The introduction of drug Arrest Referral schemes in London: A partnership between drug services and the police

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Abstract
The significant investment into developing criminal justice interventions to link drug-using offenders with drug treatment interventions, most specifically in the UK, Australia and North America, has instigated debate about the emphasis given to crime reduction vis-à-vis health and harm reduction for drug users. Key to this debate is the extent to which health and criminal justice agencies are equal partners and collaborate effectively in delivering drug interventions. Arrest Referral (AR) schemes, located in police stations, provide an opportunity for advice, information, assessment and referral to drug services at point of arrest. These form a first stage of intervention which can go on to include court enforced community drug treatment orders and prison detoxification programmes. As part of an evaluation of AR schemes in London that took place between 2000 and 2002, 84 police officers and 67 drugs workers involved in the schemes were interviewed about their working relationships and views on AR. Findings highlight practical difficulties of delivering a drug service in a police custody environment, including how to establish the ‘credibility’ of the service among drug–using arrestees. Others issues raised included differences between the police and drugs workers in their perceptions of the aims of AR and the fear among drug workers that their role in promoting harm reduction was being ignored by the funders of the schemes. More positively, data showed greater collaboration and improved working relationships over time. The implications of these findings are discussed in the context of the introduction of Criminal Justice Integrated Teams (CJIT) in the UK, which aim to integrate criminal justice and community drug treatment interventions and promote inter-agency case management thus increasing the need for partnerships between health and criminal justice agencies at all points of the Criminal Justice System (CJS).

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Introduction
The reduction of drug-related crime has been a central aim of the UK drug strategy (HM Government, 1998, 2002). This has resulted in significant investment into the development of interventions for drug users located at key points in the Criminal Justice System (CJS): arrest, sentencing, prison and community (Kothari, Marsden, & Strang, 2002; Turnbull and Webster, 1998); and is consistent with developments in the US (Marlowe, 2003), Australia (Bull, 2003) and across mainland Europe (EMCDDA, 2003). In 2003, the Drug Intervention Programme (DIP) was launched in the UK to integrate these various CJS interventions and with a budget of almost £0.5 billion over three years, to promote an inter-agency case management approach to dealing with drug users from point of entry into the CJS through to ‘aftercare’ and ‘re-settlement’.

The substantial investment in CJS interventions has intensified international debate about the focus of policy approaches to problem drug use. In recent years in the UK, it has been argued that there has been too great a policy emphasis on crime reduction at the expense of public health strategies that promote harm reduction, health and...
social gain for drug users (Hunt and Stevens, 2004; Stimson, 2000).

**Drug use and crime**

In the UK the association between illicit drug use and crime has sometimes been exaggerated, and is often oversimplified (Best et al., 2001a; Hough, 2001; MacGregor, 2000; McSweeney and Hough, in press; Seddon, 2000; Simpson, 2003). The common failure, when discussing the links between drug use and crime, to differentiate between types of drug user has also been criticised (Hough, 2001). Behavioural data collected from drug users entering treatment services in the UK (Best, Sidwell, Gossop, Harris, & Strang, 2001b; Inciardi and Pottinger, 1994; Parker and Bottomley, 1996) show that problem drug users who are dependent on heroin and crack cocaine often commit crime to finance their drug use. The National Treatment Outcomes Study (NTORS) found that just over half the sample of 1100 drug users had committed a crime (other than drug possession) in the 3 months prior to entering drug treatment. The most commonly reported offence was shoplifting (Gossop, Marsden, & Stewart, 1998). Ten percent of the sample accounted for three-quarters of the total acquisitive crimes committed. By contrast, half reported that they had not committed any acquisitive crime in the three months prior to starting treatment (Stewart, Gossop, Marsden, & Rolfe, 2000).

