opened ready for analysis.

3.2 Drug analysis

- 3.2.1 The analysis of drugs in urine or saliva at the laboratory must be conducted using appropriate high quality scientific techniques. This generally involves an initial immunoassay screening test followed by a

confirmation analysis using mass-spectrometry. This not only confirms the exact identity of any drug present, but also indicates how much is present.

3.3 Quality standards

- 3.3.1 Any drug testing laboratory used by a police force, or nominated by an officer for the independent testing of a sample, must be specifically accredited for drug-testing work through appropriate national standards (UKAS and BSI).
- 3.3.2 Any drug testing company used by a police force must satisfy the minimum chain of custody requirements set out above.

4. Overview of Alcohol Testing Procedures

- 4.1 Impairment of judgement increases with increasing blood alcohol concentration. Different people can demonstrate very different degrees of impairment with comparable concentrations of alcohol in their bodies. Experimental studies have shown that for most people some degree of impairment can be measured at a blood alcohol concentration of 40 to 50 mg%, and for some individuals first impairment could be detected at a concentration as low as 30 mg%. At these levels, the individual may not be aware of any impairment, but it may nevertheless be present.
- 4.2 In line with these experimental observations, a workplace alcohol limit of 29 mg% in blood has been adopted in respect of safety critical posts, where any risk of impairment is unacceptable.
- 4.3 An alcohol limit of 29 mg% in blood does not preclude moderate drinking, for example during the evening before a period of duty that commences the following morning. The relationship between alcohol consumption and blood alcohol concentration will depend on many variables, such as the pattern of consumption, the type of beverage consumed, and the individual's body mass, metabolism and gender. Nevertheless, as with guidance given in relation to the 80 mg% blood alcohol limit for driving, broad indications can be provided to help individuals avoid situations in which they might exceed a workplace alcohol limit.
- 4.4 An average 70 kg male consuming 2 units of alcohol (e.g. one pint of lower strength beer, 3.5% v/v) could achieve a theoretical maximum blood alcohol concentration of 30 mg%. (The actual concentration is likely to be lower, as the alcohol is not absorbed instantaneously.) The body eliminates alcohol at about the rate of 15 mg% per hour; thus an average person might expect a blood alcohol concentration of 30 mg% to fall to zero over a period of approximately 2 hours. It must be emphasised that these figures are only illustrations and provide only broad indications of alcohol levels for an average individual.