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Evaluation of the Mandatory Drug Testing of Arrestees Pilot

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EVALUATION OF THE MANDATORY DRUG TESTING OF ARRESTEES PILOT

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EXECUTIVE SUMMARY

Background

In 2000, Scottish Ministers published the Drugs Action Plan and set the framework for a ten year drugs strategy 'Tackling Drugs in Scotland: Action in Partnership'. The 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) is the latest of such initiatives and reflects the policy drive towards assisting vulnerable drug users towards the help that they need.

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 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.

Mandatory Drug Testing of Arrestees 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 is due to run until 11 June 2009 (total two year pilot). This report presents the findings of a process evaluation of the Mandatory Drug Testing of Arrestees pilot scheme.

Research Aims

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

The evaluation also sought specifically to provide a cost effectiveness analysis of the pilot schemes. This included a description of the spending on the pilots 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 as a result of the pilot. An overall cost-effectiveness analysis was undertaken for MDTA alone, as well as a cost effectiveness 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 all interviewed as part of the research. A small sample of arrestees took part in the research to provide 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 in the set up, implementation and operation of the schemes as well as the efficiency 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) across the three sites would be tested, and that around 50% of these would test positive. The table below shows the actual numbers of people tested, alongside those who tested positive and were referred on to initial assessment in each of the pilot sites. It also shows the numbers of people who attended their initial assessment and those who went on to engage in drug treatment services.

	Aberdeen	Edinburgh	Glasgow
Drug Tests Carried Out	848	1830	630
Positive Tests	334	471	301
Referral for Assessment	310	381	301
Attendance at Assessment	263	247	152
Engagement with Treatment	67	46	110
Number not already in treatment	42	Not Known	68

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. That said, 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 in the 18 month period between June 2007 and November 2008. While MDTA funding is awarded by financial year i.e. April to March, calculations were carried out which showed that MDTA grant spend by area between June 2007 and November 2008 was £658,000 in Aberdeen, £809,000 in Edinburgh and £732,000 in Glasgow.

Similar calculations were used to estimate 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 £485,000 in Glasgow.

In comparing the cost effectiveness of MDTA and Arrest Referral, separate analyses were conducted for the number of individuals who attended assessment and, perhaps more importantly, the number of arrestees who engaged with drug treatment as a result of referral into each of the two services, as follows:

	Aberdeen/Northern		Edinburgh/Lothian & Borders		Glasgow	
	MDTA	Arrest Referral	MDTA	Arrest Referral	MDTA	Arrest Referral
Number attending Assessment	263	162	247	1,077	152	616
Number Engaged with Drug Treatment	67	32	46	208	110	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/Northern		Edinburgh/Lothian & Borders		Glasgow	
	MDTA	Arrest Referral	MDTA	Arrest Referral	MDTA	Arrest Referral
Grant by Individual Attending Assessment	£2,502	£1,811	£3,275	£540	£4,816	£815
Grant by Individual Engaged with Drug Treatment	£9,821	£9,169	£17,586	£2,797	£6,655	£865

Comparing the impacts of the three MDTA pilot schemes reveals that, over the evaluation period, both Edinburgh and Aberdeen have performed better than Glasgow in terms of the number of arrestees referred for assessment and the number of arrestees attending assessment. 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 grant 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, on the whole 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, the level of grant spend per individual engaging with drug treatment in the Edinburgh MDTA pilot scheme is the least cost effective of all.

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.

Other barriers to the referral of more arrestees appeared to have been presented by the legislation which 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 outwith 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.

Arrestees who contributed to the evaluation all 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

The pilot schemes all 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 of a MDTA scheme 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 also 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 broken down 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 different 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. Again, 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 initial 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.

CHAPTER 1 INTRODUCTION

Background

1.1 In 2000, Scottish Ministers published the Drugs Action Plan and set the framework for a ten year drugs strategy 'Tackling Drugs in Scotland: Action in Partnership'. The Action Plan aimed to increase the number of individuals referred into drug treatment at their initial contact with the criminal justice system. It is widely established that addiction problems are one of the main drivers for criminal behaviour in Scotland and there is evidence linking drug taking and particular crimes, for example, the abuse of heroin and crack/cocaine is often associated with acquisitive crime. More than three out of four people who receive a custodial sentence from the Courts show signs of drug abuse at the point of entry into prison and 70% of cases dealt with by the Scottish Courts are believed to be of a drug related nature.¹

1.2 Scotland's new national drugs strategy 'The Road to Recovery: a New Approach to Tackling Scotland's Drug Problem' was unveiled in June 2008. It reported that £94 million will be spent tackling drug use over the next three years. This represents a 14% increase in funding by 2010-11 and reflects the growing concern of drug use in Scotland.

1.3 Mandatory Drug Testing provides the latest example of a number of initiatives to reduce drug-related crime and to encourage problem drug users into the appropriate treatment and support services, thus breaking the cycle of drug use and offending. It follows on from such initiatives as Drug Courts, Drug Treatment and Testing Orders and Arrest Referral, further details of which can be found in Appendix A.

Principles of the Scheme

1.4 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 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.

1.5 Mandatory Drug Testing of Arrestees 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 is due to run until 11 June 2009 (total two year pilot).

1.6 The drugs test is for people aged 16 and over and tests for the Class A drugs, heroin and cocaine. For those who test positive, there is a statutory requirement for them to undergo a mandatory drugs assessment with a view to assisting them into treatment. The testing itself is carried out in police station custody suites using oral fluid samples, and results are available immediately.

¹ The Road to Recovery: A new Approach to Tackling Scotland's Drug Problem, Scottish Government, 2008 (<http://www.scotland.gov.uk/Resource/Doc/224480/0060586.pdf>)

1.7 In Scotland, legislation dictates that refusal of any part of the testing and assessment process without reasonable excuse constitutes an offence and is liable to criminal charge, resulting in a fine not exceeding £2500 and/or up to 3 months in custody. A summary of the legislation underpinning MDTA and a list of the trigger offences is presented in Appendix B.

1.8 The pilot sites are each operating using different models, and the processes being used in each area, their relative strengths and weaknesses and the efficacy of the three models were all subject to this evaluation.

The Evaluation

1.9 This evaluation sought to explore whether the pilot schemes, as originally conceived and implemented, were successful in encouraging drug users to engage with treatment services. It explored both the systems introduced and the activities undertaken by each of the main partners in delivery for the scheme.

1.10 The evaluation also sought specifically to provide a cost effectiveness analysis of the pilot schemes. This included a description of the spending on the pilots 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 as a result of the pilot. An overall cost-effectiveness analysis was undertaken for MDTA alone and a comparison of the cost effectiveness of MDTA against Arrest Referral was also undertaken.

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

1.12 One of the aims of this evaluation is to allow evidenced based recommendations to be made on the future of Mandatory Drug Testing in Scotland, by providing an account of the perceived efficiency and effectiveness of the pilot schemes. That said, it is important to note that there was limited scope for an outcome evaluation using a more longitudinal research design, due mainly to the short period of time over which the pilots had been operating and the early reporting of the evaluation before the pilots had themselves reached an end.

1.13 Consequently, the focus of the evaluation was on the processes involved in the set up, implementation and operation of the schemes as well as the efficiency of the schemes, and, to a lesser extent, the outcomes and impacts for arrestees.

Research Methodology

1.14 Given the requirement for a process evaluation rather than an impact or performance evaluation, and the absence of reliable outcome data, the methodology adopted a necessarily audit focused approach employing methods such as secondary data analysis and desk based scrutiny of narrative data to explore historical developments with Mandatory Drug Testing, rather than using more projective techniques which explore likely future impacts of the schemes.

1.15 The MDTA pilot evaluation comprised three core elements, as follows:

Desk Research and Documentary Analysis – collation and analysis of written and numerical start-up information held by the three pilot schemes, including such documents as minutes of meetings, funding proposals, action plans and strategy documents, job descriptions for those employed in the pilots and operational documents. This involved collation and analysis of all throughput data held by the schemes (including demographic data for arrestees and drug use/offending history data), as well as national data held in relation to new entrants into drug treatment services;

Consultation Activity – principally, interviews with key stakeholders involved in the pilot schemes, including criminal justice and health professionals and arrestees; and

Costing Exercise – collection of appropriate cost data for analysis to allow comparisons to be made of the relative effectiveness of the three pilot schemes.

1.16 A large quantity of secondary data were provided to the evaluation team from the three sites, but was not presented in any uniform fashion. Each of the schemes were administered differently, with different management systems and procedures for collecting and storing monitoring data. Whilst efforts were made to standardise the hard data collected, to enable comparisons between the schemes, this was not always possible, and is noted where relevant in the analyses.

1.17 Primary data were collected by means of semi-structured qualitative interviews with each of the key stakeholders in each of the pilot sites. This included the police, assessors, drug treatment providers, Crown Office and Procurator Fiscal Service (COPFS) representatives and other supporting service providers. A full list of consultees is provided in Appendix C and the interview schedules are presented in Appendix D.

1.18 A small number of arrestees who had been referred into the MDTA scheme also took part in the evaluation (four from Aberdeen, one from Edinburgh and four from Glasgow). The number of arrestees consulted was lower than initially hoped for, due mainly to problems identifying persons willing and available to participate. The evaluation took part in a period when the referral into assessment and treatment activity was especially slow, meaning fewer arrestees were available for recruitment. Further, although access to clients was sought via the various assessment and treatment provider agencies in each of the three sites, and was designed such that interviews could take place at times when service users were already accessing services, the attendance rate at pre-arranged meetings was poor. This was most likely due to the inherently complex and chaotic lifestyles of those subject to the MDTA scheme.

1.19 Whilst the sample of arrestees who took part in the scheme may not be considered as representative (ie no feedback was provided from those who chose not to take part in the test, assessment or to engage in treatment), the views of those who did engage fully from beginning to end still provided valuable insight into the ways that the scheme was received. Those who did participate were also asked to reflect on possible reasons why counterparts may not have engaged with the service, and this provided some useful understanding.

1.20 This aside, the research approach provided a comprehensive means of accessing and exploring all data and documents collected in each of the three areas, combining

analysis of statistical data with attitudinal data from those involved in running or targeted by the schemes.

1.21 The costing exercise ran in parallel with the desk research and consultation activity, and drew upon data collected therein, as well as drawing on other data sources, such as financial data held by the Scottish Government.

Research Caveats

1.22 The evaluation began more than 12 months after initial implementation in each of the three sites, and, consequently, much of the data gathering has been retrospective. This does mean that the quality of some of the 'perception' data might not be as reliable as might be hoped, since much is dependent on the recollection of the partners involved. Further, due to some staff turnover among police, assessors and treatment providers across the three areas, some of the early observational data that might have been captured if the evaluation had been run in parallel with the pilot set up, has been lost.

1.23 The evaluation was also largely based around data provided to the team from the staff in the three pilot sites. The quality of data provided was a reflection of the systems in place to collect, store and manage the local data and these systems were, in turn, subject to the evaluation itself. This means that, in some cases, gaps in the data present not only limitations to our understanding of how the schemes worked but also point towards shortfalls of the schemes in their data gathering mechanisms. It is important to note, however, that no minimum standards of data required were set at the start of the pilots.

1.24 In addition to not being able to offer any reliable data regarding impacts of the pilots, the timescale of the evaluation has meant that the pilots will continue to run after the evaluation is complete. This means, therefore, that analysis of information and resource utilisation has had to be limited to a snapshot of the pilots, rather than for the whole period of their operation. It was decided that, for comparison purposes, a full 18-month period would be used for the evaluation, from the beginning of June 2007 (when the pilots were first implemented), to the end of November 2008. For costing purposes, a time period of June 2007 to March 2008 (financial year 1) and April 2008 to March 2009 (financial year 2) was used, with figures prorated to generate cost 'per head' figures.

1.25 Finally, whilst the evaluation seeks to compare the three pilots both against one another, and against the arrest referral scheme, the different models used in Glasgow, Edinburgh and Aberdeen mean that it is not possible to make entirely reliable comparisons, since there may be a number of variables linked to the different models which have directly impacted on numbers of referrals processed, and resource utilisation required. This means that any figures presented in the costing exercise that relate to 'per head' estimates, must be considered in the context of the infra-structural context in which the schemes are operating.

Report Structure Overview

1.26 The remainder of this report provides a description of the planning and implementation of the pilots in each of the three areas (Chapter Two) and of the operation of the schemes (Chapter Three). Chapter Four presents the cost effectiveness analysis undertaken as part of the evaluation, drawing on data presented in earlier chapters. The

perceptions of the efficiency of the schemes from each of the main stakeholders involved in the pilot, namely, the police, assessor and drug treatment agencies, COPFS and arrestees is presented in Chapter Five. Chapter Six provides a discussion of the main findings from the research, and posits possible options for the future of MDTA in Scotland.

CHAPTER 2 PLANNING AND IMPLEMENTATION OF THE SCHEMES

Planning of the Pilot Schemes

Local Implementation Groups

2.1 At the start of the pilots, a local implementation group was set up in each area with membership from the police, assessors' organisations (usually the city council or local social work), Drug Action Team (DAT) representatives, including the Health Board, and representatives from the Crown Office and Procurator Fiscal Service (COPFS). The purpose of the groups was to make clear the responsibilities of each of the main partners in delivery (the police, assessor and treatment agencies) and to put in place the accommodation, staff and other resources required to make the pilots operational from June 2007. Details of the meetings of these groups are provided in Appendix E.

2.2 Across all schemes, the planning and implementation meetings seem to have provided a clear forum for discussion of emerging issues as the pilot has progressed. There has, however, been limited involvement from the Crown Office and Procurator Fiscal Service at these meetings, and this absenteeism has, in the eyes of some of the other people involved in delivering the pilots, been disappointing. Importantly, there appears to have been no formal or regular feedback to the police, assessors or treatment providers regarding the numbers of people charged under the Act for non-compliance with either the drugs tests or attendance at assessment. Many of those interviewed in the consultation stages of the evaluation suggested that it would have helped them to understand the 'whole' process more fully had COPFS representatives played a more active and visible role in the schemes planning, operation and ongoing monitoring. A more detailed discussion of the impact of limited engagement from COPFS on the pilots operation is presented in Chapter Four.

Accommodation for the Pilots

2.3 In each of the sites, legislation permits that initial assessments may be carried out either at the site of detention (ie police offices) or off-site, at a time and date agreed with the participant, the police and assessor organisations.

2.4 In Aberdeen, it was decided that on-site assessments would have to be carried out in the then Aberdeen District Court interview rooms, adjacent to the custody suite. These rooms are also used by solicitors to conduct interviews with their clients, and on occasion, assessments have had to be conducted quickly in order to assure solicitors can also conduct their interviews before the client's court case is called. Both interview rooms were refurbished for the purpose of the MDTA scheme. Secure custody 'booths' (including a wired partition) were installed, preventing any kind of physical contact. Off-site assessments are also undertaken in a central location, at Gallowgate, Aberdeen.

2.5 In Edinburgh, plans were put in place for assessments to be carried out in the Nurses Room at St Leonard's police station (a room usually reserved for Nurses completing paperwork, storing paperwork, and team meetings). A nurse is onsite 7pm – 7am weekdays and from 7pm Friday until 7am Monday. A small window on the door of the Nurses Room was installed when the MDTA scheme began to allow for better reassurance of security for the assessors during an assessment. There was some early

discussion of a panic alarm being installed in the Nurses Room, however, when this issue could not be resolved, personal attack alarm were issued for each assessor instead. The use of the room meant that assessments were sometimes delayed as nurses were using the room for meetings. Off-site assessments are undertaken near the police station, in the Turning Point Office in Forrest Road, Edinburgh.

2.6 In Glasgow, assessors were initially invited to use an open office located in the police station. This presented some difficulties in terms of it being awkward to navigate arrestees from the cells to the room, and, more importantly, from a police perspective, contravened health and safety rules since it provided no separation of arrestees from assessors. This meant that police staff had to guard the door of the room while assessments were underway; a resource demand which could not be sustained. As the pilot progressed, the MDTA staff started to use the same room as Arrest Referral staff working at Glasgow London Road which caused some complications with overlapping shifts, but was more fit-for-purpose with regards to safety. This facility consists of two small rooms, separated by a wall of glass with an intercom system linking the two. Off-site assessment in Glasgow are carried out the East Community Addiction Team offices in Parkhead, just a short distance from London Road police office.

Recruitment and Staffing

2.7 In each of the pilot areas, there was need to recruit staff for delivery of the schemes. Specifically, it was identified that the police would require additional Police Community Support Officers (PCSOs) to handle the day-to-day administration of the MDTA scheme, whilst existing police Constables and Custody Sergeants would also need to be trained in the testing and administration procedures to provide back-up support and to maximise delivery of the scheme.

2.8 In each of the three areas, resources were also allocated to existing assessor and drug treatment agencies, to enable them to advertise and appoint staff specifically to the pilot schemes for the length of its delivery.

2.9 In Aberdeen, it was intended that PCSO interviews were to be held during the first week of May 2007, with an intended start date of 2 July 2007. The PCSOs were not in place for the beginning of the pilot and initially police officers carried out the drug tests until the PCSOs were trained. PCSOs commenced training on the 2nd July and were operational by the beginning of August 2007. In total 16 PCSOs were employed (15 full time and 1 part-time).

2.10 For the assessor post in Aberdeen, job advertisements were placed in April/May 2007, but it was thought that initially, on-site assessments would be provided by DTTO staff on an overtime basis during evenings and weekends. There had been only three suitable applicants for the four assessors' posts and two persons were selected. There were potentially suitable candidates amongst the applicants for the Arrest Referral posts. In May 2007, it was decided that due to the time needed for the Disclosure Certificate process, the new MDTA assessment staff would not be in place for 12 June 2007.

2.11 The later advertisement of positions in Aberdeen compared to the other pilot sites, coupled with the perceived lack of suitable assessment staff in Aberdeen, meant that

DTTO staff undertook assessments in Aberdeen on an overtime basis until appropriate assessors were recruited and trained to start in July 2007.

2.12 In Edinburgh, the Scottish Government funded 85 per cent of four PCSO posts. Recruitment of new PCSOs at St Leonards was part of a major change in custody staffing, totalling 20 new PCSOs. This recruitment was undertaken in two phases, the first phase being 12 new PCSOs (including four for MDTA) who started on 15 June 2007, on shift after training on 2 July 2007. The second phase of recruitment started on 30 July 2007. Therefore, staffing at St Leonards was increased by one PCSO per team. However, prior to the 12 June pilot start date, there were at least four members of staff on each team who were trained, and one member of staff on each team who was designated as a trainer, to cascade the training to the new staff. All PCSOs at St Leonards have been trained to carry out the drug testing.

2.13 Turning Point, who undertake the assessments in Edinburgh, planned for five full-time assessors posts, backed up by administrative support from existing Turning Point staff. In March 2007, four assessors' posts had been advertised and Turning Point stated they were seeking people with a higher level of skills and experience to maximise the opportunity for high quality assessments. By June 2007, Turning Point had undertaken two rounds of recruitment, and had identified suitable candidates. Training was carried out the week beginning 11 June 2007, and assessors were available to carry out assessments by the end of that week.

2.14 In Glasgow, at the planning stages, a request was made to the Scottish Government for four PCSOs, but only two posts were funded and recruited. One officer started in October 2007 and the other started in December 2007. Up to this point, mandatory drug testing was undertaken by the Custody Sergeants and bar officers, and other conventional PCSOs alongside their usual duties.

2.15 In Glasgow, job advertisements for a Practice Team Leader, a Senior Addiction Worker and four mandatory drug testing addiction assessors were placed in February 2007. Resources were also made available for a medical officer and two addictions nurses to work on the pilot, and for one clerical officer and one administrative assistant. All posts were filled in time for the start of the pilot, with the exception of the Practice Team Leader and the Medical Officer, who both came into post in November 2007. The clerical officer who was originally appointed left the scheme early on. This post was not re-filled until the second year of the pilot.