Drug use is common among arrestees in the UK. The NEW-ADAM (Arrestee Drug Abuse Monitoring) survey (Bennett, 1998, 2000; Bennett, Holloway, & Williams, 2001; Holloway and Bennett, 2004) involved drug-testing and interviewing samples of arrestees in England and Wales. Its final sweep interviewed 3091 arrestees in 16 locations – equivalent to around 28% of the estimated 11,000 arrestees processed by these sites and half of those who were eligible for entry to the study – (arrested for acquisitive and drug related offences). Thirty-eight percent tested positive for either or both opiates and cocaine (Holloway and Bennett, 2004). The average weekly expenditure for those using opiates and crack and cocaine was £323; with the main sources of illegal income coming from property crime followed by undeclared earnings and claiming social security benefits and drug dealing. Heroin and crack/cocaine users had an average annual illegal income of around £24,000 – compared to almost £6000 for non-drug using arrestees.

**The role of drug interventions in reducing crime**

Reductions in criminal activity have been reported among drug users receiving treatment for substance use (Coid, Carvell, Kittler, Healey, & Henderson, 2000; Gossop et al., 1998; Strang et al., 1997; Turnbull, McSweeney, Hough, Webster, & Edmunds). Several UK reviews of the international evidence have examined the effectiveness of the main types of treatment in the UK: inpatient programmes; community prescribing; care planned counselling; and residential rehabilitation (Department of Health, 1996; Holloway, Bennett, & Farrington, 2005; Hough, 1996; Marsden and Farrell, 2002). Methadone maintenance, in particular, has been shown to offer a way of reducing drug use and enabling improvements in physical and mental health, and personal and social functioning (Marsch, 1998).

It is, however, important not to over-simplify the effects of treatment on drug use or offending behaviour (Gossop, 2005; Gossop, Marsden, & Stewart, 2001) or to under-play the various difficulties involved in engaging and retaining drug users in treatment. Clearly, the quality of treatment and the context in which interventions are delivered are critical determinants of outcome. For example, recent analysis of data from the UK National Drug Treatment Monitoring System noted that “the strongest predictor of retention or completion of treatment was not the characteristics of the client, but related to the agency they had attended” (Millar, Donmall, & Jones, 2004, p. 4).

The Audit Commission (2004) and others (Gossop, 2005) have stressed that clinical intervention alone is unlikely to be effective and needs to be accompanied by social care and support: an issue that the UK Drugs Intervention Programme is designed to address via the development of ‘throughcare’ and ‘aftercare’ services. The often short-term nature of funding for many interventions has also been a concern and not easily reconciled with the fact that problem drug use is a chronic and relapsing condition that is unlikely to be dealt with by a single period of treatment (Kothari et al., 2002). There are also factors related to an individual’s readiness to address problem drug use. For example, Cahill, Adinoff, Hsng, Muller and Palliaim (2003) have suggested that external forms of pressure like that exerted by the CJS might increase treatment entry and short-term retention but appears to have little impact on longer-term outcomes.

**Exploiting the coercive potential of the CJS**

The expansion of drug services as part of a drug and crime reduction policy agenda raises concerns that treatment provision and the relationship between provider and client may be distorted (Barton, 1999; Parker, 2004; Stimson, 2000). Criticism of CJS drug interventions have tended to focus on the ethics of ‘coercion’ and its impact on treatment processes and outcome (De Leon, Melnick, Thomas, Kressel, & Wexler, 2000; De Miranda, Kressel, & Wexler, 1996; Hunt and Stevens, 2004). There is often the assumption that any referral from the CJS will be coercive and that all drug users seeking help in the community will do so voluntarily. Bean (2001, p. 63) and Farabzz et al. (1998, p. 8) by contrast, have criticised the voluntary/coerced dichotomy as misleading, stressing the need to examine the views of drug users about the extent to which they feel ‘coerced’ into treatment via the CJS.
Further, the benefits of drug treatment are incremental and thus retention in treatment is a key predictor of positive outcome. It has been noted (mainly by North American studies) that initial ‘coercion’ can help keep drug users in contact with services longer, particularly during the difficult first stages of treatment and is no less effective than treatment entered into ‘voluntarily’ (Anglin, 1988; Barton, 1999; Farabee, Prendergast, & Anglin, 1998; Hser, Maglione, Polinsky, & Anglin, 1998). However the lack of any long-term outcome studies, particularly in the UK and European context, on the effects of ‘coerced’ versus ‘voluntary’ treatment make it difficult to draw any firm conclusions at present (see Stevens et al. (2005) for a recent review).

