Probation service makes harm reduction official policy

Promotion of harm-reduction approaches with drug using clients is now official policy in the Inner London Probation Service (ILPS), breaking through the ideological barrier against criminal justice officers being seen to collude with continued offending in the form of illegal drug use.

The policy statement sent out in early June by ILPS's Chief Probation Officer also applies to alcohol misusers, building on the work of the service's innovative Demonstration Unit.

The unit was established in 1988 to identify best practice in probation work with alcohol or drug misusing clients. Its survey of inner London's probation officers conducted last year confirmed that the probation service is probably the caring profession in contact with the greatest number of problem drug users.

The survey indicated that probation officers were supervising 1829 clients believed to have a significant drug problem, 1278 of whom were out of prison, constituting a fifth of the service's community caseload. A further 821 clients were in trouble with alcohol but not using other drugs.

Heroin predominated involving 1136 clients, but at 438 cocaine use was surprisingly prevalent. A third were also misusing alcohol.

Only half the drug users were in contact with drug services and many that were had been referred by their probation officer. Nearly half the 1829 drug users admitted to injecting but less than a fifth of these were using a syringe exchange. These figures underline the importance of probation as an entry point into drug services, but the Demonstration Unit believes the absence of an explicit harm-reduction strategy in the criminal justice system seriously hampers work with drug users.

In a thoughtful presentation to April's Harm-Reduction conference in Liverpool, unit staff called for harm-reduction approaches to be an acknowledged element of a flexible probation response. They argued that the dominant abstinence philosophy gives clients little reason to disclose drug use and every incentive not to if the probation officer and the court treat illegal drug use as a breach of supervision. Without this disclosure neither the offender nor the public can be protected from the consequences of continued drug use.

But the fact that drug misuse is illegal and associated with other forms of offending makes departure from a purely abstentionist approach professionally risky for probation officers and other criminal justice personnel. In practice probation staff have exercised their wide discretion to encourage disclosure of drug use without taking clients back to court for re-offending.

But the greater visibility of harm-reduction resources (such as needle exchanges) and closer and more public oversight of probation work likely as a result of criminal justice reforms will restrict probation officers' scope for 'private' harm-reduction initiatives, argued Marilyn Bild and Paul Hayes in April. They concluded that the space for harm reduction must be re-opened by an official and open policy commitment, which up till then probation management had been unwilling to risk.

ILPS's initiative in issuing just such a policy may set an example for other services to follow. Many practise harm-reduction but Inner London appears to have been the first to have made it official policy.

Minister 'misrepresented' fears over rehab funding, claim three national agencies

On 14 June a crucial amendment to the NHS and Community Care Bill which could have safeguarded the funding of residential drug and alcohol services was withdrawn after a government minister told the Lords that voluntary drug and alcohol projects had been ''reassured'' by what she'd said to them.

Her statement dismissed widespread concern over what will happen after April 1991 when funding of residential drug and alcohol services has to be carved out of a general local authority allocation with no sums specifically earmarked for this purpose. The amendment sought to establish a transitional period of direct government funding until the Health Secretary was satisfied that other funds were available.

Astonished drug and alcohol field representatives from SCODA, Alcohol Concern and Turning Point rushed out a press release accusing Baroness Hooper of having ''misrepresented'' their position. The Baroness's statement followed a question from Lord Ennals asking whether she'd consulted the organisations supporting the amendment.

SCODA, Alcohol Concern and Turning Point – its joint supporters – say they have consistently expressed concern that wholesale closures could follow unless the bill was amended.

As the national representative bodies for voluntary drug and alcohol agencies and the single largest service-provider, the three agencies were at a loss to know who was being referred to when the minister claimed that ''all the organisations that I met intimated they had been considerably reassured by what I had to say''.

Dianne Hayter of Alcohol Concern, the only one of the three agencies the Baroness had actually met, wrote to the minister saying she was ''alarmed, dismayed and bewildered by your statement... In our meetings, Alcohol Concern has never expressed anything other than the deepest anxiety over the future survival of residential projects''.

Just a week before the amendment was debated, SCODA's Residential Services Forum had issued a press release warning of ''wholesale closure'' of residential drug services unless their funding was earmarked under the NHS and Community Care Bill.

Turning Point predicts that 75 per cent of their 20 or so residential drug and alcohol projects could close within nine months of the NHS and Community Care Act coming into force. They have calculated that over the two years' implementation period £26 million would be needed to replace Department of Social Security payments currently made to alcohol and drug rehab residents.

With no statutory responsibilities for these client groups, all the major agencies are convinced local authorities will prioritise their statutory duties to care for the elderly, the handicapped and children, leaving services for the 'undeserving addicted' to cut back or close.

Exactly this kind of consideration led the Government to make provision for earmarking community care funding for the mentally ill. On 14 May Baroness Hooper explained this was because local authorities ''have not been able to give as much priority'' to the mentally ill as to other groups.

Refusing to extend earmarking to funds for drug and alcohol dependents, the minister said it was inconsistent for the Government to aim to make local authorities more accountable to their electorates and at the same time ''determine from the centre how resources should be deployed''.

After this statement the original attempt to get drug and alcohol funding singled out was withdrawn, to be introduced in amended form on 14 June. Though again withdrawn, there is still a possibility of its being reintroduced at the third reading of the bill or when the bill goes to the Commons (see below).

■ The only concrete reassurance the Government has so far been able to give residential drug and alcohol services is a commitment to explicitly include these in official guidance to local authorities on their responsibility to provide community care.

Attempts to amend the NHS and Community Care Bill to give legal force to this requirement for England and Wales were resisted on the grounds that reference to ''illness'' and ''disability'' in the bill covers all potential client groups. The argument was that being explicit about which groups were included might imply others were excluded.

■ **Just as *Druglink* was going to press a Department of Health official confirmed that the Government intended to introduce its own amendment to ring fence community care money for drug and alcohol services. This unexpected concession could give residential services the protection they need from adverse funding decisions by local authorities. The amendment is due on 27 June but may be delayed to the end of the month.**