Training

2.16 Training on how to use the oral fluid testing equipment was provided to police staff in each of the three pilot sites. Operator training sessions were carried out by the appointed contractors at each pilot site, with further training available if required. Each pilot site was provided with two electronic readers and all other necessary equipment to carry out tests in-house.

2.17 At the start of the pilots, there were some problems with the performance of the drug testing equipment, but these were resolved within the early months by additional training.

2.18 Assessors and police staff in each pilot were also provided with policy background information, with further training for assessors and treatment staff given at the discretion of those providing the service in each area.

Information Provision

2.19 In preparation for the pilot's launch, information leaflets were produced by each of the three pilot site assessor organisations. These were designed to provide information to arrestees on the background and rationale for MDTA, provide an explanation who was involved in running the service, explain the benefits of participation and outline the consequences of decisions to attend or not attend assessments. Further contact details for support were also provided.

2.20 The information leaflets were designed to be placed with the belongings of arrestees on release, or to be handed to arrestees by assessors at the time of assessment.

Anticipated Throughput Numbers

2.21 The financial memorandum accompanying the Police, Public Order and Criminal Justice (Scotland) Bill (SP Bill 46) asserted that the MDTA pilots in Scotland might achieve some 6000 tests per year. This forecast was based on a combination of information about the numbers of trigger offences that might be expected in busy city police stations, and on management information from the England and Wales pilots of on charge drug testing.

2.22 At the planning stages for the pilot's implementation, this figure had changed to an anticipation that up to 15,000 people a year (based on 420 per month) across the three sites would be tested, and that around 50% of these would test positive. It was also anticipated that around 50% of those would go on to engage in treatment.

2.23 The staffing and resource allocation for the pilots were based on these assumptions. It became apparent, however, as the pilot progressed that the estimated numbers were greatly overestimated. The actual numbers of tests carried out are presented in Chapter Three below, and issues around the initial over-estimation of eligible arrestees to be tested are presented in Chapter Four.

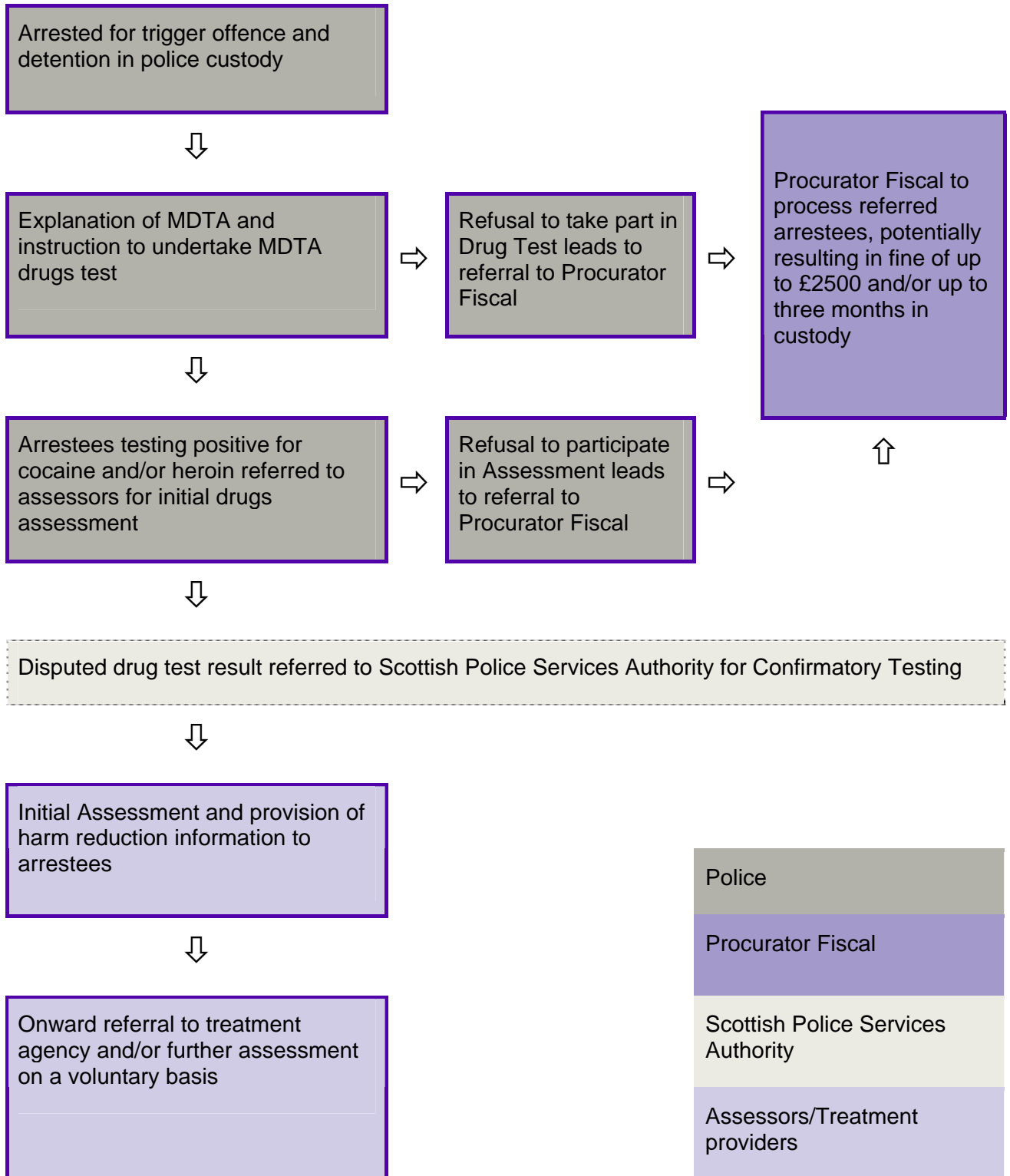
Implementation of the Schemes

2.24 It was hoped that each of the pilot schemes would be operational from the 12 June 2007, and would run for a full 2-year period. In Aberdeen and Glasgow, the police began testing on 12 June, whilst in Edinburgh the scheme began on 14 June.

Core Pilot Processes

2.25 Despite some variations in the organisations responsible for carrying out the initial assessments and for providing treatment to arrestees, each of the three pilots follows the same core model. Figure 2.1 provides a pictorial representation of the main processes involved in the MDTA pilots and the stages of engagement with each of the main organisations involved in delivering the pilots.

Figure 2-1 Summary of the MDTA Processes and Roles of Key Partners in Delivery



2.26 The figure shows that, once up and running, three main stakeholder groups were involved in the delivery of the scheme, these being:

Police – responsible for arrest of persons committing trigger offences, safe custody of eligible arrestees in police cells, identification of those meeting the eligibility criteria for the MDTA pilot, carrying out the mandatory drugs test and making initial referrals for assessment to those carrying out assessments in each area. The police are also responsible for dealing with disputed drugs test results and sending these for confirmatory testing to the Scottish Police Services Authority (SPSA). Those with positive test results are notified of the requirement to attend assessment, by the police. The police also provide details of arrestees who fail to comply with the mandatory drug test of assessment to the Procurator Fiscal.

Assessors – responsible for carrying out the initial MDTA assessment, as well as more detailed assessments for those who choose to engage further. Assessors also refer persons requiring further treatment to relevant treatment provider agencies/colleagues.

Treatment Providers – those offering drug treatment services and continued engagement with arrestees following their initial assessment. This includes medical staff as well as social work staff and others in both the public, private and voluntary sectors, as appropriate to the needs of drug users.

2.27 In addition to these core partners in delivery, the Crown Office and Procurator's Fiscal Service play a role in processing those who fail to comply with the mandatory requirement of the MDTA pilot.

2.28 The SPSA play a role in providing confirmatory feedback regarding disputed test results ie those testing positive for either heroin, cocaine or both, as well as testing samples taken from individuals who declare that they have taken medication which may have affected the test result. The SPSA also carry out a key role in checking a random 2% of all samples taken by the police for quality assurance purposes, irrespective of the test result.

2.29 In addition to these key staff, each of the pilot schemes has involved a number of 'other' partners in running the scheme. These include, for example, staff working in aligned service provision for some of the most vulnerable and at risk groups identified through the MDTA scheme.

2.30 While the procedures for drug testing and initial referral by the police for assessment is the same in each site, the models of service delivery for assessment and voluntary uptake of treatment, differs in each of the three pilot areas. Specific details regarding the assessment and treatment provision in the three areas is provided in Appendix F.

Changes over Time

2.31 As each of the pilots progressed, some changes occurred to both the staffing and the ways in which the schemes were being delivered.

2.32 In Aberdeen, recruitment and training of PCSOs was not operational until August 2007, where police officers were carrying out drug tests until the PCSOs were fully trained. Assessors were not in place until July 2007, and took over the assessment work which had been carried out by DTTO staff as an interim measure. Due to lower than anticipated numbers referred to both the MDTA scheme and the Arrest Referral scheme, the two MDTA assessors are now also able to carry out Arrest Referral assessments until the vacancies for the Arrest Referral posts are filled. Treatment for arrestees who wanted to engage further with the scheme in Aberdeen did not begin until April 2008.

2.33 In Edinburgh, not all PCSOs were able to be trained by the time the pilot commenced, and were gradually trained over the first few months of the pilot. Due to the anticipated arrestee throughput numbers at the beginning of the MDTA pilot, four assessor posts and two employability link-up worker posts were created. In addition, a part-time Service Co-ordinator was appointed in January 2008. However, as uptake of the scheme was not as anticipated, the employability link-up worker posts were made redundant in June 2008. While long term sickness was a notable issue among assessors in Edinburgh, resignations among assessors was the major problem, with temporary staff brought in to cover assessor posts towards the end of 2008.

2.34 In Glasgow, two main changes occurred during the life of the pilot. The first was with the police for whom an independent and non-pilot related review of police resources in custody suites meant that the Police Bar Officer role was removed. At the start of the pilot, the Bar officers had all been trained to perform MDTA tasks, but, as the role became redundant at the higher level, this meant that MDTA was taken on exclusively by the Police Community Support Officers (PCSOs).

2.35 Additionally, a Sergeant who was originally working in the Glasgow pilot, and who provided a clear link between the police and Glasgow Addiction Services (GAS), moved post after just a few months of operation. This meant that the administrative link was lost between the two organisations and there was also a loss of important information regarding the set up and operation of the scheme, as well as in the training capacity for other officers who had previously been trained by him.

2.36 The two dedicated PCSOs who were appointed at the start of the pilot, work in two shifts - one works 10am to 6pm and the other 6pm to 2am. There is no cover on a Sunday or on a Monday before 6pm. Originally, there was hope that all the testing could be done by the two PCSOs, but as time went on it became apparent that the time testing took made it completely unsustainable for PCSOs to do it alone. Although other PCSOs have been trained in testing and referral, they undertake the activity infrequently and so are less proficient at it and this has resulted in some cases where MDTA is not performed if one of the dedicated PCSOs is not available. Periods when there is no cover include the times when the MDTA PCSOs have to attend court, are on annual leave or absence through sickness. At these times, the ability to test is greatly reduced.

2.37 The second major change in Glasgow was in the role of the drugs assessor staff appointed for the pilot. Lower than anticipated referral numbers at the start of the pilot meant a redefining of the MDTA team's roles in the early stages to include care management and care of other GAS clients in their portfolios. This meant that the social work staff were engaging more fully with the arrestees after their initial assessments than

had been expected, but this has, perhaps, been a beneficial outcome of the lower than expected throughput numbers and is discussed, as such, in Chapter Four.

Ongoing Operation and Monitoring

2.38 At the start of the pilots, it was intended that a central database would be set up to hold data from each of the three pilot sites and to allow for monitoring and evaluation of the schemes. This Management Information System, which would be managed by the Scottish Government, encountered problems early in the pilot due to software complications, and so individual schemes were instructed to collect and store information locally until it was resolved. At the time that the evaluation was carried out, the central database had not become operational and data were instead still being held on individual and bespoke databases created and managed by the police and assessors in each of the three sites.

2.39 The lack of a centralised data management system and different administrative processes in each area meant that the data that was actually captured and held was somewhat *ad hoc*. The biggest gap, perhaps, was in the information being routinely logged by the police in respect of the pilot. In particular, in each area, there does not appear to have been any regular recording of the numbers of people who were arrested for trigger offences at each site and who were subsequently charged or not charged. Information was also not routinely recorded for the total number of arrestees eligible to be tested (regardless of their eventual participation). This made it difficult to extract numbers retrospectively for the evaluation and, in Glasgow, the scale of the task was too great to be achieved.

2.40 It is important to stress that the requirement for this data had not been made clear at the start of the pilots and therefore should not be considered as a failing on behalf of the police in delivering the scheme. It is noted simply as it presented a gap for evaluation purposes.

2.41 Similarly, at the start of the pilot, it was intended that all MDTA participants who went on to engage in drug treatment services as a result of MDTA, and who were previously unknown to drug treatment services, would be formally recorded as such on the Information Services Division (ISD) Scottish Drug Misuse Database (SDMD). Information Services Division collect data on new entrants to drug treatment via service providers completing the SMR25 form for all new attenders. This information explicitly identified Arrest Referral, for example, as a route into service provision.

2.42 At the time of the pilots' implementation, the SMR25 form had not been modified to allow Mandatory drug Testing of Arrestees to be included as a specific entry route, however, an 'other' box on the form under the category of criminal justice referral could be used that would allow a free text field to be completed to identify MDTA clients. The data held by ISD show, however, that this was not used in Edinburgh and, although used in Glasgow and Aberdeen, the information held by ISD may be an underestimate because of the incomplete source of referral text field information on many forms. This may be explained either by a lack of training or awareness on behalf of the treatment providers in each area of the need to complete this field.

2.43 The absence of information collection for those at both the start of the pilot process (ie arrested and eligible but not tested) and those engaged at the end of the pilot process (ie those engaging with drug treatment services for the first time), has, to a certain degree, been problematic, since it makes calculations of the true effectiveness of the pilot less reliable.

2.44 With these information gaps in mind, the following chapter presents the monitoring data that was collected by each of the partner organisations to provide an account of activity undertaken by each of the main stakeholders, and explores in detail the profile of those referred into MDTA in each of the three pilot sites.

CHAPTER 3 THE SCHEMES IN OPERATION

3.1 This chapter details the activities undertaken in each of the three pilot sites over an 18-month period from June 2007 to the end of November 2008. It presents the data on the numbers of arrestees referred into MDTA, and provides an analysis over time in the main trends of referral activity.

3.2 The period of analysis has been restricted to this 18-month timeframe to meet the reporting timescales of the evaluation. At the time of writing, each of the pilot schemes continues to be operational, but the time required for processing, cleaning and entering the data into local data systems meant that it was not possible to perform a 'real time' analysis of cases in each area.

Summary of Testing, Referral and Treatment Activity

3.3 Table 3.1 provides a summary of the numbers of drugs tests carried out in each of the three pilot sites, as well as the numbers of referrals into assessment, attendance at assessment and people who subsequently went on to engage with drug treatment services as a result of participating in the MDTA scheme.

Table 3.1 Summary of Testing, Referral and Treatment Activity

	Aberdeen	Edinburgh	Glasgow
Drug Tests Carried Out	848	1830	630
Positive Tests	334	471	301
Referral for Assessment	310	381	301
Attendance at Assessment	263	247	152
Engagement with Treatment	67	46	110
Number not already in treatment	42	Not Known	68

3.4 The table shows that the number of people tested in Edinburgh was significantly higher than in the other two sites. The numbers of referrals for assessment were broadly similar in all three areas but attendance at assessments was lower in Glasgow than elsewhere. Despite this, the Glasgow pilot had the highest number of people engage with drug treatment services, followed by Aberdeen and Edinburgh.

3.5 The remainder of the chapter provides a more detailed analysis of activity in the three areas to provide a fuller understanding of these figures.

Detailed Analysis of Testing, Referral and Treatment Activity

Arrested and eligible to be tested

3.6 The number of people who were arrested and who were eligible to be tested as part of the MDTA scheme should, in theory, match the total number of tests carried out in each site. All forces pointed out, however, that there would inevitably have been some time periods in which arrestees were brought into custody who met the eligibility criteria, but were not processed for MDTA. This would have occurred at times when dedicated trained MDTA police staff were not at work due to annual leave or illness, or where capacity

issues with the numbers of arrestees being held prevented staff from concentrating their time on MDTA.

3.7 In Aberdeen, the total numbers of people arrested and eligible to be tested was 1565. In Edinburgh, this number was 2639.

3.8 In Glasgow, a total figure for the number of people who were eligible to be tested was not provided. With more than 7000 arrestees overall passing through custody in London Road each year, it was felt that keeping a record of those eligible to be tested for MDTA was too difficult to achieve.

Eligible but not tested

3.9 In Aberdeen and Edinburgh, information was provided on the number of people who were eligible to be tested in terms of meeting the trigger offence criteria, but who were not processed. The main reasons for not undertaking the test were that arrestees were excluded on the basis of legislation ie that arrestees had been detained for more than 6 hours, that they had already been tested in the previous three months, they lived outwith the pilot area, or that they were too violent or too intoxicated.

3.10 This information was not available for Glasgow, but Table 3.2 details total numbers for Edinburgh and Aberdeen for the period from 12 June 2007 to the end of November 2008.

Table 3.2 Eligible to be Tested but not Tested

Reason	Aberdeen	Edinburgh
Outwith 6 Hours	286	358
Already Tested	Not Recorded	131
Too Violent	51	108
Too Intoxicated	Not Recorded	104
Medical Case	Not Recorded	37
Refusal	26	6
Staff/Workload	220	Not Recorded
Address Outwith Pilot Area	4	Not Recorded
Unfit	50	Not Recorded
Released	56	Not Recorded
System Problems	5	Not Recorded
No Fixed Abode	5	Not Recorded
No Interpreter ²	9	Not Recorded
No Reason Provided	6	65
Total	718	809

Arrestees refusing to be tested

3.11 The numbers of arrestees refusing to take part in the drugs tests, where the MDTA process had been initiated, was low across all sites.

3.12 In Aberdeen, a total of 26 arrestees refused to be tested while in Edinburgh, a total of 6 arrestees refused to be tested in the period from 12 June 2007 to the end of November 2008. In Glasgow, there were no recorded cases of arrestees refusing to take part in the MDTA drugs test, where offered.

Drug tests conducted

3.13 At the start of the pilot, it was anticipated that 15,000 people a year across the three sites might be tested, that around 50% would test positive and that around 50% of those would go on to engage in treatment.

3.14 Table 3.3 shows the number of drug tests successfully completed in each area broken down by month.

² During interviews with local stakeholders, no issues were raised in relation to meeting the needs of people from equalities groups. The absence of an interpreter in these nine cases is the only occasion noted where language barriers prevented MDTA referral.

Table 3.3 Number of Drug Tests Carried Out in each Area

	Aberdeen	Edinburgh	Glasgow
June 2007	75	13	38
July 2007	98	63	42
August 2007	32	54	57
September 2007	59	70	26
October 2007	65	113	50
November 2007	61	141	36
December 2007	54	120	25
January 2008	46	122	33
February 2008	40	124	44
March 2008	57	117	39
April 2008	41	106	36
May 2008	40	112	35
June 2008	44	128	35
July 2008	36	109	24
August 2008	44	74	25
September 2008	25	68	28
October 2008	18	90	30
November 2008	13	109	27
Total	848	1830	630

3.15 The numbers show that the number of tests performed were significantly below the anticipated numbers, representing around 15% of the numbers predicted in the first 18-months operation.

3.16 Edinburgh carried out more than two times as many tests than Aberdeen or Glasgow, but also had considerably more eligible arrestees to be tested compared with Aberdeen. This might also be explained by the fact that there were more PCSOs in Edinburgh, than there were in either Aberdeen or Glasgow, therefore, a PCSO team was on duty over all time periods covered by the pilot and was available to perform the tests.