The basis of CJS drug interventions, and indeed the development of the Drug Intervention Programme, is collaboration between the CJS and health services, which in effect has meant forging a union between agencies with different agendas and perspectives on drug use and drug users (Barton, 1999; Hough, 1996; Turnbull et al., 2000). A multi-agency ‘partnership’ approach to dealing with drug use has been promoted by the UK government since Tackling Drugs Together (Home Office, 1995). It was this document that instigated the formation of local Drug Action Teams (DATs). These were established to bring together various statutory authorities to assess the nature and extent of local drug problems and implement a co-ordinated plan to tackle these. Increasing communication between the agencies that have contact with drug users (including health services and the police) to ensure a more concerted response seems sensible. However, a key issue is the extent to which agencies are genuinely equal partners. The most unsatisfactory outcome of such collaboration would be one where the CJS agency is always the dominant partner, so that harm reduction and health goals are always subsumed to those of enforcement and crime reduction. Bean (2004: 91) has described the experience of bringing together health and CJS agencies in the USA as one where compromise on working style and agenda is largely being made by health agencies with little change in practice from the CJS. In the UK, practice guidelines for DTTOs give the CJS the ultimate power in treatment decisions as the courts and probation service can override the advice of the treatment provider (Falk, 2004; Kothari et al., 2002; Turnbull et al., 2000).

**Arrest referral**

Arrest Referral (AR) schemes are intended as partnership initiatives between police and local drug services that use the point of arrest within custody suites (at police stations) as an opportunity for drug-using offenders to be assessed by an independent drugs worker who can then refer them to drug treatment services. AR schemes have been in use in various forms in the UK since the 1980s (Dorn, 1994, Drug Prevention Advisory Service, 2002). Their introduction into every custody suite in England and Wales was an objective of the Government drug strategy (1998) and by 2002 this target was achieved. Annual monitoring data for the period October 2000–September 2001 showed that 48,810 individuals were screened by an AR scheme and, of those, over half were voluntarily referred to a drug service (Drug Prevention Advisory Service, 2002).

The schemes did not offer an alternative to prosecution or due process and participation was voluntary; arrestees were under no obligation to be assessed or referred by a drug worker. They functioned in much the same way as peripatetic outreach, an intervention that has been encouraged since the late 1980s as a way of ‘reaching out’ to ‘hidden’ drug users to reduce drug-related harms and encourage entry to drug treatment (Ball, 1998; Rhodes and Stimson, 1998). Discussion between an arrest referral worker and an arrestee was confidential, except in instances where the arrestee might disclose information about harm to self or others or an involvement in a serious crime that police were unaware of. The parameters of the confidentiality policy were to be made clear to the arrestee prior to any interview with the AR worker.

In this paper, we take the introduction of Arrest Referral schemes in London as an example of the “meeting” of health services and the CJS, and review the extent to which this initiative functioned as a partnership at “grassroots”. By this we mean between operational police officers and drugs workers rather than at senior management level. By April 2000, 14 drug services had been awarded contracts to operate 25 schemes in police stations across London and approximately 100 drugs workers had been employed to deliver this service. A number of service requirements were stipulated, including using the proactive model of AR, which involved having dedicated drugs workers on-site at the custody suite and all arrestees were to be offered the opportunity to see a drugs worker (hereafter arrest referral worker) (Drug Prevention Advisory Service, 1999, 2002; Edmunds, Hough, Turnbull, & May, 1999; Edmunds, May, Hough, & Hearnden, 1998).

**Method**

The way in which the AR scheme functions in the police station (e.g. how drugs workers make contact with arrestees, what services they can offer at point of contact, what hinders service delivery) is explored by reference to interviews with AR workers and custody sergeants; the latter are the police officers responsible for the management and care of arrestees. These interviews examined the views of both parties on working practice and working relationships, perception of the aims of AR and its usefulness and effectiveness at providing help to drug users. The findings formed part of a UK Home Office-funded evaluation of AR (Drug Prevention Advisory Service, 2002; Kothari et al., 2002; Oerton et al., 2002).

