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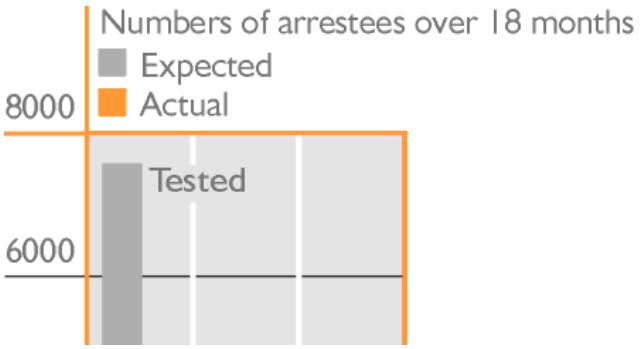
▶ Evaluation of the mandatory drug testing of arrestees pilot.

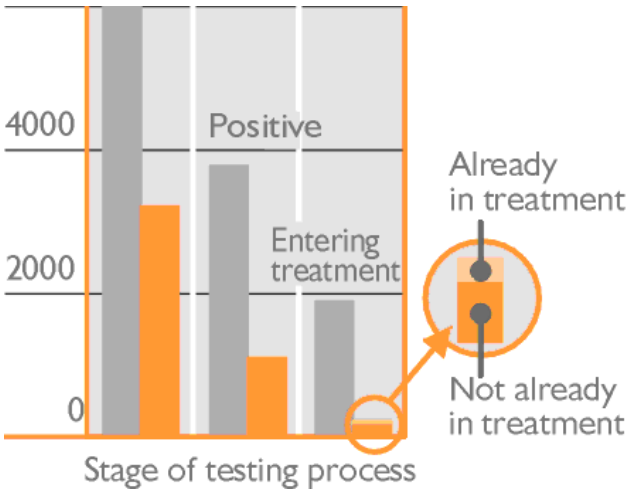
Skellington Orr K., McCoard S., McCartney P.
Scottish Government Social Research, 2009.

Scotland withdrew funding when it saw this evaluation of testing for heroin/cocaine use on arrest. It looked like a very expensive way to get a few users in to treatment; at two of the three sites, six to eight times more costly per treatment entry than voluntary referral.

Abstract Mandatory drug testing 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 problems and associated offending. Under the scheme, anyone arrested for defined 'trigger' offences (acquisitive crime and drug offences) are required to undergo oral fluid testing for heroin and/or cocaine. Those testing positive must attend for an assessment by a drugs assessor to determine any dependence on drugs. Individuals who would benefit from treatment are introduced to drug treatment providers; any subsequent uptake of treatment services is voluntary.

For two years from June 2007 this procedure was piloted at three police stations in Scotland (in Edinburgh, Aberdeen, and Glasgow) known to have high levels of drug use among arrestees. An evaluation sought to establish how well the schemes had worked, drawing on interviews with service providers involved in the schemes and with a few arrestees, plus records kept by the schemes on their first 18 months in operation. Voluntary arrest referral schemes perform a similar function to the pilots but do not involve mandatory testing or sanctions for failing to attend for assessment. Data from local arrest referral schemes provided a rough benchmark against which to compare the pilots.

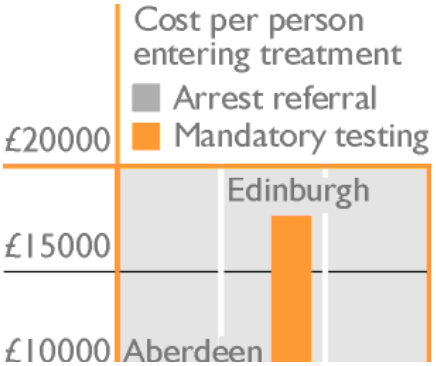


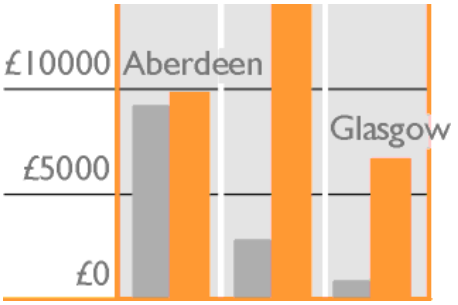


In Aberdeen and Edinburgh police saw 4204 people whose offences and other characteristics made them eligible to be tested under the schemes. Of these, just over a third were not tested, largely due to having already been detained for six hours, intoxication, violence, or staff unavailability. Of those tested, about a third were positive for heroin or cocaine and the great majority were referred for assessment. Of those assessed, the assessors reported that just over a fifth had attended treatment services. Refusal to be tested was rare but a third referred for assessment did not attend, sometimes because they were already in prison. Once an assessment had started no one was recorded as having left early.