3.17 As the total number of eligible arrestees in Glasgow is not known, it is not possible to provide an estimate of the number of tests carried out as a proportion of all those eligible to be tested. For Aberdeen and Edinburgh, however, the proportions were 54% and 77% respectively. This suggests that, in addition to having the highest potential workload of the two sites, Edinburgh managed to provide a more comprehensive regime of testing than their Grampian counterparts.

3.18 In general, the number of tests carried out in each area fluctuated over time. In Aberdeen, there were no discernable trends in the testing data, with only a slight decline in the number of tests in Aberdeen towards the end of the evaluation period.

3.19 Edinburgh saw a gradual rise in the number of tests performed in the first six months of pilots, before plateauing as the pilot progressed. The Edinburgh pilot showed a drop in testing activity in the summer of 2008, before rising sharply at the end of the evaluation period (November 2008). The police provided no explanation for this rise, but it may have been linked to an increase in evaluation activity, and extra impetus put behind the scheme at that time.

3.20 In Glasgow, there was some fluctuation in the number of tests carried out at the start of the pilot, which may be linked to changes in staff in that period, but once the two PCSOs were in place, the number of tests appears to have been relatively stable over time.

Positive and negative tests

3.21 In total, there were 334 positive tests in Aberdeen (39% of total tests undertaken), 471 in Edinburgh (26% of total tests undertaken) and 301 positive test results in Glasgow (51% of all tests undertaken), over the 18-month period.

3.22 In both Glasgow and Edinburgh, heroin/opiates accounted for the largest proportion of positive tests (n=125; 42% in Glasgow and n=296; 63% in Edinburgh). In Aberdeen, heroin alone was found in 33% of positive tests (n=110).

3.23 The proportion of positive tests in which cocaine was the sole drug present was 26% in Aberdeen (n=88), 24% in Edinburgh (n=111) and 31% in Glasgow (n=94).

3.24 In Aberdeen, traces of both heroin and cocaine were found in the greatest proportion of positive drug tests (n=136; 41%). Combined heroin and cocaine use accounted for the fewest cases of positive tests in both Edinburgh (n=64; 13%) and Glasgow (n=82; 27%).

3.25 The total number of people disputing a test result was 19 in Aberdeen and 144 in Edinburgh for the period from 12th June 2007 to the end of November 2008. The figure is not known for Glasgow.

Confirmatory Testing

3.26 Oral fluid samples from each of the pilot sites are sent to the Scottish Police Services Authority (SPSA) for confirmatory testing, for one of three reasons: for quality assurance, as part of a random 2% of all tests taken (both positive and negative); following a dispute by the person tested; and to test for medication, where a client declares that they have taken medication which may affect the test result.

3.27 Table 3.4 details the number of tests sent for confirmatory testing in each area, and the reason for the test.

Table 3.4 Number of tests sent for confirmatory testing, by area and reason.

	Aberdeen	Edinburgh	Glasgow
Quality Assurance	7	5	9
Disputed	10	34	12
Medication	89	35	2
Other ³	20	99	36
Total	126	173	59

³ Other includes tests sent for a combination of any of the other reasons (Quality Assurance, Disputed, and/or Medical) and includes Not Specified reasons.

3.28 The total number of confirmatory tests carried out for the Glasgow pilot (n=59) was considerably lower than for either Aberdeen (n=126) or Edinburgh (n=173). When looking at these numbers as a proportion of all tests carried out, Aberdeen had 15% of all tests sent for confirmatory testing, compared to around 9% in both Edinburgh and Glasgow.

3.29 While the proportion of tests sent for confirmatory testing was much higher in Aberdeen, Table 3.5 shows that a large number of these were sent in the first two months of the pilot when the Aberdeen staff were encountering problems with the testing equipment. The monthly pattern of testing in Edinburgh seemed to fluctuate the most whilst in Glasgow, numbers sent for testing were relatively stable over the course of the pilot, with only one peak in August 2007 which cannot be explained.

Table 3.5 Number of Tests sent for confirmatory testing by area and by month

	Aberdeen	Edinburgh	Glasgow
June 2007	16	0	1
July 2007	21	15	4
August 2007	4	4	23
September 2007	8	9	2
October 2007	14	21	2
November 2007	9	17	4
December 2007	16	20	3
January 2008	4	10	1
February 2008	1	9	3
March 2008	8	17	6
April 2008	3	2	1
May 2008	6	11	2
June 2008	4	3	2
July 2008	6	9	0
August 2008	1	4	2
September 2008	3	1	1
October 2008	1	15	2
November 2008	1	6	0
Total	126	173	59

3.30 In Aberdeen, 24 tests were overturned, 95 tests were confirmed, and 7 tests were unable to be confirmatory tested. In Edinburgh 38 tests were overturned, 92 tests were confirmed, and 43 tests were unable to be confirmatory tested. In Glasgow, 17 tests were overturned, 35 tests were confirmed, and 7 tests were unable to be confirmatory tested. There were no notable trends over time in the numbers of tests that were overturned.

3.31 Reasons for the SPSA not being able to carry out a confirmatory test included result printout not enclosed in bag, packaging not signed, bag not sealed, result printout not enclosed in bag, and accused details on printout.

Attendance at Assessments

3.32 The total number of referrals for assessment in each area was broadly comparable with 310 in Aberdeen, 381 in Edinburgh, and 301 in Glasgow.

3.33 Attendance at assessments amongst those referred was variable between the sites. A total of 263 assessments were completed in Aberdeen (85%), 247 in Edinburgh (65%) (4 arrestees will have been referred for assessment to attend the following week) and 152 in Glasgow (50%).

3.34 The total number of people who did not attend their assessment for the period from 12 June 2007 to the end of November 2008 was 47 in Aberdeen (15%), 130 (34%) in Edinburgh and 149 (50%) in Glasgow. Four cases in Edinburgh cannot be accounted for because the arrestees had been given an assessment time in the period outwith the evaluation period, and so their attendance was not known.

3.35 Interestingly, Glasgow also kept a record of the reasons for non-attendance. Whilst it would not be reliable to generalise the findings to the other pilot sites, this may be cited as an example of good practice to emerge from the pilots, since it enables learning about some of the practical and logistical barriers affecting engagement potential among arrestees.

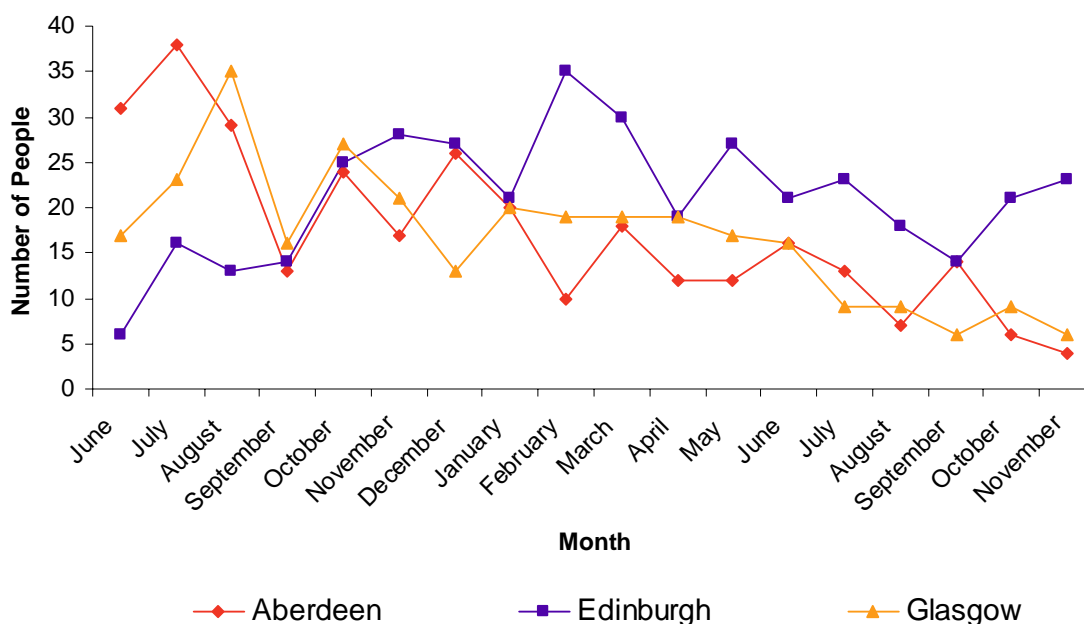
3.36 Of the 149 people who did not attend in Glasgow, reasons for non-attendance were traced for 46 clients. Of these 33 were in prison, 2 were at court at the time of the assessment, one was in hospital and one was in police custody. In the remaining nine cases, mistakes were made with setting up the appointments.

3.37 Across all sites, assessors reported that no-one left their assessment early (ie before it was complete).

Assessments over Time

3.38 Figure 3.1 shows the number of people who were referred for assessment for the period from 12 June 2007 to the end of November 2008. This data is presented in table form in Appendix G.

Figure 3.1 Number of People Referred for Assessment by Area and Month



3.39 In each area, the number of referrals from June to July 2007 went up considerably, but in both Aberdeen, and later in Glasgow, this dropped again significantly, perhaps due to the fall in the number of drug tests being carried out. The number of referrals seemed to stabilise in all sites between September 2007 and January 2008, at which point, the number of referrals in Edinburgh showed a large increase and the number in Aberdeen dropped once more. From March 2008, the number of referrals in both Aberdeen and Glasgow showed a slow decline. This was also mirrored in Edinburgh until the latter months of the evaluation (October and November 2008).

3.40 The trend in the number of referrals in Edinburgh and Aberdeen seems to simply reflect the trends in numbers tested, particularly the downward trend in Aberdeen. This is not the case in Glasgow where the number of tests seems to have remained stable, and the number of referrals decreased.

3.41 It is interesting, however, that in both Aberdeen and Glasgow there was a downward trend towards the end of the pilots, something that might be explained by a decrease in motivation to undertake MDTA activity as the pilot was coming to an end.

Characteristics of Those Attending Assessments

3.42 The evaluation sought to explore in detail the profile of those referred into MDTA, focussing specifically on the extent to which it met the needs of those most vulnerable and at risk drugs users.

3.43 While a great deal of qualitative data were generated from interviews with stakeholders (which is presented in Chapter Four), the level of demographic data held on the profile of people referred to or attending assessments in each area was restricted

mostly to age, gender and ethnicity information. This was not collected consistently across the three sites.

3.44 In Aberdeen, a breakdown of those referred for assessment was provided, but not for those attending assessments. The majority of referrals were for males (79%). Most males were between 21 and 35. Most women referred in Aberdeen were also between the ages of 21 and 35. An analysis of the data that is held shows that the majority of arrestees were of White Scottish ethnicity, with a small number of mixed ethnicity, or 'Other British'.

3.45 In Edinburgh, the majority of people attending assessments were male (74%). Most males were between 26 and 45. Most women attending assessments in Edinburgh were between the ages of 26 and 35. Information on ethnicity is recorded on Turning Point Scotland's database, however, at this time the information cannot be extracted in a report.

3.46 In Glasgow, just under two thirds of people attending assessments were male (63%). Most males were between 25 and 39. Most women attending assessments in Glasgow were between the ages of 25 and 34. All but 22 of those who attended assessments were classified as White Scottish. Of the remaining 22, two were White Other British, one was White Irish, one from a mixed background and one was Other South Asian. In 17 cases, ethnicity information was unspecified/unknown.

Engagement with Drug Treatment Services

3.47 The primary aim of the Mandatory Drug Testing of Arrestees is to encourage problem drug users to engage in treatment services as a means of addressing the individuals' drug misuse problem and associated offending behaviour. Data were therefore requested from each of the pilot sites regarding the total numbers of clients engaging with treatment services for the duration of the MDTA pilot to the end of November 2008.

3.48 It is important to note that, in Aberdeen and Glasgow, the numbers provided included both MDTA clients who were already engaged with drug treatment services before being referred into MDTA, as well as those who were previously unknown to drug treatment services. Although the focus of the evaluation was on those not already engaged with drug treatment prior to MDTA referral, the data for both categories of client are presented for fullness of coverage.

3.49 Similarly, many more who did not accept the offer of a formal treatment appointment were provided with harm reduction information and other information about services in their area which may be able to offer them assistance and support as part of their initial assessments. Although the numbers cannot be captured, this group represents an important number who will have arguably received at least some small benefit from their time spent with assessors in each area.

3.50 Table 3.7 provides a summary of the numbers of people who engaged with treatment in each of the pilot sites, and provides a breakdown of those who were previously engaged with treatment serves and those who were not.

Table 3.7 Numbers of Arrestees Engaging with Treatment Services

	Aberdeen	Edinburgh	Glasgow
Total Number Engaged with Drug Treatment	67	46	110
Number not already in treatment	42	Not Known	68

3.51 In Aberdeen, a total of 67 people entered into treatment as a result of MDTA. Of these, 42 people (63%) were not already in existing services. The remaining 25 people (37%) reported that they were already engaging in treatment, but were referred on for further treatment through the MDTA pilot.

3.52 In Edinburgh, 46 people were referred by Turning Point at their initial assessment to a treatment agency. The proportion of these people who were already engaging in treatment is not known.

3.53 In Glasgow, a total of 110 people entered into treatment as a result of MDTA. Of these, 68 (62%) were not registered with Glasgow Addiction Services (GAS) as being currently engaged with their treatment services. This group represents those who, had it not been for the MDTA pilot, may have remained unknown to Glasgow Addiction Services. The remaining 42 (32%) were already engaging in treatment, but were referred on for further treatment through the MDTA pilot.

3.54 In understanding the extent of engagement in drug treatment services, data were also requested from Information Services Division (ISD) Scotland on the number of patients/clients resident in Aberdeen City, Edinburgh City of Glasgow City, reporting to the Scottish Drug Misuse Database (SDMD), with Mandatory Drug Testing as their source of referral.

3.55 At the end of February 2009, 86 clients from Aberdeen and 43 clients from Glasgow were registered on the database with MDTA as their source of referral. There were no cases from Edinburgh.

3.56 Analysis of these numbers presents a somewhat confusing and contradictory picture of the total number of arrestees who engaged with drug treatment services as a result of their referral into MDTA. In Aberdeen, whilst the scheme managers provided a number of 42 people entering treatment for the first time, independent data from ISD suggests that this number was somewhat greater at 86. Conversely, in Glasgow, the number of people recorded on GAS databases as receiving treatment from GAS directly was 68, compared to a figure of 43 from ISD. In this case, the discrepancy may be due to the time period for which analysis was provided by ISD (April 2007 to March 2008) which was not consistent with the pilot evaluation period. Indeed, at the general level some under-reporting to ISD should be expected due to differing and inconsistent recording local practices for information being provided on the SMR25 forms. In some areas, a free text field may have been used to note MDTA as the referral route, whilst in others, a pre-coded Criminal Justice tick box may have been used to indicate the referral route. This may explain why no cases were observed in Edinburgh since the ISD search focussed solely on the free text field and not on the Criminal Justice option.

3.57 Due to the differences in data recording systems and, more importantly, the need to protect the anonymity of clients and the confidentiality of data provided by them, it was not

possible to reconcile these figures. For the purposes of the evaluation, and for the costing exercise, therefore, the numbers provided by the assessors in each pilot area have been used as the definitive numbers of people engaging in treatment services as a result of their engagement with the pilot.

Multiple Referrals

3.58 In Aberdeen/Edinburgh data was not available on the number of people being referred into MDTA twice.

3.59 In Glasgow, 21 people were referred into MDTA twice, and no-one was referred three or more times. In Glasgow, information was also kept on the patterns of attendance non-attendance for this sub-sample of arrestees. It showed that, of the 9 clients who did attend their first appointment, 6 went on to attend their second appointment with 3 failing to attend. Of the 12 clients who did not attend their first appointment, 8 went on to attend their second appointment with 4 failing to attend.

People Charged under the Act

3.60 It is an offence under section 88(2)(a) of the 2006 Act for a person not to report to the place at which their drugs assessment will take place to obtain details of their appointment with a drugs assessor.

3.61 If a person fulfils the requirements of their initial appointment (ie the requirements imposed under section 86(2)(b) of the 2006 Act), but fails to attend their drugs assessment, or does not remain for the duration of a drugs assessment, without reasonable excuse, he or she will be liable to prosecution under section 88(2)(b) or (c) of the 2006 Act.

3.62 In total, the Crown Office and Procurator Fiscal Service received 197 reports under section 88(2)⁴. Table 3.8 provides a breakdown of the reasons for referral to the COPFS by area.

Table 3.8 Reasons for Referral to the COPFS by area

	Aberdeen	Edinburgh	Glasgow	Total
Section 88(2)(a)	20	6	58	84
Section 88(2)(b)	13	76	23	112
Section 88(2)(c)	-	-	1	1
Total	33	82	82	197

3.63 For the 20 Aberdeen cases referred under Section 88(2)(a), no action was taken in two cases, a fiscal fine was offered in one case, warnings were offered in three cases, and 14 cases were prosecuted. In Edinburgh, no action was taken in one case, and five cases were prosecuted. In Glasgow, no action was taken in six cases, warnings were offered in 2 cases, 44 cases were prosecuted and six cases were yet to be marked at the time of the evaluation.

3.64 For the 13 Aberdeen cases referred under Section 88(2)(b), no action was taken in three cases and 10 cases were prosecuted. For the Edinburgh cases, no action was

⁴ Numbers relate to the period from June 2007 to mid-March 2009. It was not possible to provide a figure for the period June 2007 to November 2008.

taken in 11 cases; a fiscal fine was offered in one case, in two instances the case was proceeded with but this particular charge was not, 61 cases were prosecuted and one was yet to be marked. For the Glasgow cases, no action was taken in six cases; 16 were prosecuted and one has yet to be marked.

3.65 The Crown Office and Procurator Fiscal Service received one report under s88(2)(c). This was a Glasgow case and was prosecuted.

Comparison with Arrest Referral

3.66 A core component of the evaluation was to provide a comparison of the cost effectiveness of Mandatory Drug Testing of Arrestees with the cost effectiveness of Arrest Referral (AR). To this end, data were requested on the numbers of people referred into the Arrest Referral schemes operating in each of the three geographical areas which match the MDTA pilot sites. For the purposes of comparison, the Arrest Referral areas that were selected were Northern (which includes Aberdeen), Lothian & Borders and Glasgow (east End) areas.

3.67 Table 3.9 details the number of arrestees who were referred into Arrest Referral for the time period of June 2007 to November 2008, to allow direct comparison with the numbers of referrals made into MDTA for the same period.

Table 3.9 Arrestees referred into Arrest Referral, June 2007 to November 2008

	Northern	Lothian and Borders*	Glasgow (East End)
June 2007	No AR service	176*	233
July 2007	12		161
August 2007	47		124
September 2007	34	173	143
October 2007	24		166
November 2007	18		130
December 2007	15	124	105
January 2008	27		208
February 2008	22		257
March 2008	26	192	236
April 2008	9		192
May 2008	15		189
June 2008	10	169	340
July 2008	9		248
August 2008	9		326
September 2008	9	234	259
October 2008	6		207
November 2008	3	191*	159
Total	295	1259	3683

*Only quarterly figures were available in Edinburgh, and include April and May in 2007 and December in 2008.

3.68 In Aberdeen, of the 295 people referred into Arrest Referral, 162 attended an assessment. Of these, 32 were referred onto drug and alcohol treatment services. It is

worth noting that Arrest Referral was introduced in Aberdeen at roughly the same time as the MDTA pilots were introduced (ie. July 2007).

3.69 In Edinburgh, of 1259 people referred and seen by an Arrest Referral worker and completing an assessment in the court cells, 448 people agreed to treatment options including referral into drug treatment/specialist drug agency, GP liaison, referral into alcohol treatment/specialist alcohol agency, and referral into mental health services as part of Arrest Referral. In particular, of these 448 people, 242 were referred to continue in drug treatment/referral to specialist drug agency.