Interviews were conducted at two points (Time1: October 2000–February 2001 and Time2: November 2001–February 2002).
to review changes or developments in collaboration and working practice. Sixty-seven interviews were conducted with AR staff from 11 of 25 AR schemes in London, 35 at Time1 and 32 at Time2. In total, 13 managers and 38 AR workers were interviewed (16 AR staff were interviewed at both times). In addition, three focus groups were conducted between May and December 2001, two with workers and one with managers, to discuss further some of the issues raised in the individual interviews.

Eighty-four interviews were conducted with custody sergeants from 24 police stations (linked to the 11 AR schemes), 52 at Time1 and 36 at Time2. Four respondents interviewed at Time1 were re-interviewed at Time2. At Time2, no effort was made to exclude those sergeants who had been interviewed before. The relatively small number of repeat interviews was, in part, indicative of police staff turnover.

A semi-structured interview schedule was used for AR staff. The interviews took approximately 1 h and were tape-recorded and transcribed. Interviews with custody staff were conducted while they were on duty and for that very practical reason, tape recording interviews was not viable and a semi-structured questionnaire was used instead. Common topics were covered in both interviews, although clearly the AR workers had opportunity to discuss in greater depth their views on AR.

Questionnaire data were analysed using SPSS. Semi-structured interviews and focus group discussions were tape-recorded and transcribed. Qualitative data were analysed by the assignment of codes to collate the data under key categories. These ‘first level’ coding categories reflected the areas outlined above. Within each ‘first level’ code, a number of ‘second level codes’ were also identified and these formed the basis for further analysis and interpretation.

Findings

Our findings present interview data on the extent and nature of information and training about AR for police and AR workers, their understanding of working procedures, views on working relationships, their perception of the aims of AR and the factors that made it effective/ineffective.

Drug agencies provided the AR service, although police custody officers were involved in the process in a number of important ways. It was the custody sergeant who first asked an arrestee if s/he wanted to meet with a worker. The offer was made as part of a risk assessment interview (comprising questions on physical and mental health) before being taken to a cell. The officer could also inform AR workers about potential contacts when they are off-site. Importantly it is the custody sergeant who served as gatekeeper to the arrestee in that the AR worker required police permission to visit the arrestee in a cell or to take the arrestee out of a cell to conduct a drug use assessment.

Information and training about AR and the Criminal Justice System

Given their central role, it is important that custody officers were clear about the aims of AR and their responsibilities for the AR process. However, introducing the concept of AR to custody staff was done on a rather ad hoc basis. Less than a third of respondents (16/52) reported participating in a formal training session about AR prior to its implementation at their station. At Time2, similar proportions reported receiving introductory information from both the police (13/36) and the AR schemes (11). Information about AR for police officers often came in the form of a memo (Time1 14/52), via a chat with a senior officer (3), through contact with a scheme at a previous station (11) or ‘by picking up information from colleagues’ (4 at Time1, 8 at Time2).

Only a quarter of respondents at Time1 (13) and one-third at Time2 (12) reported receiving more general training from the police authorities on drug awareness with many describing their knowledge about drug users as being picked up on the job. Their stated training needs regarding drug use included information on infectious diseases (9), an overview of drug use issues (6), the effects of different drugs (5), health implications of drug withdrawal in custody (3), and more information about policy and practice of AR schemes (3).

AR workers also noted a lack of knowledge among some officers about the aims and working procedures of AR as described below:

“It was difficult from the start, because it’s partly a police project but the policemen didn’t seem to know. It’s still a case of some people don’t have a clue, even after so many months.” [Time1, ARW 7: Scheme 2]

In turn AR workers had to feel confident about working in the police station. Just under two-fifths had previous experience of working in the CJS, including for other AR schemes and the probation service. While almost all workers reported receiving an induction to AR, a common complaint was that it did not prepare them for working in a police custody environment. For example, one worker described his lack of familiarity with criminal justice ‘jargon’ as an initial problem:

“Being new to it, criminal justice, there is a lot of jargon and especially the people you are talking to [arrestees] tend to have been in the system before so they’re talking about ‘remand’ and ‘licence’ and stuff. You can get a bit confused in there.” [Time1, ARW 11: Scheme 1]

Others requested guidance about the working ‘etiquette’ of the custody suite:

“There was nothing in any of our books when we started up, or when you’re in the custody suites, whether or not you’re allowed to take them into the doctor’s room, absolutely
nothing about any of that kind of stuff and it changes from station to station.” [Focus Group 1: ARW 02]

AR working procedure – making contact with arrestees

Co-operation between custody sergeant and AR scheme started with the initial offer made to arrestees to meet an AR worker. In practice custody staff reported making judgements about the appropriateness of offering the scheme to arrestees. For example, exceptions were made by some officers for juveniles, ‘old people’ those who were drunk or violent, those arrested for ‘white collar crime’, anyone who required an interpreter, those who were deemed to be mentally unfit and when it was thought that such a question might cause offence. Overall, police respondents at Time 1 were more likely to state that the scheme was offered to every arrestee (43/52) than respondents at Time 2 (22/36). Almost without exception, AR workers considered this to be an inadequate means of introducing the service. A key issue was the ‘context’ of the offer in that it was the last of many questions, which tended to elicit an automatic ‘no’. As described below:

“I’m satisfied they’re made aware, I’m not satisfied in the manner that they’re made aware and that’s something I will confront police with. That’s got to be re-addressed, because all these questions, it’s ‘no, no, no, no’, and right at the end is the drugs question, and it doesn’t mean anything. I’m sure there must be some other way.” [Time 1, ARW 3: Scheme 1]

There was also concern among AR workers that the police were not promoting the scheme because of their negative opinions about drug users and the view that arrestees would consider the scheme to be something to do with the police and therefore be unlikely to request the service:

“I get the feeling that only one or two sergeants actually believe in the service and actively are selling it. I get the feeling that the perception of drug users as incorrigible is there and I think it’s going to be really hard to break that down”. [Time 1, ARW 8: Scheme 1]

“There is the relationship with the police and how the service is sold by the police. Whether or not they trust the police, whether or not they trust that we are an independent service. I fear that an awful lot of people are falling on the other side of that mistrust barrier. It’s the more trusting police that will see us.” [Time 1, ARW 4: Scheme 1]

Co-operation from police was also required if the service was requested at a time when the AR worker was not present (no scheme offered 24 h cover). Some workers felt that the many other responsibilities of custody sergeants meant that contacting them was not a priority:

“There’s times where I don’t think the co-operation is seen as important. If someone has asked to see a drug worker, and I’m not there at the time. I don’t think they see it as important to get back to me. They might be busy and ask me to come back. . . . I come back an hour later and they’ve [arrestee] gone.” [Time 1, ARW 5: Scheme 1]

“There are a couple [of sergeants] that do contact us but a huge percentage of them don’t, so you know they’ll tick the box [stating request for AR service] but they won’t call”. [Time 2, ARW 2: Scheme 6]

The interviews with custody staff confirmed this view. By Time 2 even fewer sergeants were likely to make an effort to contact workers if they were not present when the service was requested. While over three-quarters (45/52) of police respondents at Time 1 reported contacting the AR worker by telephone, this fell to over half (21/36) of respondents at Time 2. By this stage police respondents were more likely to pass on the arrestee’s contact details to the worker the next time they attended the station or simply give the arrestee the number for the AR scheme and leave it to them to contact the service. Although, custody staff justified this by stating that AR workers were attending the police station daily and thus it was easy for them to pick up messages.

AR workers believed that the most successful way of encouraging arrestees to take up the offer of AR was by the workers visiting the cells to introduce the scheme (proactive work):

“Most of our referrals are proactive, we get very little from the police . . . they do refer to us . . . they refer a couple a week but most of our referrals come from going round the [cells]” [Focus Group 01, 03]

“It’s probably 75% we get from knocking on the cell doors.” [Time 2, ARW 8: Scheme 2]

To do this, AR workers required permission from the custody sergeant. Over three-quarters (40/52) of police respondents at Time 1 and almost all at Time 2 (35/36) were happy to allow workers access to the cells. The initial reticence shown by a minority of sergeants at Time 1 (10), was related to concerns about prisoner rights if the offer of the service had been refused on the risk assessment form (4), a lack of any clear police procedure for allowing workers to do proactive work in the custody suite (1), and safety concerns (5). By Time 2, such concerns seemed to have abated with only two sergeants unhappy for AR staff to conduct proactive work.