It had been expected that the three schemes would in total test 420 people a month, half of whom would test positive and a quarter of whom would start treatment. In the event (▶ chart upper right) numbers were far fewer than anticipated and the proportions moving from one stage of the process to the next were smaller. The net result was that over 18 months, 3211 arrestees were tested instead of the expected 7560, and 223 attended for treatment instead of the expected 1890. Of the 223 treatment entrants, up to 156 were not already in some form of treatment. People assessed but not entering treatment may nevertheless have received valuable information, help and support.

These throughput figures were combined with estimates of how much of the grant for each of the schemes had been spent over the same 18 months: £658,000 in Aberdeen, £809,000 in Edinburgh and £732,000 in Glasgow. The key calculation was the cost per person who started treatment. For the same areas this was £9821, £17,586 and £6655 respectively. Similar calculations were made for voluntary arrest referral schemes in areas as closely aligned as possible with the three mandatory schemes. For these the cost per person who started treatment was (in the same order) £9169, £2797 and £865. The implication is that as a treatment recruitment mechanism, the mandatory scheme was about as cost-effective as arrest referral in Aberdeen, but less cost-effective by a factor of from six to eight in Edinburgh and Glasgow ▶ chart lower right.



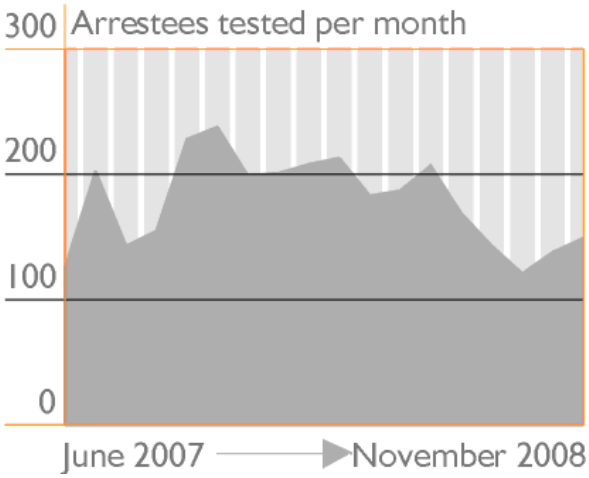


The main concern of staff involved in delivering the schemes was the far lower than anticipated numbers of referrals. Police and assessor organisations said the expectations had been unrealistic and their genesis unclear. Resources allocated to assessor organisations reflected these expectations, resulting in too many staff for the numbers actually referred by the police. As the pilots progressed, schemes modified their working practices so that assessors became more involved in delivering care rather than just initial assessment. In contrast, police seemed under-resourced in terms of staff availability to identify eligible arrestees and do drugs tests. Time required to complete associated paper-work was also seen as creating bottlenecks and the legislation was universally seen as too restrictive, especially the rule preventing testing after more than six hours in detention. The restricted range of trigger offences, exclusion of people on warrant, and restriction to people living in pilot areas, also limited throughput. Assessors were sited in police stations, the right location it was felt, but accommodation was sometimes unsuitable and on two sites for safety reasons they were shielded from arrestees by physical barriers, impeding rapport. Due to the low numbers of people being processed, partners had reservations about the true success of the schemes. Nevertheless, there was a shared view that a small number of vulnerable drug users had been helped to enter treatment, aided by funding enabling rapid access, particularly to methadone programmes. The few arrestees who contributed to the evaluation felt their interaction with service staff had been positive and enabled ready access to a wide variety of care and treatment programmes, resulting in reduced drug use and offending.

