Probation, harm reduction, and drug services

The probation service was committed to harm reduction – but were the services it needed to implement its policy?

by
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This review of a three-year project to establish good practice in a probation service explains the difficulty of implementing a harm reduction strategy in the face of services often unattractive to many users and unwilling to cooperate in achieving harm reduction objectives. To help overcome this, the probation service is setting up its own prescribing service and inviting drug agencies to operate sessions from its offices. The volume and type of drug users seen by probation mean the service should be given a pivotal role in planning services.

IN DECEMBER 1988 the Inner London Probation Service (ILPS) established, within its Demonstration Unit a three-year project with a brief to identify 'best practice' in working with substance misusing offenders and to develop this across the 12 inner London boroughs. It was a unique initiative which revealed the size of probation's drug misuse caseload and brought ILPS face to face with the difficulties of adapting its own practice. It also cast a fresh light on the nature of the drug services in the capital – the main subject of this article.

The Demonstration Unit undertook two major pieces of research within ILPS which identified almost 2000 people whose drug use was problematic (20 per cent of ILPS's field team caseload) and highlighted the dominance – and lack of success – of probation officers' abstinence-oriented practice. As a result ILPS became the first British probation service to explicitly adopt a harm reduction policy.[1,2]

Our task was then to devise a strategy for implementing this policy and to test how far it could be carried out. The focus in this article will be on our experience of attempting to negotiate access to the 'outside' resources identified as essential to our harm reduction strategy. Despite repeated calls from the Advisory Council on the Misuse of Drugs for harm reduction to be prioritised, our experience was all too often frustrating.

Inflexible prescribing

Any probation service which adopts a harm reduction orientation – a public health approach – must show this is consistent with its primary role in the criminal justice system – confronting offending. One of the most vital components of harm reduction for our client group, two-thirds of whom are heroin users, is the availability of flexible prescribing services. Unless drug using offenders are offered the opportunity to legalise at least part of their drug supply, efforts to reduce drug-related offending will be rendered ineffective.

But the response to our initial approaches to London's drug dependency units early in 1990 swiftly shattered any illusions that practice similar to the 'Merseyside model' could be discovered in the capital. It seemed incredible to us that representatives of the probation service should have to attempt to persuade drug clinic consultants to take note of recommendations from the Advisory Council on the Misuse of Drugs (ACMD) – recommendations endorsed by government, their own regional health authorities, the Drugs Advisory Service, and supported by the increasing body of international research evidence suggesting maintenance programmes can improve many essential areas of drug users' lives, including patterns and frequency of offending.

Although the reality of day-to-day practice varies from one clinic to another, the most flexible practice we could find was confined to the 'old hippy users' being maintained by some clinics, sometimes on injectable drugs. In relation to the 'new heroin users', policy was universally stated as short- or occasionally medium-term withdrawal, ranging from six to ten weeks at one end to three to six months at the other.

Despite this overt policy, some variation in practice did exist: it did not take us long to learn 'drug-speak' in which 'longer-term withdrawal' can be a euphemism for 'maintenance' – for which, more recently, 'stabilisation' has become the preferred alternative noun. However, such deviation from policy was not widespread and, where it was to be found, was covert and confined to a few patients.

Probation had to persuade consultants to take note of harm reduction recommendations

Two major arguments were advanced against liberalising practice and, concomitantly, dispensing with the charade of routine urine testing as part of a prescribing contract. There was resistance to colluding in prolonging the dependence of patients – perceived by the very nature of their dependence as manipulative, untruthful and untrustworthy – and a fear of creating 'new addicts' through leakage of prescribed drugs onto the streets, meaning doctors would inadvertently have joined in supplying the illicit market.

Approaches to NHS general practitioners were almost equally unsuccessful. Across inner London there are small numbers of GPs who will prescribe for drug users, but generally they do so under the direction of drug clinic doctors and offer methadone reduction regimes very similar to those on offer in the clinics. Most are highly resistant to becoming involved in this area of work, subscribing to the popular stereotype of drug users and, consequently, fearful of the disruptive effect such patients might have on their practice.

Self-fulfilling stereotype

The prescribing patterns we found in London not only collude with perpetuating the stereotype of drug users, but actually set it up. It seems accepted that drug using careers last on average ten years before individuals begin to feel that the disadvantages of use outweigh the benefits, a precondition of the motivation to change. Drug users who have not reached this stage but still wish to legalise their supply – often because they have come into conflict with the law – *have no alternative but to lie.*

To obtain 'scripts' they must falsely present themselves as 'motivated' to stop or reduce their drug use: if they present themselves honestly as drug users who have no intention of stopping they are unlikely to receive any prescribing service.

Having presented this way, the service offered will consist of 'scripts' for drugs which are not those of choice and, for injecting users, to be administered in ways which are not those of preference, almost invariably in quantities and over a timescale which do not meet the user's real requirements. Inevitably prescribed drugs will be supplemented by street drugs and some will be used either in part exchange or to raise funds for more attractive alternatives. Completing the vicious circle, the drug user's deceit and leakage of prescribed drugs justify the stereotypes behind the doctor's prescribing decisions.