Working relationship between the police and the AR workers

Developing a good working relationship with custody staff was considered by many AR workers to be essential to establishing an effective scheme. In the main, AR workers
considered their relationship with police to be good. However, this had not been immediate as the following interview extracts show:

“I’d describe it [working relationship] as very good. That’s been through persistent hard work and being in the custody suite and making my presence known, and engaging with them on a personal and professional level. Right at the beginning they were very frosty and very sceptical.” [Time1, ARW 6: Scheme 3]

“I think it’s individual rapport. If you do go in guns blazing, ‘I’m the Arrest Referral worker, get them out of the cell now’ you’re going to build a bad rapport. We are working with different agendas. The more I’ve been there, the more I’ve been accepted.” [Time1, ARW 11: Scheme 1]

Of note, however, was that problems in working with the police reported by workers at Time1 had often reduced by Time2, as illustrated below:

“There were teething problems and I think there have been pretty much nationally, and I think most of those have been about the cultural difference between the police and the way drug workers work. It seems to me that if nothing else, if referrals are anything to go by, that’s really fine and we’re working well together”. [Time2, AR manager: Scheme 8]

“I would say that it [working relationship] has improved overall. I mean there’s still a bit of distance from a few of the old stalwarts but mostly it has improved” [Time2, ARW 2: Scheme 4]

AR workers perceived a positive aspect to improved working relations was that the police were more likely to encourage arrestees to take up the offer of the AR scheme:

“I think, for us it’s gotten a lot better, just through us being there all the time, getting to know, and their attitudes aren’t quite as hard and that’s sort of rubbing off on how they introduce it to clients, they’re selling the service a bit more.” [Focus Group 1, 02]

“The sergeants are used to seeing us every day and are friendly. Attitudes have really changed.” [Time2, ARW 2: 05]

The vast majority of police respondents’ at both Time1 and Time2 considered their working relationship with AR staff to be very/fairly good (44/52 and 29/36, respectively).

Perception of the aims and effectiveness of AR schemes

The extent to which custody staff will co-operate and/or become more involved in the AR process is likely to be influenced by how much additional work it creates for them, their views on the aims of the schemes and whether or not they think the schemes can achieve these aims.

Over three-quarters (41/52) of police respondents at Time1 believed that having the AR scheme in the custody suite had no additional impact on their work, however, at Time2 this had decreased to just over half (21/36) of respondents and a number of issues were mentioned, including the responsibility of supervising AR workers (11/36); of trying to accommodate AR work with the needs of other professionals such as solicitors and medical staff (7); the paper work the AR process created (4) and that it involved moving prisoners about more often (e.g. taking them to and from interview rooms to speak to AR worker) (4).

At both Time1 and Time2, police respondents most commonly noted the key aim of AR to be crime reduction (open question) (40/52 at Time1 and at 21/36 at Time2). Under half (24) at Time1 and over one-third at Time2 (21) mentioned ‘helping people get off drugs’ or into drug treatment. Other key aims, noted by a minority included the promotion of a multi-agency approach to dealing with drug users, identifying people who need support and improving the health of drug users.

When asked how likely they thought it was that AR schemes would achieve such aims, most police respondents (40/52) at Time1 did not know or felt that it was too soon to say; by Time2 over two-thirds (25/36) considered it unlikely. Yet despite this, nearly three-quarters at both Time1 and Time2 (37/51 and 26/36, respectively) considered the AR schemes to be useful. A range of reasons were given for this including the view that arrest was a good point to speak to people about drug use (15 at Time1 and 20 at Time2), that AR was a good resource for the police to offer to drug-using offenders in custody (10 at Time1 and 8 at Time2) that it was an example of multi-agency working (4) at Time1 and 3 at Time2) and that even if only a few arrestees took up the offer of the scheme it could still have an impact on crime (1 at Time1 and 3 at Time2).