3.70 In Glasgow, of the 3683 people referred into Arrest Referral, 616 attended an assessment. While data was not available for the number of people who entered treatment for the period June 2007 to March 2008, a total of 251 people in the period April 2008 to the end of November 2008, were referred onto treatment services⁵.

3.71 Recognising that there are fundamental differences in the referral processes adopted for MDTA and Arrest Referral, and between the various areas in which the schemes operate, Table 3.10 provides an indicative comparison between the numbers of people referred into MDTA and Arrest Referral, those attending and their onward engagement with treatment in each of the three areas.

Table 3.10 Comparison of MDTA and Arrest Referral Throughput Figures

	Aberdeen/Northern		Edinburgh/Lothian & Borders		Glasgow	
	MDTA	Arrest Referral	MDTA	Arrest Referral	MDTA	Arrest Referral
Number Referred for Assessment	310	295	381	1259	301	3683
Number Attending Assessment	263	162	247	1259	152	616
Number Engaged with Drug Treatment	67	32	46	242	110	251

3.72 Whilst the data presented above covers slightly different time periods (and as such, was revised for the cost effectiveness component of the work), the table shows that there were more people referred for assessment, attending assessment and entering drug treatment via MDTA in Aberdeen/Northern compared to Arrest Referral. This may be explained by the later introduction of Arrest Referral in that area. In both Edinburgh and Glasgow, however, the numbers referred, assessed and entering drug treatment via Arrest Referral, was considerably higher than the numbers for MDTA.

⁵ The total number of people referred into Arrest Referral in Glasgow between April 2008 and November 2008 was 1920, which includes those referred for drugs misuse, alcohol misuse and drug and alcohol misuse combined. Of the 1920 referrals made, 138 were referred for drugs only, 115 were referred for alcohol only, and a further 75 were referred for combined alcohol and drug misuse. The remaining cases had no classification. A breakdown of the number of people who attended their Arrest Referral assessment and who went on to engage with treatment for drug and/or alcohol misuse is not available.

3.73 The following chapter uses the throughput data presented above to provide a cost effectiveness analysis of MDTA and Arrest Referral,

CHAPTER 4 COST EFFECTIVENESS OF THE PILOT SCHEMES

4.1 This chapter considers the cost effectiveness of the Mandatory Drug Testing of Arrestees across the three pilot schemes, as well as a comparison against The Scottish Government's Arrest Referral scheme. The chapter outlines what the pilot schemes have achieved, in terms of the number of people referred for assessment, the number of people who turned up for assessment and the number who engaged with drug treatment services in the three pilot schemes. It then considers the financial cost of these impacts to determine the relative effectiveness of the various schemes.

4.2 The Scottish Government's study brief explained that the indicators of effectiveness were to include:

A description of the spending on the pilots in each area, broken down into specific costs relating to the pilot;

An indication of the numbers of arrestees entering treatment services for the first time as a result of the pilot;

An assessment of the cost effectiveness of the pilot; and

A comparison of the cost effectiveness of MDTA with the cost effectiveness of Arrest Referral.

4.3 Each of these areas will be considered in turn. In considering the cost effectiveness of the various schemes, the analysis aims to focus on what the process has achieved per pound of grant. This section will therefore compare the level of grant per individual referred for assessment and the level of grant per individual who turned up for assessment in the MDTA pilot schemes. More importantly, given the aims of the pilot schemes, comparisons will also be made of the level of grant per individual who engaged with drug treatment as a direct consequence of the MDTA pilots. This will also be compared with the same figure for the Arrest Referral scheme to provide an indication of the relative cost effectiveness of the two schemes.

4.4 It should be emphasised that the cost effectiveness analysis does not compare the impact of the MDTA and Arrest Referral schemes as it is too early to conclude on this issue. The aim is to focus on the relative cost effectiveness of the process and concentrate on how the schemes fare in getting arrestees, who would not otherwise do so, to engage with drug treatment.

Funding

4.5 Scottish Government funding for the three MDTA pilots is split into funding for assessments and funding of treatment. Each of these is discussed in turn below.

Assessment

4.6 Grant funding from The Scottish Government to cover assessment for those meeting the eligibility criteria is £600,000 per annum. This is split equally across the three councils. Because the pilots are scheduled to run from June 2007 to May 2009, the £200,000 is split proportionately across the three financial years that the two years of the pilot cover i.e.

June 2007 to March 2008, April 2008 to March 2009 and April 2009 to May 2009. The funding for the three periods is set out in Table 4.1 below.

Table 4.1 Grant for Assessment in the Three Pilot Areas, June 2007 to May 2009

	June 2007 to March 2008	April 2008 to March 2009	April 2009 to May 2009
Aberdeen	£166,000	£200,000	£33,000
Edinburgh	£166,000	£200,000	£33,000
Glasgow	£166,000	£200,000	£33,000

Treatment

4.7 A total of £1,000,000 per annum is allocated in grant funding treatment and this is split as follows:

£400,000 for Aberdeen;

£300,000 for Edinburgh; and

£300,000 for Glasgow.

4.8 The grant is ring-fenced and paid through the respective city councils on a monthly basis. Similarly to the funding for assessments, the grant is split proportionately across the three financial years of the pilots, as outlined in Table 4.2 below.

Table 4.2 Grant for Treatment in the Three Pilot Areas, June 2007 to May 2009

	June 2007 to March 2008	April 2008 to March 2009	April 2009 to May 2009
Aberdeen	£320,000	£400,000	£66,000
Edinburgh	£250,000	£300,000	£50,000
Glasgow	£250,000	£300,000	£50,000

4.9 The total grant funding from the Scottish Government available for assessment and treatment of arrestees for the three pilot schemes is set out in Table 4.3.

Table 4.3 Total Grant for Assessment and Treatment in the Three Pilot Areas, June 2007 to May 2009

	June 2007 to March 2008	April 2008 to March 2009	April 2009 to May 2009
Aberdeen	£486,000	£600,000	£98,000
Edinburgh	£416,000	£500,000	£83,000
Glasgow	£416,000	£500,000	£83,000

4.10 In carrying out the cost effectiveness exercise it is important to use the amount of financial resources actually used rather than the total funding available to the three pilot schemes over the period. While the tables above outline the level of grant available from the Scottish Government for the three pilot schemes, it should be noted that not all of the

allocation given to the respective pilot schemes was spent. For example, of the total £416,000 allocated to Glasgow for 2007-08, the total spend, including overheads, was only £230,152. A total of £186,000 was overpaid and therefore reallocated to other CJA non-core items or returned to the Scottish Government.

4.11 Similarly for Edinburgh, the audited spend, including overheads, totalled £311,600, resulting in an overpayment of around £104,000.

4.12 For Aberdeen, of the total payment of £486,000 only £84,641 was spent, resulting in an overpayment of around £401,000.

4.13 The following table shows the total spend out of that paid by the Scottish Government in 2007-08.

Table 4.4 Actual Spend in the Pilot Areas, June 2007 to March 2008

	2007-08 Audited Spend
Aberdeen	£84,641
Edinburgh	£311,596
Glasgow	£230,152

4.14 The cost effectiveness exercise covers the period from June 2007 to November 2008. It is therefore necessary to calculate the grant awarded over the evaluation period. While the amount paid from June 2007 to March 2008 is set out above, the grant awarded for the eight months from April 2008 to November 2008 is equivalent to eight times one twelfth (one month) of the total sum available for 2008 as a whole⁶. The total amount for assessment and treatment which was actually spent in the period June 2007 to November 2008 is set out in Table 4.5.

Table 4.5 Grant Spend on MDTA in the Three Pilot Areas, June 2007 to November 2008⁷.

	Grant Spend June 2007 to November 2008
Aberdeen	£484,600
Edinburgh	£645,000
Glasgow	£563,000

4.15 In addition to the funding for treatment and assessment under MDTA, each of the three pilot areas has been allocated additional ring-fenced funding to cover police activities supporting the pilots⁸. The amounts are set out in Table 4.6.

⁶ For example, one twelfth of the total grant for Aberdeen is equal to £600,000 divided by twelve, which is £50,000. Multiplying this by eight, to account for the months April to November, gives a total of £400,000 for Aberdeen.

⁷ Audited expenditure is not available from March 2008 and will not be available until the end of the financial year i.e. April 2009. It is therefore assumed, for the purpose of this exercise, that all grant allocated for the period is spent by each of the pilot schemes.

⁸ In addition to this funding Grampian Police Force explained that there has been further expenditure associated with running the MDTA pilot in the Aberdeen area. However, it has not been possible to obtain an accurate estimate of this figure and it has therefore not been included in the analysis.

Table 4.6 Police Funding for MDTA Pilots⁹

	2007-08	2008-09	2009-10
Grampian	£90,000	£96,000	£16,000
Lothian and Borders	£80,000	£96,000	£16,000
Strathclyde	£84,880	£96,000	£16,000

4.16 In addition to the funding for police resources, funding was also provided for the production, use and storage of medical equipment. The total sum was approximately £60,000 and this is assumed to have been split equally across the three pilot areas.

4.17 Including the funding for police and medical resources gives the total expenditure figures set out in Table 4.7 for the three areas between June 2007 to November 2008. The table shows that the Edinburgh pilot received £809,000, while the Glasgow and Aberdeen pilots received 732,000 and 658,000 respectively. The figures set out in Table 4.7 are the figures for the three pilot areas used in the cost effectiveness exercise.

Table 4.7 Total Grant Spend on MDTA in the Three Pilot Areas, June 2007 to November 2008.

	Grant Spend June 2007 to November 2008
Aberdeen	£658,000
Edinburgh	£809,000
Glasgow	£732,000

Arrest Referral

4.18 To allow a sensible comparison of MDTA with the cost effectiveness of the Arrest Referral scheme it is first necessary to select comparable areas. The areas chosen are Northern (which includes Aberdeen), Lothian & Borders and Glasgow areas. The following table shows the funding allocated to the three areas for 2007-08 and 2008-09.

Table 4.8 Arrest Referral Funding Allocations for 2007-08 and 2008-09

	2007-08	2008-09
Northern	£230,000	£230,000
Lothian & Borders	£389,542	£389,542
Glasgow ¹⁰	£293,292	£292,155

4.19 The actual spend for each of the areas in 2007-08 is set out in Table 4.9. This ranges from £40,438 (18% of the amount paid) in the Northern region to almost the total allocation in Lothian & Borders. Subtracting the audited spend from the amount paid reveals the amount overpaid in each pilot scheme.

⁹ While some of the police authorities explained that all of the funding did not necessarily go on resourcing the MDTA scheme, the allocation was provided in grant and is therefore included in the cost effectiveness analysis.

¹⁰ The Glasgow figure is for London Road only to allow comparison with London Road MDTA. Total figure for Glasgow area is £1,083,175.

Table 4.9 Actual Spend and Overpayments for Arrest Referral 2007-08

	Paid	Audited Spend (inc Overheads)	Overpaid
Northern	£224,256	£40,438	£183,818
Lothian & Borders	£379,808	£386,411	£3,131 ¹¹
Glasgow	£293,292	£288,430	£4,862

4.20 For comparison with MDTA a funding figure for Arrest Referral for June 2007 to November 2008 for Northern and Lothian & Borders has been calculated using a similar methodology to that used to calculate the funding for the MDTA scheme. The figure for Glasgow has been supplied by the Arrest Referral Finance Department. The total spend for the period for the three areas is set out in Table 4.10 below¹². These are the figures to be used in the cost effectiveness comparisons with the MDTA pilot schemes.

Table 4.10 Spend on Arrest Referral, June 2007 to November 2008

	Total Spend June 2007 to November 2008
Northern	£293,400
Lothian & Borders	£581,700
Glasgow	£502,000 ¹³

Comparison of Referrals for Assessment

4.21 This section compares the cost effectiveness of the three MDTA pilots against the Arrest Referral scheme. While a key focus of the evaluation, as indicated in the study brief, is to look at numbers of arrestees entering treatment services for the first time as a result of the pilot, this has not been possible due to the figure for the number of people in Arrest Referral who were already receiving treatment not being available. In place of this, the cost effectiveness analysis compares the number of people entering drug treatment. Overall, the cost effectiveness analysis compares:

The number of arrestees referred for assessment;

The number of people who turned up for the assessment; and

The total number of people who engaged with drug treatment through the schemes (including those who were already in treatment).

4.22 In Aberdeen, the figures from the pilot schemes show a total of 310¹⁴ people were referred for assessment between June 2007 and November 2008. Out of the figure of 310 however, only 263 turned up for assessment. Out of this figure only 67 arrestees engaged with drug treatment, 42 of whom were not already involved in treatment. These figures are set out in Table 4.11 below.

¹¹ Overpayment for Lothian & Borders equals the allocated funding minus the audited spend

¹² This assumes that for Edinburgh and Lothian & Borders the 2008-09 allocation for each month is actually spent, unlike the previous year. Similarly to the MDTA figures, audited spend will not be available until the end of the 2008-09 financial year.

¹³ The figure for Glasgow includes £45,000 to fund PCSO staff which was not awarded to the other Arrest Referral areas.

¹⁴ These figures are discussed in more detail in Chapter Three

4.23 Table 4.11 also shows that in Edinburgh, under the MDTA scheme between June 2007 and November 2008, a total of 381 people were referred for assessment, while a figure of only 247 actually turned up for the assessment. Out of the 247 who turned up for the assessment, only 46 of them went on to engage with drug treatment. The figure for those that were already engaged in treatment is not known for the Edinburgh pilot scheme.

4.24 In Glasgow, a total of 301 arrestees were referred for assessment under the MDTA pilot scheme. Of these, just over half (152) turned up for assessment. Of the 152 who turned up for assessment, 110 went on to engage in drug treatment, with 42 of these arrestees already involved in some form of drug treatment. A total of 68 people, who had not already done so, ended up engaging in drug treatment.

4.25 Table 4.11, in summarising these results, shows that while Edinburgh had the highest number of arrestees referred for assessment between June 2007 and November 2008, it had the lowest number of arrestees who actually ended up in treatment. Also from the table it is clear that while the Glasgow scheme had the lowest number of arrestees referred for assessment during the period, it had the highest number of people who engaged in treatment. It also had the highest number of people who were not already in treatment.

Table 4.11 Comparison of MDTA Pilots, June 2007 to November 2008

	Aberdeen	Edinburgh	Glasgow
Number Referred for Assessment	310	381	301
Number Attending Assessment	263	247	152
Number Engaged with Drug Treatment	67	46	110
Number Not Already in Treatment	42	Not Known	68

4.26 While Table 4.11 shows, in absolute terms, the number of people in each category per MDTA pilot scheme, it takes no account of the level of grant or expenditure. A more reliable indicator of relative cost effectiveness is the financial cost per person under each category, particularly the cost per arrestee entering treatment services for the first time as a result of the pilot. Table 4.12 therefore sets out the level of grant spent per head for each of the pilot scheme under each category.

Table 4.12 Scottish Government Grant Spend per MDTA Arrestee by Category, June 2007 to November 2008

	Aberdeen	Edinburgh	Glasgow
Grant by individual referred for Assessment	£2,123	£2,123	£2,432
Grant by number Turned up for Assessment	£2,502	£3,275	£4,816
Grant by number Engaged with Drug Treatment	£9,821	£17,586	£6,655
Grant by number not already in treatment	£15,667	n/a	£10,765

4.27 The figures in Table 4.12 reveal that the level of grant spend by each individual referred for assessment is the same in Aberdeen (£2,123) and Edinburgh (£2,123), with both of these lower than the figure for Glasgow (£2,432). The level of grant spend, divided by the number of arrestees who turned up for assessment, is lower in Aberdeen, at £2,502, than both Edinburgh and Glasgow, with figures of £3,275 and £4,815 respectively.

However, it is clear from the figures that the amount of grant spend per arrestee who engaged with drug treatment through MDTA is lower in Glasgow (£6,655) than in Aberdeen (£9,821) and Edinburgh (£17,586). The figure for grant spend per individual engaging in treatment who is not already doing so is also much lower in Glasgow compared to Aberdeen. This suggests that while the Glasgow pilot may not result in a large number of people, per grant spend, being referred for assessment, it is relatively more cost effective in achieving the objective of getting people into treatment. This is particularly so for those arrestees who were not already engaged in treatment.

4.28 Table 4.12 also shows that overall the Glasgow pilot scheme performs best in terms of the number of arrestees entering treatment services for the first time as a result of the pilot per pound of Scottish Government grant expenditure¹⁵.

4.29 The study brief included a request to compare the cost effectiveness of the MDTA scheme against the cost effectiveness of the Arrest Referral scheme. Table 4.13 below shows that the number of people attending assessment under the Arrest Referral scheme between June 2007 and November 2008 was 162 in Northern, 616 in Glasgow and 1077¹⁶ in Lothian & Borders. In terms of the number of people engaging with drug treatment through Arrest Referral, there were 32¹⁷ in Northern and 208¹⁸ in Lothian & Borders. The figure for Glasgow for the period is not available. However, a figure of 251 is included for the period April 2008 to November 2008.

Table 4.13 Comparison of Arrestee Referral by area, June 2007 to November 2008

	Northern	Lothian & Borders	Glasgow
Number Attending Assessment	162	1077	616
Number Engaged with Drug Treatment	32	208	251 ¹⁹

4.30 Similarly to the figures for the MDTA scheme, the following table sets out the level of grant under Arrest Referral per individual attending assessment and also per number engaged with drug treatment²⁰. The table shows that the level of grant per individual attending assessment is lowest in the Lothian & Borders at £540. This is followed by Glasgow at £815. The highest sum in this category is Northern with a grant spend of £1,811 for each individual attending assessment. In terms of the level of grant per arrestee who engaged with drug treatment, Glasgow is by far the lowest at £865, followed by Lothian & Borders at £2,797. The comparable figure for the Northern area is the highest by a significant margin at £9,169. This figure would increase if only taking into account those engaged with drug treatment and not include those engaged with alcohol treatment.

¹⁵ It should be noted that these figures do not take into account that it is possible these people may have entered drug treatment in any case, even if MDTA was not available.

¹⁶ The figure in Table 3.9 includes April and May 2007 and December 2008 and has therefore been amended accordingly.

¹⁷ The figure of 32 includes those who engaged with drug and alcohol treatment. From the official data it has not been possible to differentiate between those who engaged with drug treatment and those who engaged with alcohol treatment.

¹⁸ The figure provided for Lothian and Borders for drug treatment only was 242 for April 2007 to December 2008 i.e. one quarter period too much. This gives an average quarterly figure of 34. This was therefore subtracted from the total to estimate the figure for the six quarters between June 2007 and November 2008.

¹⁹ Treatment figures for Glasgow are for the period from April 2008 to November 2008 only. Figures for June 2007 to March 2008 are not available

²⁰ The grant by number engaged with drug treatment for Glasgow is based on the grant spend for April 2008 to November 2008 of £217,191.

Table 4.14 Scottish Government Grant per Arrest Referral Arrestee by Category, June 2007 to November 2008

	Northern	Lothian & Borders	Glasgow
Grant by Individual Attending Assessment	£1,811	£540	£815
Grant by Number Engaged with Drug Treatment	£9,169	£2,797	£865

4.31 Table 4.15 below provides a comparison of the MDTA and Arrest Referral figures where these are available: for the number of individuals attending assessment and, perhaps more importantly, the number of arrestees who engage with drug treatment. The figures cover the period June 2007 to November 2008, excluding the latter figure for Glasgow which covers April 2008 to November 2008. The figures show that in Aberdeen /Northern area, MDTA was higher than Arrest Referral for both the number of arrestees attending assessment and the number engaged with drug treatment. In Edinburgh/Lothian & Borders the opposite is true, with the numbers under the Arrest Referral scheme at least four times higher for both categories. The outcome in Glasgow was similar to Edinburgh, with the Arrest Referral figures also significantly higher than the figures for MDTA.

