

Crime and Justice

Evaluation of the Mandatory Drug Testing of Arrestees Pilot

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Mandatory Drug Testing of Arrestees (MDTA) aims to encourage problem drug users who come into contact with the criminal justice system to engage with treatment services, as a means of addressing the individual's drug misuse problem and associated offending behaviour. Under the scheme, anyone arrested for defined 'trigger' offences (acquisitive crime and drug offences), and testing positive for heroin and/or cocaine via oral fluid testing are required to undergo an assessment with a drugs assessor. Those who would benefit from treatment are introduced to drug treatment providers on a voluntary basis. The MDTA pilot scheme was implemented in June 2007 in three police stations (one each in Aberdeen, Edinburgh and Glasgow), and is due to run until June 2009. This paper presents the findings of a process evaluation and cost effectiveness analysis of the pilot scheme.

Main Findings

- The pilot has assisted fewer arrestees into drug treatment than was originally anticipated; especially those who were not previously engaged with drug treatment services.
- The numbers of referrals into the assessment were broadly similar with 310 in Aberdeen, 381 in Edinburgh and 301 in Glasgow.
- Attendance at assessment varied between the schemes, with 263 (85%) attendees in Aberdeen, 247 (65%) in Edinburgh and 152 (50%) in Glasgow.
- In Aberdeen, 67 people engaged with treatment, 42 of whom were not already in treatment. In Edinburgh 46 people engaged in treatment. The number who were not already in treatment is not known. In Glasgow, 110 engaged with treatment, 68 of whom were not already in treatment.
- Cost effectiveness analysis showed the level of grant spend by individual attending assessment was lowest in Aberdeen (£2,502), followed by Edinburgh (£3,275) and Glasgow (£4,816).
- The level of grant spend per person entering treatment was lower in Glasgow (£6,655) compared to Aberdeen (£9,821) and Edinburgh (£17,586).
- Comparing the cost effectiveness of the MDTA pilots against Arrest Referral in terms of individuals attending assessment and engaging with drug treatment, Arrest Referral schemes appear to be more cost effective than the MDTA pilot schemes.
- The police, especially in Glasgow, experienced some under-resourcing in terms of ability to perform tests and to make onward referrals to assessor staff. The low throughput of arrestees resulted in a redefinition of the role of assessors appointed to work on the pilots, and a greater involvement of assessment staff in care-management of clients.
- Arrestees who took part in the evaluation viewed the scheme positively, especially the wider package of support that was offered. The schemes do appear to have been effective at providing information, help and support at the generic level at the point of assessment.
- Despite low numbers, most staff involved in the pilots viewed it positively, and there was consensus that the pilots were reaching some of the most vulnerable and at risk drug users. The pilot also contributed to learning about the drug using populations in each of the areas in which it operated.

Background

'Tackling Drugs in Scotland: Action in Partnership' was published in 2000, and set the framework for a ten year drugs strategy. This Drugs Action Plan aimed to increase the number of individuals referred into drug treatment at their initial contact with the criminal justice system. Mandatory Drug Testing of Arrestees (MDTA) was established in June 2007 and is the latest initiative reflecting the policy drive towards assisting vulnerable drug users access the help they require.

MDTA aims to encourage problem drug users who come into contact with the criminal justice system to engage with treatment services as a means of addressing the individual's drug misuse problem and associated offending behaviour. Under the scheme, anyone arrested for defined 'trigger' offences (acquisitive crime and drug offences) are subject to mandatory oral fluid testing for heroin and/or cocaine. Those testing positive are required to undergo an assessment with a drugs assessor with a view to determine any dependency on drugs. Upon completion of the initial assessment, individuals who would benefit from treatment are introduced to drug treatment providers, although any subsequent uptake of treatment services is voluntary.

MDTA pilots were implemented in three police stations in Scotland known to have high levels of drug use among arrestees (Edinburgh, St Leonard's; Aberdeen, Queen Street; and Glasgow, London Road), and should run until 11 June 2009.