Most AR workers also noted the ‘official’ aim of AR to be crime reduction via channelling drug users into treatment, although they considered their capacity to achieve this to be restricted by various structural factors and the motivation of individuals to address problem drug use, as discussed below:

“We are up against it. We’re not in a position to fast track [quick entry to drug treatment services]. Six to eight week waiting list for assessment and that really sets us up because we’re offering everything and delivering nothing. Clients can’t wait that time.” [Time1, ARW 6: 04]

“...the waiting lists. If you are assessing people and they are quite vulnerable and people think that arrest referral doesn’t require many skills but you are dealing with people who are vulnerable, often coming down from crack, or heroin. You do work hard and then...
people don’t turn up for treatment, or there are waiting lists and they lose their motivation and that does get to you.” [Time2, ARW 2: 05]

A common concern of AR workers was that while much had been invested into setting up AR schemes, there had been little focus on how AR services would be integrated into drug service provision more generally:

“It’s been very good in terms of cementing a much more productive working relationship with the police. Ten years ago we were very wary of the police and would not have thought about having shared initiatives . . . It’s difficult to say how successful I think it is in terms of diverting people into treatment.” [Time2, AR manager: Scheme 7]

“It seems to have come the wrong way around, getting all those workers generating new referrals or re-generating old referrals and not having anywhere to send them, that’s just mad.” [Time2, ARW 8: Scheme 2]

Because of this, AR workers were keen to stress the more immediate aspects of their work and there was a common emphasis on the importance of using the AR encounter as brief intervention to provide harm minimisation information to drug users as illustrated in the following quotes:

“The aim of my scheme is to see as many people as possible. To give them as much information as possible about what’s available, what’s going on about harm reduction. I think that’s probably more important and to advise on various things from Hep C to overdose. Irrespective of whether these clients go on to see anyone afterwards.” [Time1, AR W 8: Scheme 1]

“The intervention of the AR worker, why not see that as important. Bear in mind how many people come to drug services anyway, they wait until they’re in real crisis so why you’d think that just because someone’s been arrested they’ll attend the service the next day. I mean they may do but if you’ve done some good work and passed on some good advice then that’s great too.” [Time2, AR manager: Scheme 10]

Yet their capacity to promote public health strategies such as safer drug use practices and prevention of drug overdose was perceived by workers to be largely ignored by the funders (Home Office and Metropolitan Police) because this aspect of their work was not being monitored routinely by these agencies:

The main focus is getting people into treatment, that’s what the Met [Metropolitan police] want to hear and that’s what the Home Office want to hear. They don’t take account of the information and advice giving, harm minimisation, that’s not counted as a result. Stuff like that is completely ignored by government and the police and it’s a big part of our work.” [Time2, AR W 6: 05]

Discussion

A number of issues are raised by these findings about AR and the nature of partnership between police and AR workers at ‘grass roots’ level. These include the sometimes poor communication between AR workers and the police, the lack of training and preparation for both parties about the running of the schemes in the custody environment, the perceived lack of emphasis given to the harm reduction role of AR workers and the isolation of the schemes from community-based drug services.

The integration of the various CJS and community drug treatment interventions is a key aim of the Drug Intervention Programme in the UK and therefore, these issues need to be addressed in laying the foundations for the effective delivery of Criminal Justice Integrated Teams (CJITs).

In some areas the expansion of drug testing arrangements in custody has already become an important mechanism for identifying potential CJIT clients (ICPR & CRDHB, 2004). This involves compulsory testing for Class A drugs for all those arrested for acquisitive and drug-related offences. In most cases, however, arrestees who have been tested constituted a small number of those engaging with DIP. Testing on charge appears to be a key problem with arrestees preferring to leave the police station as soon as possible rather than engage with AR (ibid). A key challenge for CJITs then will be to develop and implement a number of different strategies for improving take-up and engagement rates with treatment services.

Restriction on bail measures (which introduces the possibility of withdrawing access to court bail for those refusing a drugs assessment and any follow-up treatment after a positive test) and the expansion of drug testing provision under the Drugs Act 2005 will make meeting with a CJIT worker a mandatory requirement for bail. Consequently, the AR route will remain a key part of the overall CJIT process and demand even greater cooperation between police and health workers.

In terms of the practical operation of AR schemes in police custody, it is possible to say that in general police custody officers did not obstruct AR workers in conducting their duties and over time often a ‘rapport’ and constructive working relationship was achieved between these parties. However, whether the AR process could be described as a partnership of equals between police and drug workers is questionable.