Table 4.15 Comparison of MDTA and Arrest Referral, June 2007 to November 2008

	Aberdeen/Northern		Edinburgh/Lothian & Borders		Glasgow	
	MDTA	Arrest Referral	MDTA	Arrest Referral	MDTA	Arrest Referral
Number Attending Assessment	263	162	247	1,077	152	616
Number Engaged with Drug Treatment	67	32	46	208	110	251

4.32 The figures in Table 4.15 are simply the absolute numbers under each category. Figure 4.16, on the other hand, compares the level of grant divided by the numbers of arrestees under each category. Comparing the level of grant per individual attending assessment for the various schemes shows that the cost per person under MDTA is higher than Arrest Referral in all areas. In the Northern/Aberdeen areas the level of grant per individual attending assessment under MDTA is £2,502, compared to a figure of £1,811 for Arrest Referral.

4.33 The comparisons in Lothian & Borders/Edinburgh and Glasgow are much more marked. For the former, the grant by individual attending assessment under MDTA is £3,275, compared to a figure of only £540 under Arrest Referral. In Glasgow, the figure under MDTA is £4,816 compared to £815 under Arrest Referral.

4.34 Focussing on the level of grant by individual engaged with drug treatment under the two schemes tells a very similar story, with the figures for grant per arrestee higher under MDTA than Arrest Referral. This is particularly so in Glasgow and Edinburgh/Lothian and Borders where the level of grant per individual is higher under MDTA by at least five times. The Glasgow figure of £865 under Arrest referral is the lowest grant spend per head for

those engaged with drug treatment, while the MDTA figure for Edinburgh of £17,586 is by far the highest figure under all categories.

Table 4.16 Comparisons of MDTA and Arrest Referral grant spend per head

	Aberdeen/Northern		Edinburgh/Lothian & Borders		Glasgow	
	MDTA	Arrest Referral	MDTA	Arrest Referral	MDTA	Arrest Referral
Grant by individual Attending Assessment	£2,502	£1,811	£3,275	£540	£4,816	£815
Grant by individual Engaged with Drug Treatment	£9,821	£9,169	£17,586	£2,797	£6,655	£865

Conclusion

4.35 Comparing the impacts of the three MDTA pilot schemes reveals that, over the evaluation period, both Edinburgh and Aberdeen have performed better than Glasgow in terms of the number of arrestees referred for assessment and the number of arrestees attending assessment. 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.

4.36 In cost effectiveness terms, the level of grant by individual attending assessment under MDTA 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).

4.37 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 Arrest Referral figures are the lowest of all the schemes, with a significantly lower level of grant spend per head. On the basis of the figures provided, the level of grant spend per individual engaging with drug treatment in the Edinburgh MDTA pilot scheme is the least cost effective of all.

CHAPTER 5 PERCEPTIONS OF THE PILOT SCHEMES

Eliciting Views

5.1 The main stakeholder groups (police, assessors and treatment agencies) 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. This involved semi-structured depth interviews with all three groups, as well as with Crown Office and Procurator Fiscal Service (COPFS) representatives in each area. A total of 39 stakeholder interviews were carried out. A full list of participants consulted in each area is provided in Appendix C and the interview discussion guides are attached as Appendix D.

5.2 A total of nine arrestees also took part in the evaluation (four in both Aberdeen and Glasgow and one in Edinburgh). It is important to note that this group is not representative of all those who were eligible to be referred into MDTA, or who took part at any level. Indeed, the nine arrestees who took part in the evaluation were continuing to engage with treatment services after their initial assessment, unlike the majority of arrestees who had participated only in the mandatory drug test and/or assessment.

5.3 This chapter presents the main findings from the consultation activity, under a number of key themes, these being: the pilot processes; staffing and resource issues; partnership working; perceived impacts of the scheme; feedback from arrestees; MDTA and Arrest Referral; and lessons for the future.

Pilot Processes

5.4 For the most part, those involved in delivering the MDTA pilots provided positive feedback about the processes involved and the general day-to-day running of the schemes. The two main emerging issues affecting the pilot, however, appear to be the significantly lower than expected referral numbers, in addition to some smaller issues around the accommodation of the pilots in each area, and the drug testing equipment.

Throughput Numbers

5.5 In each of the pilot sites, there remains some confusion around the origins of the original estimates for throughput numbers, ie around 15,000 per year across each of the sites. It is thought that the initial estimates came originally from the police in each of the three areas, but changes in police staff mean that it was not possible to track a definitive explanation for the way in which the numbers were originally calculated.

5.6 The impact of this miscalculation has, perhaps, been felt most acutely by the assessor and treatment agencies. The numbers of staff appointed to these posts were a reflection of the anticipated level of activity that would be required for the pilot and, in practice, the workload generated by the pilot has been considerably less than is required to occupy all staff appointed.

5.7 Assessors in each of the three pilot areas generally felt under-worked, with several assessors reporting feeling demoralised and unmotivated. This may have contributed to the resignations that have taken place in some of the pilot sites. Several assessors

reported carrying out other work not related to MDTA, as there is not enough MDTA work to fill their day and keep them interested. Similarly, assessors have reported undertaking work in addition to their MDTA workload, such as group work with arrestees, looking at 'life-skills' and relapse prevention work – goal setting, confidence, communication, etc.

"We're just not as busy as I thought we would be." [Assessor, Aberdeen]

"It can be quite demoralising for them just sitting there waiting for a customer." [PCSO, Edinburgh]

"I just think that it's a very good scheme in principle but the practice has fallen so far short it's very frustrating, you know, on your own part because you want to, you want to do your job but you sort of see, um, that you're unable to." [Assessor, Glasgow]

5.8 In Edinburgh, there have been a number of resignations among assessment staff, as well as one long term absence. In Aberdeen, there was no treatment capacity at the start of the pilot and, due to a shortage of work, MDTA assessors in this site are now carrying out a dual MDTA/Arrest Referral role. A general issue is perhaps the need for greater motivation among those involved with the pilots ie more detailed feedback on the actual impacts of the scheme for those referred.

5.9 It emerged early on that carrying out assessments alone would be insufficiently stimulating or time consuming for the volume of staff appointed. In Glasgow, a decision was made to include care management of arrestees/clients in the social workers' portfolios, and this has been beneficial both for arrestees and the workers, in terms of their motivation and job-satisfaction.

5.10 This presents an important lesson to be learned from the pilots, that assessment activities alone are insufficient to occupy the time and motivational needs of staff. The additional benefits to clients from working directly with the same worker from assessment through to treatment engagement may be considered as justification for adoption of this model in any future continuation of the schemes.

Accommodation

5.11 In each of the pilot sites, assessors have a presence in police stations for speedy access to arrestees at the time of initial identification of eligibility to take part. In all cases, specific accommodation has been provided.

5.12 Almost all interviewees agreed that carrying out assessments at the police station resulted in more arrestees undertaking and engaging with the assessor, than if the arrestee was given an appointment to attend an assessment at a later date. This reduced the number of people potentially failing to attend initial assessments due to travel convenience issues, maximising opportunities for arrestees to engage with assessors early on. Importantly, it provides the full support network at a time when arrestees may be at their most vulnerable.

5.13 While the presence of assessors in police stations was seen a positive facet of the pilot by all, there do remain some reservations regarding the suitability of accommodation provided for MDTA assessors; they are either too hot, too cold, arrestees are separated from assessors by either a glass window or a wire grill, or assessments take place in the nurse's Room, or in the solicitor's room, which does not facilitate confidentiality and open discussion.

5.14 In particular, in Glasgow and Aberdeen, physical barriers are restricting communication between assessors and arrestees. In these sites, wire grills in Aberdeen, and glass screens in Glasgow, are present to provide a protective shield between assessors and arrestees and (in Glasgow) the two have to communicate via a basic intercom system. This may be impacting on the quality of client-carer relationships that are being established:

"The interview set-up at Queen Street doesn't lend itself to really productive engagement with people." [Assessor, Aberdeen]

"It has a very negative effect...that's especially the case for people who aren't very motivated, if you're trying to use motivational interviewing techniques, or if someone's upset, it's really difficult...it's a real communication barrier." [Social Worker, Glasgow]

5.15 This issue is difficult to resolve as, for the police, the possibility of having MDTA assessors in a confined space with a prisoner, with no separation, contravenes health and safety rules. For assessors, this is not perceived as problematic since the perceived level of risk posed by clients is not considered any greater than the risk posed at off-site assessments (ie that take place at the assessor organisation). This issue is, perhaps, something to be resolved on a case-by-case basis should the scheme be implemented elsewhere, but is noted here as something which may have impacted on the quality of interaction that occurred between arrestees and assessment staff.

Testing equipment

5.16 Some problems with the drug testing equipment were experienced in the early stages of the pilot. PCSOs reported that while the test itself is straightforward, and the process itself on paper is not a long process, in reality, to get enough saliva on the stick to do the test properly, can be a long process, and can take anything from a few minutes to over an hour.

5.17 Other issues with the testing equipment include the wrong number of drops added to the sample, samples not being sealed properly, and samples being labelled wrongly.

5.18 Interviewees also questioned the reliability of the testing equipment. Some arrestees revealed that they had taken drugs prior to being arrested, but that their test produced a negative result. PCSOs were divided on their feelings as to why this was the case; while some thought this meant the arrestee had taken 'duff stuff', or that the drugs had not passed through their system in time for the drug test, others thought that this may be because the testing equipment was not reliable.

5.19 Issues with the testing equipment did seem to resolve as the pilot progressed and do not appear to have presented any meaningful barriers to its overall operation.

Staffing and Resource Issues

5.20 Whilst early changes were required to the pilot to increase the workload of assessment staff, in each of the three sites, the police have experienced a converse problem of being under-resourced to meet the demands of the pilot:

5.21 The police, as with other stakeholders, are unsure about where the initial estimates for throughput originated, and there is general agreement that the numbers were aspirational.

5.22 In each of the three pilot sites, the limited availability of police staff to carry out the necessary police functions associated with the MDTA pilot was an ongoing problem. This includes the presence of police staff to undertake initial identification of eligible arrestees and to initiate the MDTA process, as well as to perform the testing and fill in the associated paperwork prior to making referrals for assessments:

*“Depending on how many staff are on, and how many custodies there are, MDTA does take a back seat depending on how busy you are in that shift.”
[PCSO, Aberdeen]*

5.23 One PCSO in Glasgow provided a good summary of the likely problems encountered:

“On occasions, particularly on a Friday and Saturday night there are lots of prisoners, and we have three PCSOs on but their main job is to look after the prisoners, only one of them has the duty of drug testing and he has to look after the prisoners as well. So although Friday and Saturday nights are an ideal time to get people testing, due to the huge numbers of people coming in through the doors we often don’t have enough manpower at times, especially for the corroboration. It would be better if they had maybe two PCSOs on duty for drug testing, designated, or if we just had more staff in general.” [PCSO, Glasgow]

5.24 Assessors were frustrated by this, but were also sympathetic to the core functions that the police had to perform:

“You know, they’re too busy, they’ve got a lot of other tasks to do and testing people is really last on their list. They’ve got to care for the prisoners and make sure they don’t have any other pressing issues.” [Assessor, Glasgow]

5.25 In Glasgow, as early as the first implementation group, the police raised concern about the 10 minute observation time required prior to testing, suggesting that it would present resource difficulties. Similarly, the need for corroboration during sampling and testing may prove challenging for the police, for whom there were only two dedicated PCSOs, each working at different times to ensure maximum coverage throughout the day.

This inevitably meant that other police staff (Custody Sergeants or Constables) would need to act as corroborating officers whilst tests were performed.

5.26 Similarly, there were general staffing issues with PCSOs such as long term sickness, which reduced their availability to undertake drug tests and, therefore, may explain the low number of arrestees tested at some points during the pilot. In Glasgow, this has mainly been linked to changes in police staff which has meant that overall support for the project may have fluctuated as management has changed. Some problems with sickness absence in Glasgow among the police have also meant a lower number of referrals at some stages in the pilot.

5.27 In sum, the main barrier to performing more tests has been a lack of resources to fund more MDTA PCSOs and the fact that the primary purpose of the conventional Custody Suite PCSOs is to look after the care and welfare of the prisoners above all else.

Administration Time

5.28 A general view shared by the police and assessor organisations is that MDTA takes a lot of time, approximately 20-30 minutes for each person whether or not they test positive or negative, largely due to the paperwork involved:

“Unfortunately, 20-30 minutes isn’t time that the PCSOs downstairs can really spend, especially when their primary role is to look after the care and welfare of prisoners. It’s just not practical, so we can’t always be committed to doing the MDTA all the time.” [Police, Glasgow]

5.29 The administrative workload and testing time have been highlighted as potential barriers to police willingness to participate in MDTA at times when custody suites are busy and, in particular, is considered by most of those interviewed to be considerably more burdensome than the tasks involved in Arrest Referral:

“The Arrest Referral paperwork takes about five minutes, whereas the MDTA paperwork takes about half an hour, so you can understand the resistance.” [Social Worker, Glasgow]

5.30 Data recording, especially in light of the problems with the Management Information System, and the requirement to fill in handwritten MDTA forms, was considered labour-intensive. If the scheme were to be continued into the future, the establishment of a centralised electronic data management system was seen as something which would significantly reduce the administrative burden of data recording to an acceptable level and avert many of the data exchange issues between partner organisations that occurred during the pilot.

5.31 Among all parties, it seems that the time and administrative workload involved in the MDTA processes is a factor that is perceived as a barrier to the schemes success.

Partnership Working

5.32 Within each of the pilot sites, communication between the main partners in delivery has been facilitated by regular operational and strategic meetings. This has provided a

mechanism for feedback from each of those involved to allow greater understanding of the respective roles fulfilled by the partner agencies. It has also allowed process issues to be flagged early and to be rectified as the pilot has progressed.

5.33 Despite this, some disappointment was raised by both the police and assessors/treatment providers that the level of feedback could have been greater in terms of outcomes for referred arrestees (future offending or drug misuse). In Glasgow, presentations have been offered to the police by assessors/treatment providers to give this level of feedback, but this has been a late development and is perhaps something that would have been welcomed earlier on.

5.34 The police commented that there has been little in terms of feedback provided regarding the impact of the scheme on arrestees' future drug taking which may, potentially, have contributed to a lack of motivation for staff to fully engage with the scheme:

It might be an incentive to us to know that it is working because some people have got off drugs and are doing well, we just don't know." [PCSO, Aberdeen]

"I would be interested to know how many people attend appointments and attend assessments because then we would see if it is making a difference." [PCSO, Edinburgh]

"We do hear sometimes that MDTA has really helped somebody turn their life around, but the PCSOs don't get any feedback reminding them of how important MDTA is." [Police, Glasgow]

5.35 In all areas, the police worked closely with assessor organisations to arrange meetings between their respective staff, to help with interaction, but these could have taken place, perhaps, more regularly.

5.36 Throughout the pilot, there may have been a perception among social work staff that the police considered their role to be 'too soft':

"They think we're too soft an approach, but that's because they don't understand what we offer – it's not about tea and sympathy." [Social Worker, Glasgow]

"Wishy-washy social workers coming in to help these drug users out doesn't seem to be high on their agenda." [Assessor, Aberdeen]

"You know, obviously the police environment is a very regimented, very strict environment, well they maybe don't have an understanding of where we come from a social worker point of view. And equally, you know, well maybe we have a lack of understanding as to why they need to be so regimented in relation to these prisoners. So, I think there could have been more thought, from both sides, put into how we could understand each other a bit better." [Assessor, Glasgow]

5.37 There may also be an issue with a lack of understanding of the police role from others involved in the pilot. In particular, there may be unrealistic expectations about what the police can achieve with the resources that were allocated to the pilot. There is also, perhaps, a lack of understanding about the multiple other tasks that need to be undertaken by PCSOs in caring for arrestees, rather than simply referring into MDTA:

“I do think that quite a few individuals don’t have a good grasp of the police role here. But there is an expectation that we will do a lot more than is our job to do, there is a lot of blame placed on the PCSOs, and it just isn’t necessary in most instances.” [Police, Glasgow]

5.38 The critical approach by some partners towards the police may have been a demotivating factor for some of the police staff involved and third-party intervention may have been required to more clearly explain and delineate the respective roles of the different agencies and, importantly, where one agency’s responsibilities end and another’s begin. The role of the police should have been clear-cut but seems to have been complicated by the expectations of others involved.

5.39 In Glasgow, the police and GAS worked hard together in the later stages of the pilot to achieve a better understanding of respective roles. This included meetings between the Practice Team Leader and local Chief Inspector overseeing the pilot and the offer of a number of seminars by GAS staff to inform the police of the treatment routes available to those referred into MDTA.

5.40 In Aberdeen and Edinburgh, partnership working between the police and the assessors was perceived as both positive and negative over the time period of the pilot. Several assessors reported PCSOs were hesitant at first, and quite mistrustful. Several assessors reported that the relationship with the PCSOs was strained, and felt frustrated because, unless a drug test is carried out, they cannot undertake an assessment.

5.41 Suggestions were made for a day where the PCSOs, assessors and treatment providers could learn what each others roles are. There needs to be more communication at a grass roots level, not just amongst the managers: the assessors need to explain to them why they do not have much work to do, otherwise the PCSOs may resent the fact that assessors spend all afternoon and evenings in the police station. The assessors perceived that the police seem to think social workers are there to give arrestees a smooth path out but it would be better to show that assessors do work to challenge offending behaviour, and try to get arrestees stable on treatment.

5.42 In sum, there is a perception that the strategic priorities of the two main stakeholders (the police and assessors) have been different from the start of the pilot. This has meant that there have been some frustrations expressed by both parties regarding the running of the pilot and the level of responsibility that each should bear for its success. The importance of good partnership working seems to be a key principle underpinning the efficient running of MDTA into the future. Lack of understanding between the two types of organisation has, perhaps, been one of the biggest barriers to the success of the pilot scheme.

Engagement from Crown Office and Procurator Fiscal Service

5.43 Both the police and assessors/treatment providers would welcome more engagement and communication with COPFS for the duration of the pilots. COPFS's involvement was minimal at the early stage, and involved advising the local implementation groups of the legality of some issues surrounding the MDTA scheme, and what the perceived difficulties might be. Thereafter, the main COPFS involvement was dealing with reports from the police regarding offences being committed under the MDTA legislation and ultimately prosecuting the offenders. COPFS were also scheduled to attend quarterly meetings at the local implementation group.

5.44 Only Edinburgh could provide a rough breakdown of the statistics of arrestees going through the courts, the other areas were not aware of any data source that would provide this information, and although the system may be able to filter this out, this was only a possibility.

5.45 With regard to training, this was discussed in the planning groups, and leaflets were distributed in some areas, although staff changes render it difficult to assess how widely training took place and these leaflets were distributed. The COPFS representatives interviewed as part of this evaluation were not aware of the level of legal professionals' understanding of the MDTA pilots (for example, solicitors and sheriffs), but surmised that it would be minimal.

5.46 COPFS had little contact with other partners involved in the scheme aside from the local implementation group meetings. COPFS stated that as they are involved at the end of the process (ie when the arrestee has refused a drug test or has failed to attend an assessment), there is a slightly odd tension as, although it is a process designed to help people, they are ultimately referred to the COPFS to be prosecuted for non-attendance at assessment. The underlying objective of the legislation was to help people.

5.47 Whilst involved in the early planning stages of the pilots, the involvement of COPFS in the running of the pilot schemes has been minimal, as has their engagement with the operational and strategic planning partners.

5.48 Several PCSOs were frustrated at the time required to write a statement when an arrestee failed to attend an appointment, and felt that in most cases, even though the PCSOs received a letter from the Procurator Fiscal stating they had been cited to court, the arrestee was rarely charged for non-attendance at an assessment. When attendance at court was required, PCSOs were usually put on stand-by, meaning that the court could call at any time and they would be required to appear in court to give a statement. This was problematic, however, as the PCSO could be on duty at the time, or on annual leave, but would still be required to attend the court if they were called to give evidence. PCSOs reported feeling aggrieved when they made the effort to write a statement, and attend court when, in most cases, the case was 'thrown out' of court.