Research Aims

The evaluation sought to explore whether the pilot scheme, as originally conceived and implemented, has met this aim, exploring both the systems introduced and the activities undertaken by each of the main partners responsible for delivering the scheme.

The evaluation also sought to provide a cost effectiveness analysis of the pilot schemes. This included a description of the spending in each area, broken down into specific costs relating to the pilot, and analysis of the numbers of arrestees entering treatment services for the first time. An overall cost-effectiveness analysis was undertaken for MDTA alone, as well as a comparison between MDTA and Arrest Referral, an alternative, voluntary entry route into treatment offered to arrestees.

Methodology

The evaluation ran for a five month period between October 2008 and February 2009, in parallel with the pilots' operation.

The evaluation involved the analysis of statistical data collected by the schemes, as well as qualitative data collected by the evaluation team to achieve a better understanding of the way in which the pilots operated and were received.

The main service providers (the police, drugs assessors and treatment providers and Crown Office and Procurator Fiscal Service representatives) were interviewed as part of the research. Further, a small sample of arrestees provided feedback on the way that it had been received.

Given the short time periods over which the pilots had been operating, and the reporting deadline for the evaluation which fell before the end of the pilots themselves, there was limited scope to carry out an impact evaluation. The absence of outcomes data meant that the focus of the evaluation was on the processes involved, and the efficiency of the set up, implementation and operation of the schemes, and, to a lesser extent, the outcomes and impacts for arrestees.

Drug Tests, Referrals and Engagement with Treatment

At the planning stages, it was anticipated that up to 15,000 people a year (based on 420 per month) would be tested across the three sites, and that around 50% of these would test positive. The actual numbers of people tested, and who were referred on to initial assessment in each of the pilot sites were:

Aberdeen: 848 tests, 334 positive tests, 310 referrals for assessment, 263 attending assessment, 67 people engaging with treatment, 42 of whom were not already in treatment.

Edinburgh: 1830 tests, 471 positive tests, 381 referrals for assessment, 247 attending assessment, 46 people engaging in treatment. The number who were not already in treatment is not known.

Glasgow: 630 tests, 301 positive tests, 301 referrals for assessment, 152 attending assessment, 110 engaging with treatment, 68 of whom were not already in treatment.

While the number of drug tests performed in the Edinburgh pilot was greater than those conducted in Aberdeen or Glasgow, the numbers of people referred for assessment were broadly similar in each area. Attendance at assessments was higher in Aberdeen and Edinburgh but Glasgow had the greatest proportion of all people referred entering into drug treatment services.

Looking at the numbers alone, it would appear that the MDTA pilot has helped relatively few people enter into drug treatment services, especially those who were not previously engaged. However, the schemes do appear to have been effective at providing information, help and support at the generic level at the point of assessment.

Cost Effectiveness

The cost effectiveness analysis was based on the grant spend in each of the three pilot sites between June 2007 and November 2008. The MDTA grant spend by area was £658,000 in Aberdeen, £809,000 in Edinburgh and £732,000 in Glasgow.

A similar methodology was used to calculate the total spend on Arrest Referral in Northern, Lothian & Borders and Glasgow East End for the same time period, to allow comparison with MDTA. The grant spend by area was £293,400 in Northern, £581,700 in Lothian and Borders and £502,000 in Glasgow.

In comparing the cost effectiveness of MDTA and Arrest Referral, separate analysis were conducted for the number of individuals referred for assessment and, perhaps more importantly, the number of arrestees who engage with drug treatment as a result of referral, as follows:

Aberdeen: MDTA Attendance at Assessment = 263, Arrest Referral Attendance at Assessment = 162. MDTA Engaged with Drug Treatment = 67, Arrest Referral = 32.

Edinburgh: MDTA Attendance at Assessment = 247, Arrest Referral Attendance at Assessment = 1,077. MDTA Engaged with Drug Treatment = 46, Arrest Referral = 208.