The researchers argued that despite their relatively smooth day-to-day operation, any continuation of the scheme needs to be resourced more accurately in terms of police and assessor staff allocation. More police may increase the referrals but the numbers are still unlikely to require the level of assessor and treatment staff capacity allowed for in the pilots. In each of the areas, partnership working between police and assessor organisations had at times been slightly problematic. Police felt they lacked feedback from assessors and treatment providers in terms of eventual outcomes for people referred, while assessors and treatment staff felt police were insufficiently motivated to maximise referrals. There was, perhaps, a lack of understanding of respective roles and cultures which could have been broken down with more up-front awareness raising. Also, more rigorous data collection and management systems are needed to permit accurate monitoring and evaluation.

The conclusion was that mandatory testing does appear to be targeting some of the most vulnerable and at-risk drug users, but the numbers helped are not large. Based on these numbers, it seems the schemes have had limited impacts, especially considering the resources allocated to them and in comparison with anticipated numbers and voluntary arrest referral schemes. The true impacts on arrestees' future drug use and offending is not likely to be known for some time.

FINDINGS On average, at each of the schemes two to three people a month entered treatment who might not otherwise have done so. Some of the throughput shortfall may have been due to a slow build up, but month-by-month trends suggest this was not a major cause ▶ chart. Given that the host police stations were selected for high levels of drug use among arrestees, this seems a very disappointing payoff. The study was unable to explore why two thirds of assessed arrestees did not attend for treatment. In Glasgow, the netting of employed cocaine users who did not see themselves as having a problem may have been a factor. Others may not have required or wanted treatment or been prevented from following through on the referral due to being taken in to custody. Some may have been negative about the testing process or about their previous treatment experiences, possibly with the same services they were being referred to.



The possibly 156 people not already in treatment who started it during the first 18 months of the mandatory schemes must be set against an estimated 165 referred to the prosecuting authorities for failing to comply with laws requiring testing and assessment, of whom an estimated 126 were prosecuted. Though these crimes and prosecutions were entirely a by-product of the schemes, the associated criminal justice costs were not included among their costs, which covered assessment and treatment only. Other unaccounted costs included developing the legislation and procedures needed to bring the schemes to the piloting stage. Had these costs been included, the cost-effectiveness of the schemes would have been considerably worse.

About 5% of all arrestees tested and 14% of those who tested positive entered treatment who were not already in treatment. This compares to an estimated 5–6% and 11% respectively in England in similar mandatory schemes. In England the number of offences for which people tested on charge (rather than arrest as in Scotland and also later in England) were convicted fell by 26% from the six months before the test to the six months after. It is impossible to say to what degree testing and/or treatment versus arrest and charge contributed to the changes. Such gains as there were in crime reductions were secured at the cost of considerable 'net-widening', drawing in people not previously convicted and low-level offenders who might never otherwise have come to notice, and exposing them to the risk of conviction for failing to comply with testing and assessment requirements. In Scotland there are signs that this too may have happened in the observation that the Glasgow scheme netted many employed people using cocaine but not heroin who did not see themselves as having a drug problem.

In contrast to England, the Scottish treatment entry figures were based on the assessors' reports. Glasgow's assessment staff worked for the treatment provider so are likely to have been well informed; similarly in Aberdeen where assessors usually accompanied arrestees to their first appointments. In Edinburgh it is unclear how assessors would normally have known whether people turned up for their treatment appointments.

Partnership working difficulties due partly to the competing priorities and requirements of

criminal justice and care/treatment systems seem endemic to this kind of enterprise, having been remarked on in the early days of arrest referral in England.

The English and Scottish experiences raise doubts over whether making testing and assessment mandatory is a cost-effective alternative to voluntary arrest referral. Costs, and the potential for offences and convictions to be generated simply by the schemes themselves, are a concern, as are the ethics of forcing people in to assessment and re-assessment. If effective assessment is considered not a preparation for treatment but the start, it may be argued that this amounts to compulsory treatment. Set against this is the possibility of drawing people in to treatment who will benefit from it with consequential benefits for society, but who would not have otherwise have owned up to heroin or cocaine use or accepted the offer an in-depth assessment. Whatever the balance of these benefits and risks, it would seem financially and ethically prudent to maximise the reach of voluntary schemes before resorting to compulsion.

In the light of the featured research, on 12 May the Scottish Executive announced that it was terminating funding of the mandatory testing schemes but continuing with the voluntary schemes.

Thanks for their comments on this entry in draft to Tim McSweeney of the Institute for Criminal Policy Research at King's College London. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 23 May 2009

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