Dorn (1994), in his research on fledgling AR services in England in the early 1990s, discussed how police commitment to these schemes was often undermined by low uptake among arrestees. In London, in 2000, the routine offer of an AR service by custody officers continued to yield few referrals and thus police perception of AR may well have been tainted by this lack of interest among arrestees.
While many custody staff considered the AR schemes to be a useful resource and arrest to be a key point for intervention with drug users, officers were sceptical about the success of AR at getting drug users to engage with treatment services and therefore the likely effectiveness of AR at reducing crime; the key aim of AR as identified by the police officers we interviewed. Their level of cooperation in passing on details of those arrestees who had requested the service to AR workers had declined by second interview stage and their complaints about the additional work generated by hosting the schemes had increased.

The potentially conflicting viewpoints of CJS staff and health professionals about drug users and the goals of drug interventions is raised by a number of authors as a key problem for joint initiatives (Barton, 1999; Beyer, Crofts, & Reid, 2002; Hough, 1996; Kothari et al., 2002; Lough, 1998). For example Lough, writing about CJS interventions in Australia, noted the general conservatism of police about ways of responding to drug use and drug users as an inhibiter to partnership working. Kothari et al. (2002) have stated that all staff within the CJS need to be educated about the various methods for treating and rehabilitating drug-using offenders, including the more immediate priorities of reducing drug-related harm.

At the time of this study, there was certainly some short fall in the training of custody staff specifically about AR, with many of our police interviewees reporting the need for further training about the aims and operation of the schemes as well as on more general drug-related issues. This was a worrying oversight for the Metropolitan Police, given the proportion of problem drug users who police officers are likely to have contact with in their day-to-day work and in the light of the continued development of CJS drug treatment interventions involving the police. It demonstrates the importance of ensuring an adequate and ongoing training package for police and drugs/CJIT workers is developed and delivered. This could cover drug use issues including the rational for harm reduction and the evidence for the effectiveness of different drug treatments. However, it could also provide a forum to discuss and agree the aims of CJS interventions and the respective roles within that process, including developing protocols for making contact with potential clients and referring them to AR services. Further, meetings to review procedural issues should be scheduled on a regular basis to foster good communication between police and AR workers.

AR workers considered providing harm minimisation information to be a key aspect of their role, and a way to use skills effectively, particularly in light of difficulties of getting arrestees into drug treatment programmes. However, this type of information was not collated in routine activity monitoring and thus the promotion of public health strategies such as safer drug use practices and the prevention of blood-borne infections and drug overdose received no ‘official’ recognition from funders. This suggested to many health workers that their work was being marginalised and a particular perspective on responding to problem drug use was being ignored. However, the latest drug strategy (HM Government, 2002) does actually mention the words ‘harm minimisation’ and it seems crucial to ensure that the new CJIT maintain a clear role in reducing drug-related harm alongside helping drug users get into treatment services and others forms of intervention. For example, The Hepatitis C – Action Plan for England (Department of Health, 2004) makes clear recommendations for strengthening local harm reduction services for hepatitis C prevention and this could involve brief intervention at the police station by AR workers, including the distribution of up-to-date information on safer injecting practices. There is certainly some scope for involving police partners in this harm reduction role.

For the AR workers, alongside the practical obstacles of negotiating the custody environment, there was some worry that the credibility of their service among drug-using offenders was being undermined by an association with the police, as well as concern about the ability of AR to get drug users into treatment. While one key factor was the motivation of the drug user, there was also a range of structural difficulties, including waiting lists and service capacity and of note was the common view among health professionals that AR had been developed in isolation and not as part of a system of drug treatment. Furthermore, the Audit Commission (2004) recently noted that despite the significant expansion in drug treatment provision and capacity during recent years, a lack of integrated support often hampers its effectiveness and threatens to undermine any progress made as a result of engagement with treatment services.

These are just some of the hurdles that CJITs will have to negotiate if they are to successfully integrate the panoply of drug, alcohol, mental health, housing and education, training and employment support for drug users at each stage of the criminal justice continuum. However, increasing capacity to promote a more joined up system of drug treatment and other support for drug users, and better training for all those involved may help to foster a greater sense of joint ownership of these interventions between police and health service staff.

References


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