Glasgow: MDTA Attendance at Assessment = 152, Arrest Referral Attendance at Assessment = 616. MDTA Engaged with Drug Treatment = 110, Arrest Referral = 251.

The final stage of the cost effectiveness comparison required an analysis of the level of grant divided by the numbers of arrestees attending assessment and entering into treatment. For the period June 2007 to November 2008, the grant spend per head for MDTA and Arrest Referral was as follows:

Aberdeen: MDTA Grant by Individual Attending Assessment = £2,502, Arrest Referral Grant by Individual Attending Assessment = £1,811; MDTA Grant by Individual Engaged with Drug Treatment = £9,821, Arrest Referral Grant by Individual Engaged with Drug Treatment = £9,169.

Edinburgh: MDTA Grant by Individual Attending Assessment = £3,275, Arrest Referral Grant by Individual Attending Assessment = £540; MDTA Grant by Individual Engaged with Drug Treatment = £17,586, Arrest Referral Grant by Individual Engaged with Drug Treatment = £2,797.

Glasgow: MDTA Grant by Individual Attending Assessment = £4,816, Arrest Referral Grant by Individual Attending Assessment = £815; MDTA Grant by Individual Engaged with Drug Treatment = £6,655, Arrest Referral Grant by Individual Engaged with Drug Treatment = £865.

Comparing the impacts of the three MDTA pilot schemes reveals that, in terms of the number of arrestees referred for assessment and the number of arrestees attending assessment over the evaluation period, both Edinburgh and Aberdeen has performed better than Glasgow. However, the Glasgow scheme has clearly performed better in terms of the number of people engaging with drug treatment. This is particularly so for those arrestees who were not already engaging in treatment.

In cost effectiveness terms, the level of MDTA grant spend by individual attending assessment is lowest in Aberdeen (£2,502), followed by Edinburgh (£3,275) and Glasgow

(£4,816). However, when one focuses on the level of grant per person entering treatment, which is the key factor in the process, then it is clear that the figure for the Glasgow pilot (£6,655) is the most cost effective and performs significantly better than Aberdeen (£9,821) and Edinburgh (£17,586).

Comparing the cost effectiveness of the MDTA pilots against the Arrest Referral schemes shows that, in terms of individuals attending assessment and engaging with drug treatment, the Arrest Referral schemes appear to be more cost effective than the MDTA pilot schemes. This is particularly so in Glasgow where the level of Arrest Referral grant by individual who engaged with drug treatment is the lowest of all the Arrest Referral schemes. On the basis of the figures provided, and the level of grant spend per individual engaging with drug treatment, the Edinburgh MDTA pilot scheme is the least cost effective.

Perceptions of the Pilot

The main stakeholder groups in each of the three pilot areas were asked to reflect on the way in which the pilot had operated and, in particular, whether the processes employed could have been improved to allow for greater efficiency in the pilots' delivery.

The main concern regarding the running of the pilot was the far lower than anticipated numbers of arrestees who were referred into the scheme. Both the police and assessor organisations asserted that the expected numbers were unrealistic and it was not clear how these initial estimates had been calculated.

The impact of this was felt most acutely by the assessor staff in each region for whom the workloads early in the pilot were somewhat limited. Resources allocated to assessor organisations were a reflection of the expected throughput numbers and, in practice this resulted in too many staff for the numbers of people who were being referred by the police. As the pilots progressed, each of the schemes modified their working practices so that assessors became more involved in the care management of MDTA clients, rather than being responsible for initial assessments alone. In Aberdeen, staff also undertook some Arrest Referral work to try and fill gaps in the workload generated by MDTA. This meant that some of the funding and resources that had been allocated to MDTA was, in essence, being spent on Arrest Referral tasks.