5.49 Similarly, several assessors commented that they were required to provide paperwork and reports when an arrestee did not attend an assessment but that this proved to be time consuming and problematic for prioritising workloads and booking annual leave. Moreover, assessors felt that the time taken to receive a confirmatory test back from the lab was, on occasion, not in conjunction with the date of the scheduled assessment, and

this sometimes caused a problem because arrestees were attending assessments when their results were not back from the lab at that time, and therefore, an assessment could not be undertaken.

Perceived Impacts of the Scheme

5.50 Due to the low numbers of people being processed through MDTA, there was some general reservation among partners regarding the true success of the scheme. There was a general feeling in all areas that the pilots would have been more successful had the case loads been higher, and there was a general air of disappointment that this had not been achieved from both the police and assessors/treatment providers.

5.51 Among the police, this was perhaps mixed with some reservations about how successful the scheme may be in practice, due largely to the fact that they have received little in the way of feedback as the pilots have progressed, either from assessors and treatment provider agencies, or from COPFS. The majority of PCSOs were unaware what impact the Mandatory Drug Testing of Arrestees Pilot has had on arrestees in the short term, and said that the only feedback they receive is the arrestee coming back into custody having previously already taken the drug test.

People who are benefiting from MDTA

5.52 Among assessors and treatment staff, the pilot was considered a success for those who had engaged.

5.53 The mandatory element encourages the arrestee to take help while they are actually in the cells, this has the advantage of approaching them at what is considered an 'ideal time'; when they are low and thinking about the consequences of their actions, and when there are counsellors on hand so that they do not need to attend an assessment at a later date. Although there is also the possibility that arrestees were still under the influence, or were not feeling well while they were in the police station, this was still perceived as the best time by most interviewees to carry out an assessment with an arrestee:

"I think the mandatory nature of it forces people to come here and find out what it's about, and that's definitely a good thing." [Assessor, Aberdeen]

5.54 MDTA will have tested many people who would not normally have been tested, and therefore, given the opportunity of help and the possibility of engaging with a drug treatment service. People are accessing a service that they wouldn't normally access, and generally, counsellors in the cells were thought of as useful as people can access help 'there and then'. At the very least, MDTA has made some arrestees think about their drug use, and has identified possible ways of getting them into treatment. Assessors and treatment providers have commented that arrestees are able to more easily and quickly access treatment (particularly methadone) if referred via the MDTA pilot, when compared to GP waiting lists. The specific provision of funding to support this activity as part of the pilot is viewed by all as an essential component of the pilot.

5.55 In Glasgow, the pilot was considered especially valuable in having targeted vulnerable female offenders as well as a new and emerging group of recreational cocaine users:

“It’s captured a whole range of cocaine only users, who are mostly employed, and who would never have taken up voluntary assessment because they don’t see themselves as having a drug problem. This has given us the opportunity to issue them with a lot of detailed information about the consequences of cocaine use, and of using cocaine and alcohol together - both the long term and the short term use of these two substances...It’s enabled us to speak to a whole new group.” [Social Worker, Glasgow]

5.56 Consultees reported that MDTA does not appear to have been in any way differentially beneficial for people in equalities groups, or those with special needs.

Feedback from Arrestees

5.57 All of those interviewed provided positive feedback on the MDTA scheme. It is important to note, however, that this sample was not representative since all those interviewed were people who were engaged with treatment services. This meant that most were already feeling the benefits of engagement:

“It’s a really worthwhile programme, and if there’s one more person like me who can actually take it up then that’s a good thing...I was going to put myself into an early grave to be honest. So if it helps me there must be other people out there it can help as well.” [Arrestee, Edinburgh]

“If anyone had said to me they were tested and had to go to an assessment, I’d say go, it’s worked for me.” [Arrestee, Aberdeen]

5.58 Most arrestees demonstrated a genuine desire to change their lifestyle, and to reduce their drug habit, with the ultimate aim of eliminating their drugs consumption. Most realised that this would be a long term goal and, that, in the short to medium term, they should focus on controlling and managing their existing drug problem:

“A life, I suppose, a better life than I was living. To cope better.” [Arrestee, Glasgow]

“In another few months, I’m going to try and get a job, no not try, I am going to get a job...and then gradually I’m going to come off methadone. I don’t want to run before I can walk, but when I’m ready I’ll come off methadone.” [Arrestee, Aberdeen]

“I just wanted my life sorted out, basically. Cause I’ve got two young children, and it’s not fair on them, like, sneaking in places to put a needle in your arm, you know. And so I really wanted to get everything out my system.” [Arrestee, Glasgow]

“Trying to get on a stable dose of methadone and stick to that dose without using anything on top of it, and then to try and take things from there.”

Hopefully, then, to try and work on a reduction in my methadone once I'm at a stable point." [Arrestee, Glasgow]

5.59 Arrestees who were interviewed were also unanimous in their view that the scheme might assist in breaking the cycle of drugs misuse and offending:

"It does stop me offending as well. Cause, you see, before I came here I was on cocaine and everything. I was out and going into hotels and stealing everything, and that. I don't do that now. I don't do nothing cause I'm off everything [drugs] now." [Arrestee, Glasgow]

"I was breaking the law but now I can get help, and think about getting a job or going to college..." [Arrestee, Aberdeen]

"I've not been out stealing, or robbing or anything like that. So, it's already helped." [Arrestee, Glasgow]

5.60 Although not a representative group of arrestees, the views of those consulted provided generally positive feedback regarding the schemes success in helping them to change their lifestyle, reduce drug consumptions and reduce offending behaviour.

Interaction with Assessors

5.61 Generally, assessors commented positively on relationships with arrestees, and this was reciprocated among the clients who took part in an interview:

"They've all been truthful, you know. They've not messed about. They've always kept in contact and let me know what's happening and all that." [Arrestee, Glasgow]

"The ongoing support from here has helped, when I was feeling stressed, anything like that, and if I feel like I am slipping back I can phone them. My support worker is great, phones me all the time, etc. Just somebody to sound off at, and she's really good about it." [Arrestee, Aberdeen]

"They're always willing to help you as much as they can, and do what they can." [Arrestee, Glasgow]

"It's a bit of support, someone I can tell anything to, something I can't tell my mum or girlfriend, a bit of support." [Arrestee, Aberdeen]

"I couldn't have asked for a nicer assessor, we just clicked. She was upfront and straight with me, and I thought this was the perfect opportunity to get my life sorted, I'd been on drugs for 14 years." [Arrestee, Aberdeen]

5.62 Arrestees spoke of the difficulties they faced in tackling their drug problems, but all those who had participated in the scheme, and were in treatment, spoke positively of the

scheme, and the informative and supportive relationship with the assessors in particular. In Aberdeen, assessors were talked of positively for their relaxed and informal manner of dealing with assessments, but also for their follow up work with arrestees where arrestees stated that this follow up work such as attending a doctor's appointment with an arrestee, looking for a homeless shelter for an arrestee, providing numbers to help an arrestee sort out their debt problems, all helped provide a more supportive role in all aspects of life, not just to tackle their drug addiction.

5.63 Information leaflets designed to provide arrestees with information about the MDTA scheme have been viewed as a success by both assessors and arrestees. While arrestees recalled being given an information leaflet, and stated this was useful, they also appreciated assessors explaining the MDTA scheme to them personally, especially if they suffered from poor literacy or dyslexia. Similarly, even where arrestees participate in only the mandatory requirement of the scheme, assessors have welcomed the opportunity to use the initial MDTA assessment to provide harm-reduction information to those most vulnerable and at risk adults.

On-site assessments

5.64 Arrestees also seemed to welcome the opportunity to engage with assessors at the time they were in police cells. This was mostly because arrest was seen as a time when they could consider their current lifestyle, and make the most of the opportunity to make a change:

"You get time to think when you get arrested." [Arrestee, Glasgow]

"It's better that way [being offered assessment in the cells]. If they said to you out of there [the cells], you might not have done anything about it." [Arrestee, Glasgow]

5.65 There was, however, a small minority of arrestees who felt that the timing of the assessment in cells was inappropriate. One commented that:

"It's a bit of a bad time, because they've just been charged with whatever their offence is and then they're sitting and worrying overnight, or all weekend, what's gonna happen to them at court, and then they've got this at the back their mind as well. That's why I think it's only good for people who are ready for it, you know." [Arrestee, Glasgow]

5.66 This was also recognised by assessor staff who suggested that people seen in police stations were sometimes more hostile and less trusting of assessors than when seen in a more neutral location.

Complete Care Packages

5.67 There was a feeling among arrestees that the package of care that was being delivered by MDTA was more fit-for-purpose than some of the standalone services which they had engaged with before.

5.68 In Glasgow, arrestees placed a strong emphasis on the 'whole package' of care that was delivered, including attention to the mental as well as the physical wellbeing of clients, and attempting to meet their social (housing and employment) needs, as well as addressing their drug problems:

"[My MDTA worker] has been more helpful [than ordinary social worker], I think, 'cause he's been trying to get me housing and everything else." [Arrestee, Glasgow]

"[They offer] help to get off of drugs. Help and support. Help to get accommodation, obviously. Get a job. And, he [MDTA worker] has put me in touch with other people." [Arrestee, Glasgow]

"They [MDTA workers] listen to your more [than ordinary social workers] and take more interest in your problems. They put you in contact with people that they think might help you." [Arrestee, Glasgow]

"I've not taken drugs for a few weeks now, I've been clean for a long time. I've been keeping focussed on things, 'cause I see them every week." [Arrestee, Glasgow]

"They give you full support, and if they think you're in any danger, they try and help you out of that." [Arrestee, Glasgow]

5.69 Support and information on the drug treatment programme, but also on issues such as homelessness, debt, and family issues was cited as a particularly important to the arrestees who would appreciate a package of support:

"It's not just come in and dish out a prescription and go again, they give you advice and support. What's the point in fixing the body if it's not fixing the mind?" [Arrestee, Aberdeen]

5.70 In particular, it seemed that arrestees welcomed a service which was not focussed solely around the issuing of prescription, but that helped them to address psycho-social needs:

"I would say it's really good, I would say, go for it, 'cause it is really good. 'Cause you get a chance, to sit back, and listen to people, rather than just getting a prescription. If you listen to your worker, you get a chance in life, basically." [Arrestee, Glasgow]

"[Before MDTA] I would just go in and pick up my prescription. But in here, you're sitting and talking to your counsellor, you can come and talk to somebody when you need to. They give you a lot more options about what's out there for you. It's a lot more helpful that way, than just going and picking up a prescription and then just leaving." [Arrestee, Glasgow]

5.71 In terms of additional support and information, some suggested that the full potential of participation was not made clear. In particular, the fact that services available were not exclusively methadone provision or drug related alone:

“It would be helpful if people pointed out that they could get help for the problems that led to my drug use as well. ‘Cause you’ve got to deal with these problems, before you can deal with your drug problems, you know. It’s helped me a lot, talking about things that have happened in the past, and things that have led to my drug use.” [Arrestee, Glasgow]

“All it would be would be picking up my prescription from the doctor, and nothing else. A lot of people like me haven’t got any family connections and they need that bit of support and encouragement, you know. For somebody not to look down on you if you fall back, they’re not gonna judge you or anything like that.” [Arrestee, Glasgow]

5.72 While the pilot was considered particularly successful in terms of providing speedy access to medical staff, a cautionary note to emerge from the pilot was that increased awareness of the scheme among arrestees may result in future engagement with the scheme for the wrong reasons:

“We don’t want people getting themselves arrested just so they can get a script – so we can’t shout it from the rooftops too much.” [Assessor, Edinburgh]

5.73 Indeed, some of the arrestees interviewed, especially in Aberdeen, suggested that one of the main benefits of the scheme had been speedier access to methadone and a perception that they had by-passed waiting lists:

“Anyone coming through by MDTA will benefit because they can get a script quicker.” [Assessor, Aberdeen]

“If I wasn’t on this programme, I would be back on that waiting list, there wasn’t any other choice for me.” [Arrestee, Aberdeen]

5.74 One arrestee admitted that his initial decision to take part in the scheme was linked to his perception that, if he did not, his existing methadone prescription would be cancelled:

“They done it just before I got my methadone and so I think they maybe done it, maybe, I don’t know, to make you feel like, if I says no, you’re not getting your methadone. Well, that’s the way I felt, anyway.” [Arrestee, Glasgow]

5.75 This provides valuable learning for the future in terms of ensuring that MDTA is not considered as a fast track access scheme to methadone, but is recognised for the full potential package of support that can be offered.

Understanding of the Scheme

5.76 Despite recognising the benefits of their current engagement with services, there appears to have been a general level of confusion among arrestees about the existence of Mandatory Drug Testing of Arrestees as a standalone pilot scheme.

5.77 In particular, when asked if they understood what the MDTA pilot was all about, many believed it was a form of continuous random drugs testing:

“It’s not like, if you go to a normal drugs counsellor, they don’t always give you urine samples, and all that. They [current workers] give you one just out the blue, so if you are taking other stuff, you get caught. And I give urine samples all the time.” [Arrestee, Glasgow]

5.78 It is, perhaps, the case that some drug users in contact with other social work services or drug treatment providers will be subject to mandatory or random drug testing as part of other programmes with which they are engaged and, perhaps, this was confused with the MDTA scheme.

5.79 There was some confusion among arrestees with regard to the name of the scheme, where some arrestees thought at first that it meant they had a Drug Treatment Testing Order, because of the mandatory drug test. However, arrestees stated that the aims of the mandatory drug testing scheme were fully explained to them when they attended their first assessment, and generally, the information they were given was easy to understand, and they understood what they were required to do as a participant in the scheme.

5.80 There was also some confusion regarding the consequences of not taking part in the mandatory element of the scheme. One arrestee in Glasgow suggested that he thought his participation in the scheme would prevent him from being charged with the arresting offence (ie cannabis possession):

“If you go voluntary to this, you don’t get charged, but if you don’t go voluntary to this you will be arrested for cannabis...and they said, because you’re going to this thing, you won’t get charged.” [Arrestee, Glasgow]

“The police seen me when I got caught with cannabis and that’s when I got sent here. They says, you can go to it, or you can get the jail. They told us everything.” [Arrestee, Glasgow]

5.81 There was mixed response in terms of whether arrestees had been informed by the police of what the service entailed. Indeed, even where people said that the scheme had been explained to them, there was generally poor understanding of what was involved in agreeing to take part ie assessment after the drugs test.

5.82 There was also some confusion about who was responsible for taking the test and there seemed to be poor recollection of what had occurred at the early stages of the pilot.

Life Stages and Engagement

5.83 Arrestees who had taken up the scheme felt it important to emphasise that they took part in the scheme because they were ready to take part, and because they had made the decision to take part. Consensus was that if an arrestee was not ready to take part in a drug treatment programme, or had a chaotic lifestyle due to drug addiction, homelessness, etc, they would not take part, despite any measures that are put in place to facilitate them taking part:

“People won’t participate in the scheme if they aren’t ready, there is a lot going on, and it’s difficult to keep up appointments. When you wake up in the morning your first priority is how to get drugs, not to go to an appointment...you’ve got to be in the right frame of mind to do it.” [Arrestee, Aberdeen]

“You’ve got to want the support at the time, it won’t work if you aren’t ready for it.” [Arrestee, Aberdeen]

“It was me that decided to go for it, if it had been anyone else that had decided for me there would be no point. I think you have to make up your own mind if you want to take it further. I think just coming here had made me turn around and think, well actually there are people that can help.” [Arrestee, Edinburgh]

5.84 There was a consensus that the MDTA scheme may not help all drug users:

“It’s just getting people at the right time, isn’t it, you know? I mean, I had been in and out of jail about fifty times or something, since I was 15 and I was just sick of it. I just had enough of it. It was time to change. If they’d have done it with me when I was four or five years young, I wouldn’t have done it. It’s just getting people at the right time.” [Arrestee, Glasgow]

“The person’s got to be willing to do it themselves. If they are half-hearted about it, it won’t work.” [Arrestee, Glasgow]

5.85 Moreover, arrestees who were drug tested as part of the MDTA scheme more than once stated that the first, or even second time, they were tested they did not want to take part and missed their assessment appointment either because they did not want to attend or because their life was so chaotic that they missed the appointment and did not feel as if they could make another appointment of their own accord. However, when they felt ready, perhaps a year further down the line, the arrestee decided to take part in order to take control of their life:

“The next time I was arrested they asked me if I wanted help again and this time I took it with both hands.” [Arrestee, Aberdeen]

5.86 Personal motivation was also stressed by police and assessor staff as a fundamental requirement for success of the scheme.

“The motivation needs to be there to get off the drugs and a lot of them just don’t want to get off the drugs.” [PCSO, Aberdeen]

“If they aren’t ready to engage, then they aren’t ready to engage.” [Assessor, Edinburgh]

“I think the ones who want the help are getting it, but a lot of the arrestees don’t want to get off drugs, they don’t want to see an assessor because they don’t want to drop their habits. I do think there are a lot of decent people who come in though, who just get caught up in drugs, and who really benefit from this help with getting off them.” [PCSO, Glasgow]

5.87 The message here, perhaps, is that MDTA is especially beneficial when it reaches those who are ready to change, including those who may have been contemplating change but who lacked an easily accessible route into treatment or introduction to a suitable support agency.

MDTA and Arrest Referral

5.88 Attitudes were divided with regard to the voluntary approach of Arrest Referral and the mandatory approach of MDTA. Several interviewees felt the mandatory approach works much better than the voluntary approach because there are consequences to it, whereas there are no consequences to a voluntary approach, although those who seek help are usually motivated to do so. Some felt that motivation and engagement is just as high with the mandatory scheme than with the voluntary scheme because there seems to be some sort of realisation that people can get help. The part that is mandatory helps people who have not convinced themselves yet:

“For some clients not in the correct frame of mind, the motivation to get themselves sorted isn’t there.” [Assessor, Edinburgh]

“If I hadn’t been arrested, I wouldn’t have gone for it, so while it’s a crap thing to have happened, at least something good has come from it.” [Arrestee, Edinburgh]

5.89 Most interviewees saw a relationship between Arrest Referral and MDTA. A number of respondents felt that a combination of MDTA and arrest referral would be useful because a lot of people are happy with their lifestyle, and their friends and family are also involved in drugs, so it is only when they are in the police station and withdrawing that they may think it would be a good opportunity to participate in a drug treatment programme. The mandatory element forces them to think about it, however, if they are not ready to participate at that time, the voluntary element allows them to participate when they are ready:

“If it wasn’t mandatory, hmm, I don’t know...I would have come up actually, because I was screaming for it at the time, I’d been to the doctor’s and everywhere. It’s just waiting in line to get the help that’s the biggest problem with the scheme.” [Arrestee, Aberdeen]

5.90 On the other hand, a number of interviewees felt arrestees might be more motivated if it was voluntary, as some people are not motivated to seek help, and there was a feeling that if they are not forced, they might be more willing to participate. It was felt that the way mandatory drug testing works, if people refuse to be tested or refuse to be assessed, that can constitute a criminal offence, so although there is no coercion involved in the actual treatment, there certainly is coercion involved on the way towards it. Treatment providers in general felt that in substance misusers, change generally happens slowly, the clients have to be psychologically ready in order to even contemplate making a change, and sufficiently motivated if they are going to sustain it. If change is forced on them they are more likely to falter, revert to old behaviour and fail.

5.91 It was felt that a voluntary test might be a good idea as the number of tests carried out would go down, but the numbers of people attending assessment would go up because they are the people who do want help. This would also target police, assessor and treatment resources better.