Perhaps the probation service is the agency with the greatest vested interest in eliminating the inevitable games-playing that ensues from this situation: the games played at the clinic or GP's surgery have to be re-enacted with the supervising probation officer, to the detriment of carrying out effective work.

Our problems in gaining access to flexible prescribing services led the Home Office to fund ILPS to set up its own two-year 'prescriber' initiative (see panel). While welcome, such initiatives can only operate on a very small scale: flexible prescribing remains the most important missing link in the implementation of ILPS's harm reduction strategy.

Drug users who simply want to legalise their supply have no alternative but to lie.

Since our first discussions with drug dependency units two years ago, we have observed progress in some districts toward less rigid prescribing regimes; we fear these fragile changes will succumb to tighter fiscal controls on methadone budgets arising from the health service's new accounting procedures. If this happens, the role of GPs will become even more vital – but unless prescribing is more widely shared, similar budgetary anxieties will fetter the few who do undertake this work.

Wider involvement of GPs can only be achieved if more are encouraged to confront and demythologise their beliefs about drug users, and provided with appropriate training. Such issues can only be addressed by the medical profession as a body, but require urgent and honest self-appraisal.

Residential services

ILPS has a wide experience of using residential rehabilitation services – an experience which can, more often than not, be described as unfortunate. Recent research undertaken by ILPS on clients referred to 'rehabs' across the country indicates a dismal lack of success in achieving the only goal available at these centres – abstinence.

ILPS's clients frequently fail to complete even the initial assessment programme, mostly dropping out of their own volition.[3] Most probation referrals to residential rehabilitation take place in the context of a court appearance and involve those most likely to receive custodial sentences. Because it seems the only alternative to prison, not surprisingly these individuals *appear* eager to enter residential rehabilitation even if they are not, and many of these placements quickly break down.

Greater success is achieved when referral takes place in the context of a well-established professional relationship which has taken the client through the process of contemplation to a considered decision to opt for this form of treatment. But without the threat of imprisonment, abstinence-based residential services are the choice of a very small minority of our clients.

Until recently, abstinence has been the only interpretation of 'treatment' formally available within the criminal justice system. This narrow definition of 'treatment' need no longer be applied: the Criminal Justice Act 1991, the work of the ACMD on drug misusers and the criminal justice system, and the Home Office draft National Standards for the work of the probation service, all facilitate an interpretation of treatment which embraces the principles and practices of harm reduction services.[4,5]

Given that the criminal justice system is willing to broaden its definition of 'treatment', there is no reason why offenders now 'sentenced' inappropriately to abstinence-oriented residential resources as a condition of a probation order cannot similarly be 'sentenced' to programmes aimed at stabilising and legalising drug use. Unless 'rehabs' are willing to do this, the increasing competition for shrinking funding, combined with an absence of convincing evidence of effectiveness, will lead many to their demise.

Bridges to the street

Voluntary referral to street agencies and community drug teams in the context of a standard probation order are the most common and probably the most cost-effective way the probation service puts its clients in contact with drug services. The ACMD and the Home Office both recommend this practice continue after implementation of the new Criminal Justice Act in October.

One of the most worrying features to emerge from our initial research was the apparent lack of take-up of services. The understandable reluctance of ILPS's drug using clients to attend drug clinics seems to apply almost equally to agencies offering harm reduction services. Less than half the identified drugs users with whom ILPS was in contact, including many who disclosed intravenous use, appeared to be in touch with either drug clinics, GPs or community-based agencies. Many of those who were in touch with services had been put in contact

Probation's own prescribing service

Faced with difficulties in obtaining suitable prescribing services for its clients, ILPS secured Home Office funding to set up its own service. Home Office funding will cover three prescriber sessions a week, including the drug costs. Since probation services have no experience of directly employing doctors, ILPS decided this project could best be approached as a partnership venture. A district health authority will employ a doctor on ILPS's behalf to conduct one assessment/prescribing session in each of two probation offices in south-east London; the third session will be devoted to administrative tasks, including evaluation. This new service is scheduled to come into operation in January 1992.

via the probation service, but it was apparent that others were unwilling to act on their probation officer's advice. Whatever the reasons for this, it was clear that better bridges had to be constructed between ILPS and its local community drug agencies, and that this presented a major networking task for the Demonstration Unit team.

First we had to convince those with little experience of working with the probation service that we would not 'contaminate' them. Staff in these agencies perceived the service through the stereotypes presented by their clients. Understandably, they were anxious that being seen to be working closely with us would deter drug users from presenting to their services, but it is essential that drug workers try not to collude with the myth of 'good' drugs worker v. 'bad' probation officer.