In direct contrast, the police appeared to have experienced some under-resourcing in terms of staff availability to identify eligible arrestees for assessment and to perform drugs tests. In all sites, the core function of police staff was seen as the protection and welfare of arrestees held in police cells and, in some cases, this meant that staff were unavailable to perform routine MDTA tasks. The administration time required to complete the MDTA paper-work was also cited as something which restricted the numbers of people who could be processed by police staff at any given time.

Also, the legislation was universally considered to be too restrictive. In particular, a rule which prevented testing after more than 6 hours detention meant that some people were being missed by the scheme. The eligibility criteria were seen as too restrictive, in particular in respect to the relevant trigger offences and the exclusion of people on warrant. There was also concern that the scheme did not cover people living out with the pilot areas and it was felt that there was no reason to eliminate these people when it would have been feasible for them to attend an assessment.

Despite the low numbers of referrals, there was a shared view that the scheme was useful in assisting a small number of vulnerable drug users into treatment services.

The nine arrestees who contributed to the evaluation felt that their interaction with service staff had been positive, and that their engagement with MDTA had enabled ready access to a wide variety of care and treatment programmes. All those who participated in the consultation reported that their engagement with MDTA had resulted in reduced drug consumption and offending behaviour.

Discussion

All three pilot schemes appear to have been implemented with relatively few problems at the early stages. Considerable efforts went into the planning of logistical operations and in recruiting what were perceived to be the appropriate levels of staff to deliver the schemes effectively. This meant that drug testing was operational in all areas at the planned start time of mid June 2007.

Despite relatively smooth day-to-day running of the schemes, a number of valuable lessons can be learned from the pilots operation, both in terms of improving the effectiveness of delivery as well as how resources might be targeted in the future.

The biggest challenge faced by the pilots has been a far lower than expected throughput of referrals into the scheme. This has impacted on almost every aspect of delivery for the schemes. In particular, it has resulted in a low workload for the assessment and treatment staff appointed, and has meant a redefining of the roles of these staff to include more care management in the process. Any future continuation of the scheme needs to be resourced more accurately in terms of police and assessor staff allocation. More police staff may increase the numbers of referrals being made, but the numbers are still unlikely to require the level of assessor and treatment staff capacity as was allowed for in the pilot.

Partnership working between the police and assessor organisations has been slightly problematic in each of the three areas at different points in the pilot. In particular, the police may have perceived a lack of feedback from assessors and treatment providers in terms of eventual outcomes for people referred, whilst assessors and treatment staff may have felt that the police were not sufficiently motivated and engaged with the principles of the scheme to make as many referrals as might have been possible. There has, perhaps, been a lack of understanding of the respective roles and cultures in each of the organisations which could have been reduced with more up-front awareness raising.

Finally, the evaluation encountered some challenges due to inconsistent data recording and storage both between agencies and across the three schemes. This made it difficult to provide reliable comparisons of the true operational effectiveness of the three schemes in terms of drug testing, referral, assessment and treatment activity. Any future continuation of the scheme would require the development of rigorous data collection and management systems to allow more accurate monitoring and evaluation.

Conclusions

Mandatory drug testing of Arrestees does appear to be targeting some of the most vulnerable and at risk drug users in the three sites in which the pilot is operating. The numbers being assisted are not, however, large.

Based solely on the numbers of people who have been referred into the scheme, and attended a full initial assessment, and those who have gone on to engage in treatment services, it would appear *prima facie* that the schemes have had limited reaching impacts. This is especially true when considered against the level of resources allocated to the pilots, and when compared to both the Arrest Referral scheme and against the initially anticipated numbers who may be helped by the scheme.

Finally, in the absence of any significant outcomes data, the scope of the MDTA evaluation was limited and the true impacts of MDTA on arrestees' future drug use and offending, as well as social impacts of the scheme, is not likely to be known for some time. Therefore, any conclusions drawn about the true success of the scheme may be best reserved for the future.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: <http://www.scotland.gov.uk/socialresearch>. If you have any further queries about social research, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131-244 7560.



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