5.92 An ongoing theme throughout the pilot has been suspicion that many people who are eligible for MDTA have been referred, instead, to Arrest Referral whilst in police custody:

“Well, I think it could be quite a bit better, a lot of people have been offered Arrest Referral when their trigger offences have actually been MDTA. I think there are a lot more eligible arrestees than they’re actually testing for. We’re losing clients who we could have offered care and treatment because they’ve been offered Arrest Referral first and have refused it.” [Social Worker, Glasgow]

5.93 In Glasgow, the Practice Team Leader oversees all the MDTA staff and Arrest Referral staff, the Throughcare addiction services referrals, Persistent Offenders Project referrals, the drug court referrals and the criminal justice referrals. This single coordinative role enables the various criminal justice addiction activities to maintain a consistent approach and to ensure that individual clients are receiving the most suitable care and attention.

5.94 The role of the leader was considered essential by local staff, especially in coordinating tasks between AR and MDTA staff:

“Right from the beginning there was recognition that MDTA and Arrest Referral had quite a bit of overlap, and that the team would have to deal with them both. My view was that, as long as there was a logistic overlap between the two, it made sense for our workers to do both. And the more the scheme’s gone on, the more we’ve realised what a good decision that was in terms of the evidence. And that wouldn’t have been possible without [the Practice Team Leader’s] post, without input from a senior manager to create that agenda. In the past there were two or three of us creating the agenda, but with the introduction of MDTA it’s no longer effective to share out this task - you need a practice team leader to manage that and make sure everything runs smoothly in an integrated way, and that’s about the sheer number of arrestees coming through as well as the quality of the service.” [Social Work Manager, Glasgow]

Learning for the Future

5.95 There is a general consensus among the pilots' staff that the pilot period has been too short to provide a meaningful measure of how successful MDTA could be. Some assessors commented that, for arrestees, the pilot period had been too short to assess its real impact, but that MDTA had 'set the seed' in their mind that they could get help:

"The scheme has the potential to be a success but it needs to be tweaked quite a bit if it is to be rolled out." [PCSO, Edinburgh]

"...a lot of the benefits won't be apparent in such a short time scale, we don't yet know what the outcomes are for people who come through addiction services again and again." [Assessor, Glasgow]

5.96 Despite this, there has been some incidental learning which may be considered as an added benefit from the scheme. In particular, the pilot has been helpful in providing additional information to drug treatment workers in the three areas regarding the drug using population in the area. This has been one of the best examples of incidental learning from the pilots:

"But the information we're gathering about vulnerable clients, about cocaine users, and about poly-drug users is all very valuable too, and I don't think we would have got that sort of information without the MDTA scheme." [Assessor, Glasgow]

"...and it has made us aware of some major problems that we were only anecdotally aware of before... That evidence is becoming very clear now, it's much more concrete and we can really see how significant these problems are now." [Social Work Manager, Glasgow]

5.97 If MDTA were to be continued into the future, a number of suggestions were made for potential changes to the legislation, to assist in the smooth running and efficacy of the pilots.

'6 Hour Rule'

5.98 Legislation currently dictates that arrestees cannot be drug tested if they were held in custody for more than 6 hours without being arrested. Many interviewees have surmised that this piece of legislation was taken from English legislation where a person can be arrested straight away, compared to Scottish legislation where an arrestee can be first detained and then arrested. This piece of legislation has proved difficult for PCSOs to work under. Furthermore, even if there was time to test the arrestees during this 6 hour period, many arrestees were too intoxicated, and therefore possibly too aggressive or unwilling to undergo a drug test within 6 hours:

"At the start of the night you are running about and before you know it the 6 hours have been and gone. Friday night fingerprinting and photographing is usually done on the Saturday afternoon because it is so busy on the Friday

night, but we can't test them then too because it is after the 6 hours."
[PCSO, Edinburgh]

"I would say it could be good if that 6 hour barrier was taken down or made more flexible. Then we could test more people in the day, as far more are arrested in the evenings and night time than could possibly be tested in that time." [PCSO, Glasgow]

Trigger Offences

5.99 The trigger offences were deemed to be an issue of contention where PCSOs stated that there are both a lot of people who are 'missed' from the testing process such as street workers or those carrying a weapon, but also that there were many people tested who did not need to be tested such as people arrested for reset or embezzlement, where it is obvious the test will provide a negative result, but who are still required to be tested:

"You can usually tell whether someone's test will come up positive or negative...and these boys that have been out drinking and have gotten into a fight...they haven't been taking drugs." [PCSO, Edinburgh]

5.100 Females are hard to reach, the trigger offences do not facilitate women's access to drug services if a woman is involved in prostitution and/or is homeless, and it is thought that many women are caught up in a vicious cycle and are obliged to a lot of people for drugs and accommodation. Females may need to have the help more readily available for when they are ready for it; a package of support for this hard to reach group. Moreover, a lot of women have children and do not have appropriate childcare in place to attend an assessment or follow up treatment appointments.

Eligibility Criteria

5.101 There was consensus that the eligibility criteria may be too restrictive, in particular in respect to excluding people on warrant. There was also concern that the scheme did not cover people living outwith the pilot area 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. This was mentioned particularly in Edinburgh as arrestees can be taken to St Leonard's from Edinburgh city but also from as far away as Bonnyrigg and Musselburgh. There were general calls for the eligibility criteria to be broadened:

"Even if their original offence was stealing or shoplifting, they don't get tested because they're on a warrant. We're losing a huge amount of people that would have definitely come through the system." [Assessor, Edinburgh]

"I think it would be better to test everybody who comes into police custody, because there's a strong link between all types of crime and drug use. I know that would be very difficult with our current resources but I think it would be more useful." [Police, Glasgow]

5.102 The COPFS felt that if the scheme was to continue, some changes would need to be made including the issue with the detention time, the issue that people on warrant cannot be tested, the fact that the individual has to be resident in the pilot area, and the expansion of the trigger offences to include housebreaking with intent, opening lockfast places with intent and contraventions of s.57 of the Civic Government (Scotland) Act 1982.

5.103 In sum, there was consensus that the legislation had been taken too literally from the English experience and that it was not fit-for-purpose in a Scottish context. In any continuation of the scheme, it seems that there may be a need to revisit the legislation to ensure that it better fits the requirements of Scots Law.

CHAPTER 6 DISCUSSION

6.1 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 misuse problem and associated offending behaviour. This evaluation sought to explore whether the pilot schemes, as originally conceived and implemented, have met this aim, exploring both the systems introduced and the activities undertaken by each of the main partners in delivery for the scheme. The data presented above represents a combination 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.

Summary of Main Findings

Set Up and Operation

6.2 The pilot schemes all 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.

6.3 There was a slight delay to the recruitment of dedicated PCSO staff to deliver the scheme, but the training of conventional PCSOs and other police officers meant that it was able to get started on time.

6.4 Assessors and treatment service providers were also in place for the start of the pilots in each area, to allow the full service to be offered from the start. The exception to this was Aberdeen, for whom problems with the availability of treatment services in the early months of the pilot meant that there was slow start.

6.5 The biggest challenge faced by the pilots has been a far lower than expected throughout of referrals into the scheme. At the planning stages, it was anticipated that around 15,000 arrestees per year across the three sites might be tested. The actual number, across all three sites was considerably lower and 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.

6.6 Problems with the planned central Management Information System meant that each of the pilots had to develop their own bespoke systems for recording MDTA activity. Police monitoring systems appear to have been less than suitable for the purposes of ongoing monitoring evaluation, and this has made some aspects of the evaluation presented here more difficult. This is especially the case in Glasgow where the volume of arrestees being processed by the custody suite has made extrapolation of MDTA eligible clients difficult to identify from generic arrestee databases. It should be stressed that, the police were not unwilling or uncooperative, but were simply under-resourced and unable to find time to perform these kinds of administrative duties either to inform their own monitoring of activity or to inform the evaluation.

6.7 The administration time required to complete an MDTA referral and assessment have been highlighted as barriers to its smooth running, and also as a potentially off-putting characteristic of the scheme for the police.

6.8 The location of assessors in police stations to enable on-site assessments is something that was generally welcomed as a positive feature of the scheme, to capture arrestees at a time when they are able to reflect on their drug misuse and offending behaviour, and to access help straight away. Only a few reservations were raised about the appropriateness of this process in terms of placing additional stress on arrestee at a time when they may already be experiencing considerable anxiety and distress. Problems with the suitability of accommodation in police stations provided for the purposes of MDTA were also raised.

6.9 There have been few changes to the schemes operation as the pilots have progressed, with the exception of the role of assessors in each of the sites. Due to the considerably lower than anticipated numbers referred into each scheme, assessors have taken on more direct responsibility for the care management of arrestees referred into MDTA (in Glasgow and Aberdeen), and have sought opportunities to work across the drugs domain and to assist with Arrest Referral work (in Aberdeen) to maximise their time.

6.10 Partnership working between the police and assessor organisations has also 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 broken down with more up-front awareness raising.

6.11 At the general level, it appears that the Crown Office and Procurators Fiscal Service (COPFS) has failed to fully engage with the pilot.

Effectiveness of the Three Schemes

6.12 It was hoped that the main measure of efficacy for the schemes would be the numbers of referrals into MDTA which resulted in a positive drugs test and onward assessment, as well as the numbers of people engaging with drug treatment services as a result of their engagement with the scheme.

6.13 In practice, it has been difficult to use these criteria as stand alone measures of the effectiveness of the scheme, since the data collected has been limited in some cases and there has been some lack of reconciliation between the figures held by each of the partner agencies with regards to testing, referral and treatment activity.

6.14 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. The total number of referrals for assessment in each area was broadly comparable with 310 in Aberdeen, 381 in Edinburgh, and 301 in Glasgow. Of

these, 42 people in Aberdeen were referred for an initial treatment appointment who were not already in existing services. A further 25 people reported that they were already engaging in treatment, but were referred on for further treatment through the MDTA pilot. In Edinburgh, 46 people were referred by Turning Point at their initial assessment to a treatment agency. A total of 79 arrestees received information and advice as part of their initial assessment meeting, but were not referred on to treatment. In Glasgow, all of the 152 people who attended an assessment received treatment or support of some kind. In some cases, this was limited to information provision regarding harm reduction or service availability, but in most cases involved more in depth support and engagement with service providers. Of the 152 people who attended their assessment, 68 (45%) were not engaged with a Community Addiction Team in Glasgow, at time of assessment. This group represents those who, had it not been for the MDTA pilot, may have remained unknown to Glasgow Addiction Services.

6.15 While the numbers of people entering treatment is, therefore, relatively small, the schemes do appear to have been effective at providing information, help and support at the generic level.

6.16 The data has also shown that the pilot has been successful in engaging a small number of chaotic drug users, many of whom may not have otherwise have engaged with drug treatment services. While the demographic of those referred into MDTA in each area has not been notably different from those referred into drug treatment per se (ie mostly white, males in their 20s and 30s), there have been some smaller sub-groups who have been more prevalent in the pilots than might be the case in generic drug services, most notably recreational cocaine users and, in Glasgow, women in prostitution.

Feedback from Arrestees

6.17 Although the focus of this evaluation was not on the impacts of the schemes for arrestee in terms of their reduced offending or drug consumption (this would require a longitudinal model), efforts have been made to examine at the crude level what the perceived benefits may have been to the clients who took part in the pilot, so that it too might contribute to our understanding of the schemes' effectiveness.

6.18 Accepting the limitations of the qualitative data generated (ie that the sample was not representative), all nine interviewees provided positive feedback on the MDTA scheme in terms of it having provided them with valuable help and support. Good relations appear to have existed between assessors and arrestees, as well as with the police, insofar as they provided a reasonable level of information about the scheme and what would be involved.

6.19 Arrestees also seemed to welcome the opportunity to engage with assessors at the time they were in police cells. The time of arrest was seen as a time when they could consider their current lifestyle, and make the most of the opportunity to make a change.

6.20 Compared to alternative, conventional drug treatment services, there was feeling that MDTA was helping arrestees access a wider range of help and support options, including assistance in tackling the route causes of their offending and drugs misuse. Help

with accommodation, employment opportunities and mental health were all cited as examples of additionality from the scheme.

6.21 Among those interviewed, there was widespread recognition that MDTA was only effective among people who wanted to change their lifestyle and that it would not be appropriate for all drug users who met the eligibility criteria. Being at a point in their lives when they wanted to change appears to have been the main motivation for participation.

6.22 Despite recognising the benefits of the scheme and offering generally positive feedback on its outcomes, both in terms of reduced drug consumption and offending, there does appear to have been a certain level of confusion among arrestees regarding the principles and main requirements of participation in the scheme. These included perceptions that the scheme was a form of ongoing random drug testing, and that participation in the scheme would mean that arrestees were not charged with their arresting offence (instead of not being charged with non-compliance).

Lessons Learned

6.23 Examples of good practice to emerge from the pilots include the development of a robust data monitoring system in the Glasgow pilot, which has greatly assisted in ensuring that staff in that area can monitor the progress of clients as they progress in their treatment trajectories.

6.24 The information sharing events run in Glasgow also provide an example of good practice but this was marred by difficulties in getting the police to attend.

6.25 The main lesson learned is that resources required for the police to successfully run the MDTA pilot were hugely underestimated. The police provide a 24/7 service, however, in Aberdeen and Glasgow, there was no provision for MDTA drug testing for much of the working week. While it is unlikely that providing full 24/7 coverage would capture sufficiently large numbers of eligible arrestees to warrant the resources required to staff the operation, an analysis of peak times when eligible arrestee might be captured could perhaps allow for better targeting of police resources at busy times, including the provision of extra police staff dedicated solely to MDTA at peak times. This would help to maximise effectiveness of the scheme.

6.26 A better balance was clearly needed between police and assessor resources allocated to the schemes, since assessors were under-worked and police were over-worked for the duration of the pilots.

6.27 The smooth running of MDTA in the future would require better communication between the police and assessors, particularly in terms of feedback about the impact on arrestees future drug taking and engagement with services. There is a need to build strong bridges between organisations at the start of such schemes if they are to run successfully.

6.28 Finally, changes to the legislation may be required to ensure that a wider audience of arrestees could be captured by the scheme and, importantly, those who may benefit most from its offerings.

Comparison of the Three Schemes

6.29 It is difficult to provide a reliable comparison of the effectiveness of the three schemes, since the models employed were so different, and the level of resourcing also varied considerably. At the operational level, it seems that each of the models had their own advantages and disadvantages.

6.30 In Aberdeen, the role of the assessors in providing wider care and support packages to MDTA clients appears to have worked well. This resulted from under-utilisation at the start of the pilots, as with Glasgow. The main problem in Aberdeen was with the lack of treatment services at the beginning of the pilot.

6.31 In Edinburgh, the availability of large numbers of trained PCSOs meant that large numbers of arrestees were tested, and the assessors and PCSOs also appear to have had good relationships. The presence of the assessors in the police stations acted as a motivation for PCSOs to more fully engage with the scheme. The main problem in Edinburgh was the lack of joined up services and, in particular, people getting lost in the system between assessment and access to treatment. This was the only site where assessors did not take on the role of longer term care management for MDTA clients. This may have resulted in lower levels of eventual uptake of treatment services.

6.32 In Glasgow, the integration of the MDTA team within the wider Glasgow Addiction Services meant that clients were offered access to a wide and varied network of services which were readily available and, in some cases, co-located at the sites where arrestees were attending for assessment and ongoing treatment sessions. What worked less well was the involvement of conventional PCSO staff in the performance of MDTA tasks, and it seems that most of this responsibility fell to just two officers who were unable to provide the coverage required for the scheme.

Cost Effectiveness

6.33 The cost effectiveness analysis has shown that, under the MDTA pilots, the level of grant per person referred for assessment is lower in the Aberdeen (£2,123) and Edinburgh (£2,123) areas compared to Glasgow (£2,432). In terms of the level of grant per individual who turned up for assessment, the figures show that Aberdeen was the lowest (£2,502), followed by Edinburgh (£3,275) then Glasgow (£4,816). However, when one focuses on the level of grant per person entering treatment, which is clearly the key factor in the process, then it is clear that the Glasgow pilot (£6,655) is the most cost effective and performs significantly better than both Aberdeen (£9,821) and Edinburgh (£17,586).

6.34 Comparing the cost effectiveness of the MDTA pilots against the Arrest Referral schemes shows that, on the whole, Arrest Referral appears to be more cost effective than MDTA. This applies to both the level of grant per individual attending assessment and the level of grant per individual engaging with drug treatment. The results are particularly marked when one compares the performance of the Glasgow and Edinburgh/Lothian & Borders schemes. For example, the cost per individual engaging in drug treatment in Glasgow under MDTA is £6,655, compared to a figure of £865 for Arrest Referral. In Edinburgh, the same figure for MDTA is £17,586, compared to an Arrest Referral figure for the Lothian & Borders of £2,797. Indeed, using this measurement, the Edinburgh MDTA

pilot scheme performs poorest of all the schemes over the period June 2007 to November 2008.

6.35 Comparing the three Arrest Referral schemes shows that, in cost effectiveness terms, Lothian & Borders (£540) performs better than Glasgow (£815) and Northern (£1,811) in getting individuals to attend assessments. However, the level of grant required per individual engaging with drug treatment is lower in Glasgow (£865) than Lothian & Borders (£2,797) and Northern (£9,169). This suggests that, in terms of getting arrestees to engage in drug treatment, the Glasgow Arrest Referral scheme is the most cost effective scheme, while the Edinburgh MDTA scheme is the least cost effective.

Future of MDTA

6.36 It is difficult to make recommendations about the future of the MDTA scheme, since the level of data that are available to evidence its success are somewhat limited. It is important to stress that this research was a process evaluation, rather than an impact evaluation. Consequently, the data collected and reported here has a process focus and the research has not sought to explore or examine the impact of the pilots, to any notable degree. Whilst perceptual information has been presented from consultations regarding the likely impact of the schemes on arrestees (in terms of reduced offending and future drug use), and on the community (in terms of reduced offending), no statistical data has been collected to support this. This means that the conclusions from the evaluation are also, in themselves, somewhat limited with regard the true success of the pilots.

6.37 It may be desirable to run a remodelled version of the scheme which takes account of the need to rebalance police and assessor staff resources. The availability of more police staff to identify eligible arrestees, to perform drugs tests and to make onward referrals for assessment may impact greatly on the numbers of people being captured by the scheme. This, in turn, would increase the workload of assessors and, potentially, treatment staff, the results of which may represent better value for money than the models which have been implemented to date. Other variants to the models, including the possibility of allowing home visits for assessment purposes, assessments in prisons or the option of flexible on-call assessment services may maximise assessor staff's time and the potential reach of the scheme.

6.38 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 initial anticipated numbers who may be helped by the scheme.

6.39 It might, however, be argued that the pilots have been successful in assisting some of the most vulnerable and at risk drug users in each of the three sites to access support, help and information, as well as drug treatment services which they might otherwise not have accessed. Feedback from arrestees and from the police, assessor and treatment staff suggests that the pilots may have also reduced offending among those who have engaged with the scheme.

6.40 It seems that the hard work and enthusiasm of those involved in running these pilot schemes has provided a valuable opportunity to learn more about the patterns and associations of drug use and offending behaviour in each of the three areas targeted by the pilot. This, alongside the benefits felt by the individuals who have maximised on the opportunity to engage with support, information and drug treatment services, reflects a positive outcome of the pilots which cannot be quantified either monetarily or otherwise.

6.41 What does seem clear is that existing legislation appears to have restricted the activities of the police and others in reaching some of those who may have benefited most from the provision of a MDTA service. In addressing the problem of the low numbers of arrestees engaged with the scheme, there may be a need to revisit the '6 hour rule', to broaden the eligibility criteria and to remove restrictions imposed by the exclusion of people arrested on warrant.

6.42 A modified approach which builds on the lessons learned to date could, perhaps, be implemented in one of the existing areas as a continuation of the pilot, to provide a more accurate insight into what might be achieved with improved efficiency in the processes employed. Such a continuation would, however, need to be subject to close monitoring and evaluation and, to achieve a full understanding of its success, should be coupled with a long-term evaluation approach to explore impacts on offending for those participating in the scheme, as well as exploring the longer term benefits of their engagement with treatment services on drug use, offending, psychological and social well-being.