Almost without exception agency staff told us that they knew some clients being supervised by ILPS who had not disclosed their drug use to their probation officer. This reinforced our awareness that the number of drug users identified in our research was just a part of the total. It also reinforced our view that negative perceptions of the probation service among drug agencies meant they did little to encourage clients to disclose drug use to their probation officers.

Non-statutory agencies do not have a prerogative on concerns about confidentiality. Probation officers do not expect drug workers in any setting to tell them the names of clients they discover to be under probation service supervision. There seems to be no common practice concerning confidentiality: the quantity and quality of information exchanged between different agencies and the probation service vary significantly – a situation which could be considerably improved by the negotiation of a shared protocol, of which clients could be fully informed, and through which they could signify assent.

'Better bridges' have to be built not only between ourselves and agencies, but between drug agencies and our clients. Is this best achieved by a 'clients to services' model – or by 'services to clients'?

Several ILPS offices host satellite harm reduction services operated by local community drug agencies. Though not fully evaluated, these seem to be reaching many of the clients probation services and drug agencies are most concerned to target – drug injectors, black users, women and younger people.

Development of further satellite services must be determined by local need and availability of resources, but there are mutual benefits to be gained from this model. Among these are: for drug agencies, a demonstrable increase in workload at a time when they need to justify their existence to funders; for the probation service, the chance to demonstrate their commitment to implementing a harm reduction policy; and for both, a cross-fertilisation of knowledge and skills, improved understanding of their respective roles, and a signpost for the future of 'partnership'.

Pivotal role of probation

For too long the role of probation in planning services for drug users has been overlooked. Many local authorities in inner London have published draft community care plans with scant, if any, consultation with ILPS. Yet inner London's probation service is uniquely placed to have a strategic overview of services, combining contact with large numbers of potential consumers with an understanding of their needs.

From this vantage point it is possible to see how the drug services system exacerbates the complexity of the probation task. Health authorities responded to drug-related HIV spread by establishing community drug teams and/or increasing funding to the independent sector to provide services distinct from those offered by drug clinics. Despite the advantages of less bureaucratic, user-friendly, street level agencies, what has emerged is a system which allows drug services of all kinds to avoid confronting some of the uncomfortable criminal justice issues related to illicit drug use.

Although the vast majority of their clients are by definition offenders, neither drug clinics nor street agencies have an obligation to concern themselves with the illegality of drug use. They can and do isolate themselves from criminal justice agencies. When the criminal aspect enters the arena, a tripartite system emerges, with probation services picking up the offending associated with this criminalised activity.

However, probation cannot isolate itself from the services it needs to support its work with drug using offenders. It is impossible for probation services to work with drug-related offending without addressing drug use *per se*. ILPS's policy on working with drug using offenders requires a holistic approach, widening the definition of harm reduction to incorporate the harm to self and others arising from both drug use and offending.

Drug services have been urged to "contact as many of the hidden population of drug misusers as possible".[6] Many of this group are probation clients at every stage in their drug use from experimental to highly dependent, giving services such as ILPS a pivotal position within the structure of services for drug users – a position which has yet to be recognised by the drugs field.

This situation is unlikely to change much when the current provider/broker role of probation services is extended to include grant-aiding powers from October 1992. Although a purchaser role will allow probation services to take a firmer lead in planning joint initiatives, this will be on too small a scale for probation to become major players in the drug services field.

THE PAST THREE years has convinced us that it is possible to implement a harm reduction strategy within the criminal justice system – but how fully this can be implemented depends on the extent to which all the agencies offering services to drug users can cooperate with us and with one another. Integration and development of services require strategic planning: in the new era of partnership, the probation service has a vital and constructive role to play. ■

1. Inner London Probation Service. *Demonstration Unit drug and alcohol survey, field services divisions, 1989*. ILPS, 1991.
2. Inner London Probation Service. *Drug and alcohol misuse: summary of Demonstration Unit interviews ... 1989*. ILPS, 1990.
3. Boother M. "Drug misusers: the role of residential rehabilitation." *Probation Journal*: December 1991, p.181-185.
4. *Criminal Justice Act 1991*, schedule 1.6(1-8). HMSO, 1991.
5. Advisory Council on the Misuse of Drugs. *Drug misusers and the criminal justice system: part 1*. HMSO, 1991.
6. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse, part 1*. HMSO, 1988.

FOR MORE INFORMATION

■ **CONTACT THE AUTHOR via ILPS on 071 222 5656.**

■ **DRUG MISUSERS AND THE CRIMINAL JUSTICE SYSTEM, PART 1. ACMD. HMSO, 1991.**
Recommends probation services practice harm reduction.
Available from ISDD, £5 inc. p&p.

■ **PARTNERSHIP IN DEALING WITH OFFENDERS IN THE COMMUNITY. Home Office, 1990.**
Aims to develop partnership between probation and independent agencies.
Contact the Home Office or consult in ISDD's library.

■ **ISDD's INFORMATION SERVICE is available on 071-430 1993.**