Appendix A – Alternative Schemes

Arrest Referral Schemes

Arrest Referral (AR) is a scheme directed at people who abuse substances and who are arrested and detained in police or court custody suites. It provides an opportunity for those individuals with drug and alcohol issues who have been arrested, to engage on a voluntary basis with drug treatment and/or other appropriate services. The aim is to reduce both substance misuse and the offending behaviour that may be linked to that misuse.

An independent evaluation of the Arrest Referral Pilot Schemes in Scotland¹ found that pilots were successful in reaching arrestees with substance misuse problems, that the throughput ranged from 100-900 a year per site, that 84% of arrestees would recommend arrest referral to other people and that most arrestees were referred into treatment services.

Drug Courts

Drugs courts operating in Glasgow and Fife offer a further example of recent initiatives to tackle drugs misuse and offending. They target those with complex and enduring drug problems to help them recover from addiction and rebuild their lives. Specialist Sheriffs, multi-agency working and effective case management are key characteristics of the drug court. Evidence shows that a sizeable proportion of drug court clients achieved and sustained reductions in drug use and associated offending behaviour. The success and effectiveness of drug courts is currently being reviewed.²

Drug Treatment and Testing Orders (DTTOs)

DTTOs are aimed at providing courts with a further community-based option to deal more effectively with some serious drug misusers who primarily commit crimes to fund their habit. DTTOs were introduced by the Crime and Disorder Act 1998 where courts can require an offender to undergo treatment for his or her drug misuse, subject to the offender's consent to such an order being made. The Order contains features unique to a community penalty which can be made as a 'stand alone' option or in conjunction with another community-based disposal such as a probation order. Those made the subject of an Order are subject to regular reviews by the court and for the offender to consent to occasional mandatory random drug testing throughout the lifetime of the Order. As many as 696 orders were imposed in 2006/07, and a further 601 orders in 2007/08, which can be for a minimum of six months and a maximum of three years.

¹ Anne Birch, Fiona Dobbie, Tish Calmers – Scottish Centre for Social Research – Lee Barnsdale, Gill McIvor and Rowdy Yates – University of Stirling (2006) Evaluation of the six Scottish Arrest Referral Pilot Schemes, Scottish Executive

² Gill McIvor, Lee Barnsdale, Susan Eley, Margaret Malloch, Rowdy Yates, Alison Brown - University of Stirling (2006) The Operation and Effectiveness of the Scottish Drug Court Pilots (<http://www.scotland.gov.uk/Resource/Doc/100021/0024203.pdf>)

Previous research³ has shown that DTTOs can have a positive impact on drug use and offending. The Evaluation of the Scottish Pilots showed that, after six months on an Order an individual's expenditure on drugs decreased from an average of £490 per week pre-sentence to an average of £57 per week. Despite having extensive prior criminal histories, almost half of those who complete their orders had no further convictions within two years. DTTOs also compare well with the cost of prison – the average annual cost of a DTTO is £10,000, while the average cost of prison is £35,000 per year. Offenders receiving a probation order with a condition of drug treatment generally have a lesser criminal history than those made the subject of a DTTO but the nature of the order allows a more holistic approach to be applied to address issues of accommodation, employment, etc. in addition to the drug use.⁴

³ Susan Eley, Kathryn Gallop, Gill McIvor, Kerry Morgan, Rowdy Yates - University of Stirling (2002) Drug Treatment and Testing Orders: Evaluation of the Scottish Pilots, Scottish Executive (<http://www.scotland.gov.uk/Resource/Doc/46997/0030591.pdf>)

⁴ The Road to Recovery, A new Approach to Tackling Scotland's Drug Problem, Scottish Government, 2008 (<http://www.scotland.gov.uk/Resource/Doc/224480/0060586.pdf>)

Appendix B – Legislation

The Police, Public Order and Criminal Justice (Scotland) Act 2006¹ allows for people aged 16 and over who are arrested for certain trigger offences (acquisitive crime and drug offences) and held in police custody to be tested for heroin and cocaine.

Section 20A of the 1995 Act, as inserted by section 84 of the 2006 Act, provides that a police constable or a police custody and security officer (under the direction of a constable) (“an appropriate officer”) may require a person to provide a sample of urine or allow a sample of saliva to be taken by means of swabbing for the purpose of analysing the sample to reveal whether a relevant Class A drug is present in the person’s body.

Under section 20A of the 1995 Act, only a constable, or police custody and security officer (as defined by section 9 of the Police (Scotland) Act 1967), acting on the direction of a constable may take a sample of saliva from a person arrested for an offence in the circumstances set out in section 20A(3)(d) of the 1995 Act. A sample can be taken provided that the period that a person spends in custody in the police station has not exceeded 6 hours and the person is at least 16 years old and that the police station is in a prescribed area.

Section 20A(3) of the 1995 Act also provides that a sample can be taken for testing if a person is arrested under suspicion of committing a “relevant offence” or any other offence and a police officer who holds the rank of Inspector or above (a senior police officer) has authorised the taking of the sample. A senior police officer can authorise for a sample to be taken if he or she has reasonable grounds for suspecting that the misuse of a relevant Class A drug has caused or contributed to the commission of the offence for which a person was arrested under suspicion of committing.

Section 85 of the 2006 Act introduces a duty on the police to require a person who has tested positive for a relevant Class A drug to attend, and remain for the duration of a drugs assessment with a suitably qualified drugs assessor. Section 86 of that Act also introduces a duty on the police to inform the person where their drugs assessment will take place and to require that person to report to the place where their drugs assessment will take place on a date, or on one of such dates as stipulated by the police constable, within a period of 7 days of the requirement being made, to be given details of the date and time of the drugs assessment.

It is an offence under section 88(2)(a) of the 2006 Act for a person not to report to the place at which their drugs assessment will take place to obtain details of their appointment with a drugs assessor. A suitably qualified drugs assessor will be a person who has qualifications or experience as set out in the Drugs Assessor (Qualifications and Experience) (Scotland) Regulations 2007 (SSI/2007/8).

¹ Scottish Executive News Release, 12th October 2006 (<http://www.scotland.gov.uk/News/Releases/2006/10/12103849>)

If a person fulfils the requirements of their initial appointment (ie the requirements imposed under section 86(2)(b) of the 2006 Act), but fails to attend their drugs assessment, or does not remain for the duration of a drugs assessment, without reasonable excuse, he or she will be liable to prosecution under section 88(2)(b) or (c) of the 2006 Act.

It is for the Procurator Fiscal to decide, based on the facts and circumstances described by the police report, whether a person is considered to have a reasonable excuse in relation to these offences. The Crown Office and Procurator Fiscal Service provide advice/guidance to the police in this regard.

Trigger Offences

In terms of Section 20A (8) of the Criminal Procedure (Scotland) Act 1995, 'relevant offence' means any of the following offences:

- (a) theft;
- (b) assault;
- (c) robbery;
- (d) fraud;
- (e) reset;
- (f) uttering a forged document;
- (g) embezzlement;
- (h) an attempt, conspiracy or incitement to commit an offence mentioned in paragraphs (a) to (g);
- (i) an offence under section 4 of the Misuse of Drugs Act 1971 (c.38) (restriction on production and supply of controlled drugs) committed in respect of a relevant Class A drug;
- (j) an offence under section 5 (2) of that Act of 1971 (possession of controlled drug) committed in respect of a relevant Class A drug;
- (k) an offence under section 5 (3) of that Act of 1971 (possession of controlled drug with intent to supply) committed in respect of a relevant Class A drug.

Appendix C – List of Consultees

Glasgow	Edinburgh	Aberdeen
Police (Strathclyde) - Strategic Manager - Operational Manager - 2 x PCSOs	Police (Lothian and Borders) - Staff Sergeant in Custody - PCSO Administrator - 4 x PCSOs	Police (Grampian) - Cell Block Sergeant - 3 x PCSOs
Assessors/Treatment Providers (Glasgow Addiction Services) - Head of Service for Addictions - Practice Team Leader - Senior Addiction Worker - 4 x Social Care Workers - Addiction Medical Office - Information Officer (Glasgow Addiction Services)	Assessors/Treatment Providers - Operations Manager (TPS) - Assessor Service Manager (TPS) - 2 x Assessors (TPS) - 4 x Treatment Provider (SACRO) - Treatment Provider Administrator (Pilot 9)	Assessors/Treatment Providers - Operations Manager (CJSW) - 2 x Local Authority Assessors (CJSW) - Treatment Nurse (Health Board)
Other - Procurator Fiscal	Other - Procurator Fiscal	Other - Procurator Fiscal

In addition to these formal interviews, and to provide further context for the evaluation, attendance at local strategic and operational meetings was undertaken in both Edinburgh and Glasgow. This was valuable in providing insight into some of the cross-working issues affecting the main partners in delivery.

Appendix D – Interview Discussion Guides

Police Interview Guide

Overview

1 - Please can you describe the main tasks that you (and your organisation) perform that are associated with the operation of the MDTA service? Has your role changed as the pilot has progressed and, is it in any way different from the role that you thought you would be performing?

Arrestee Profiles

2 - How would you describe the groups of arrestees who have taken part in the MDTA scheme with regards to gender, age, ethnicity, etc?

3 - Have there been any issues with the pilot in terms of meeting the requirements of individuals from equalities groups? (arrestees of different genders, ages, races, sexual orientation, disability, faith, etc)

4 - How effective do you think the MDTA scheme is in **identifying** eligible arrestees for drug testing, assessment and treatment?

5 - And, how effective do you think it is at **identifying** those who may benefit most from drug assessment and treatment?

6 - Are there any specific groups of arrestees who you think have benefited more than others from the service? (for example, women, young people)

7 – Overall, have arrestees benefited from the service? If yes, please explain how. If no, please explain.

Operational Issues

8 - How effective do you think the MDTA scheme is in **engaging** arrestees in drug treatment? For example, do you think that they welcome the opportunity to access treatment via this route? Do you think that they understand the aims of the scheme?

9 – Is there anything about the way that mandatory drug testing of arrestees operates in this area that you think **encourages** or **discourages** uptake of assessment and treatment by arrestees? For example, the location of initial assessments, the different treatment options available, etc.

10a - What do you think are the main reasons for non-compliance with:

- initial drug testing
- assessment
- treatment

10b - Is there anything that could be done operationally to change this?

11 - Do you have any evidence which may indicate what the **impact** of MDTA has been for arrestees? In particular, do you consider that MDTA is effective in reducing drug consumption in the short term? The long term? And, has MDTA impacted on offending behaviour? If yes, in what way?

12 - What has been your experience of working with the other partners involved in the process and operation of MDTA? For example, police, social work services, other treatment providers, COPFS and the SPSA?

Training

13 – What training did you receive for the use of MDTA equipment? How effective was the training that you received for use of the MDTA testing equipment? Was there appropriate support/quality checking of the testing following training? Would you suggest any changes to the training that was received?

Comparisons with Arrest Referral

14 - Do you think that the mandatory approach to drug testing is more or less effective at targeting those who may benefit from treatment than voluntary services, such as Arrest Referral? Why do you think this?

15 - Have you experienced any differences in the level of motivation and engagement of arrestees undergoing assessment and/or treatment depending on the mandatory/voluntary route by which they reached the service?

16 – Do you think that the MDTA scheme/service has impacted on the arrest referral schemes locally and, if so, in what ways? (positive or negative impact?) Is there a relationship between the two?

Lessons Learned

17 – Is there anything about the way MDTA is run within your area that you would highlight as an example of good working practice? For example, please tell us about what works well, if anything, and what doesn't work so well, if anything.

18 – Looking back over the pilot, what (if any) have been the main factors that have facilitated the process and operation of the MDTA pilot in this area?

19 - Have there been any barriers to the running of the MDTA pilot scheme? If so, please can you say what these factors are and how they impacted on the process and operation of the scheme.

20 - Are there any lessons that you think can be learned from the pilot to inform future decisions regarding MDTA? What would you say, for example, to a colleague who has been recruited to work in a new MDTA site being set up elsewhere?

21 - What are your views regarding the way forward for MDTA in Scotland and, in particular, any impacts and barriers to its potential roll out across the country?

22 - What are your own views regarding the overall success or failure of the MDTA pilots?

Other Questions

23 – Are there any other MDTA issues would you like to discuss with us?

24 - Do you have any questions for us?

Assessors and Treatment Providers Interview Guide

Overview

1 - Please can you describe the main tasks that you (and your organisation) perform that are associated with the operation of the MDTA service? Has your role changed as the pilot has progressed and, is it in any way different from the role that you thought you would be performing?

Arrestee Profiles

2 - How would you describe the groups of arrestees who have taken part in the MDTA scheme with regards to gender, age, ethnicity, etc?

3 - Have there been any issues with the pilot in terms of meeting the requirements of individuals from equalities groups? (arrestees of different genders, ages, races, sexual orientation, disability, faith, etc)

4 - How effective do you think the MDTA scheme is in **identifying** eligible arrestees for testing, assessment and treatment?

5 - And, how effective do you think it is at **identifying** those who may benefit most from drug assessment and treatment?

6 - Are there any specific groups of arrestees who you think have benefited more than others from the service? (for example, women, young people)

7 – Overall, have arrestees benefited from the service? If yes, please explain how. If no, please explain.

Operational Issues

8 - How effective do you think the MDTA scheme is in **engaging** arrestees in drug treatment? For example, do you think that they welcome the opportunity to access treatment via this route? Do you think that they understand the aims of the scheme?

9 – Is there anything about the way that mandatory drug testing of arrestees operates in this area that you think **encourages** or **discourages** uptake of assessment and treatment by arrestees? For example, the location of initial assessments, the different treatment options available, etc.

10 - Do you have any evidence which may indicate what the **impact** of MDTA has been for arrestees? In particular, do you consider that MDTA is effective in reducing drug consumption in the short term? The long term? And, has MDTA impacted on offending behaviour? If yes, in what way?

Comparisons with Arrest Referral

11 - Do you think that the mandatory approach to drug testing is more or less effective at targeting those who may benefit from treatment than voluntary services, such as Arrest Referral? Why do you think this?

12 - Have you experienced any differences in the level of motivation and engagement of arrestees undergoing assessment and/or treatment depending on the mandatory/voluntary route by which they reached the service?

13 – Do you think that the MDTA scheme/service has impacted on the arrest referral schemes locally and, if so, in what ways? (positive or negative impact?) Is there a relationship between the two?

Lessons Learned

14 - Is there anything about the way MDTA is run within your area that you would highlight as an example of good working practice? For example, please tell us about what works well, if anything, and what doesn't work so well, if anything.

15 – Looking back over the pilot, what (if any) have been the main factors that have facilitated the process and operation of the MDTA pilot in this area?

16 – Have there been any barriers to the running of the MDTA pilot scheme? If so, please can you say what these factors are and how they impacted on the process and operation of the scheme.

17 - What has been your experience of working with the other partners involved in the process and operation of MDTA? For example, police, social work services, other treatment providers, COPFS and the SPSA?

18 - Are there any lessons that you think can be learned from the pilot to inform future decisions regarding MDTA? What would you say, for example, to a colleague who has been recruited to work in a new MDTA site being set up elsewhere?

19 - What are your views regarding the way forward for MDTA in Scotland and, in particular, any impacts and barriers to its potential roll out across the country?

20 - What are your own views regarding the overall success or failure of the MDTA pilots?

Other Questions

21 – Are there any other MDTA issues would you like to discuss with us?

22 - Do you have any questions for us?

COPFS Interview Guide

1 - Please can you describe your (level of) involvement in the MDTA pilots?

Number of cases referred?

(Has this been in any way different from the level of involvement you thought you would have?)

2 – What kind of information did you receive about the MDTA pilots before they were implemented? And ongoing information?

Training?

Information leaflets?

Involved in any planning groups?

Involvement in local implementation groups?

3 - Do you have any evidence (including anecdotal) about legal professionals understanding of the MDTA pilots?

Do arrestees understand it?

4 - What has been your experience of working with the other partners involved in the process and operation of MDTA? For example, police, social work services, assessors, treatment providers and the SPSA?

5 - Is there anything about the way MDTA is run within your area that you would highlight as an example of good working practice? If so, please describe (for example, information sharing) or please tell us about what works well, if anything, and what doesn't work so well, if anything.

6 - What are your own views regarding the overall success or failure of the MDTA pilots?

7 - What are your views regarding the way forward for MDTA in Scotland and, in particular, any impacts and barriers to its potential roll out across the country? (ie lessons learned)

8 – Do you have any views on the legislation and how it might be changed if the MDTA pilots were rolled out?

9 – Are there any other MDTA issues would you like to discuss with us? Do you have any questions for us?

Arrestee Interview Guide

1 – How were you first told about the Mandatory Drug Testing of Arrestees scheme?

2 - Have you had the MDTA scheme explained to you (YES/NO)? If yes, by whom? (*Prompt if more than one source*)

3 - Were you given an information leaflet about the scheme? If yes, where and by whom?

4 – Was the information that you were given easy to understand? Why do you say that?

5 – Do you understand why you were asked to take part in the scheme?

6 - Do you understand what you are required to do/what your role is as a participant in the scheme?

7 – Why did you decide to take part in the scheme?

8 - What are you hoping to get out of the scheme?

9 – Do you think the scheme is a good idea? If so, why do you say that?

10 – Is there anything about the scheme that you don't like?

11 – Has taking part in the scheme helped you in any way? If so, how?

12 – What contact, if any, have you had with the following: police, assessors, treatment providers?

13 - How would you describe the contact that you have had with the police, assessors and treatment providers? Was it informative, supportive, relaxed, etc?

14 – Is there any other kind of information that you would like or that would have been helpful? In particular, do you have any special needs that you think have not been taken into account by the scheme? (for example, disability issues, language barriers, childcare issues)

15 – Is there any other kind of support that you would like or that would have been helpful? In particular, do you have any special needs that you think have not been taken into account by the scheme? (for example, disability issues, language barriers, childcare issues)

16 – Is there anything else that you would like to add or any questions that you would like to ask me?

Appendix E – Local Implementation Group Meetings

In Aberdeen, local implementation groups began in January 2007 (five months before the start of the pilot), and ran monthly until May 2007. The group then ran once every two months until February 2008 where the responsibility for running the pilot was handed over from the Scottish Government to Aberdeen City Council, and quarterly meetings commenced. The group is chaired by a representative from Aberdeen City Council and meet to discuss matters arising from the Aberdeen pilot and to determine any methods of best practice that can assist the pilot to run more efficiently.

In Edinburgh, local implementation groups began in December 2006 (six months before the start of the pilot), and ran monthly until July 2007, a month after the introduction of the pilot. Meetings then ran on a quarterly basis, at a slightly reduced size. The group is chaired by a representative from Edinburgh Council and meet to discuss any issues arising within the Edinburgh pilot.

In Glasgow, local implementation groups began in January 2007 (five months before the start of the pilot) and ran on a monthly basis until the end of May 2007. After this, meetings became less frequent, operating on a quarterly basis. In March 2008, the local implementation group was replaced by an operational and strategic meeting, with a smaller membership made up mostly of police and assessor/treatment service staff. These meetings have been running every two months since this time and continue to provide a forum at which staff discuss problems arising with the running of the scheme.

Appendix F - Differences in the Three Pilot Models

While the procedures for drug testing and initial referral by the police for assessment is the same in each site, the models of service delivery for assessment and voluntary uptake of treatment, differs in each of the three pilot areas.

Aberdeen

In Aberdeen, the assessments are being undertaken by staff employed by the local authority (Criminal Justice Social Work) and the treatment services are provided by the local health board.

In addition to carrying out a drug test in Aberdeen, if the drug test is negative, the PCSO will ask the arrestee if they would like to be considered for treatment under Arrest Referral. Their answer is noted on the spreadsheet and if they would like to be considered for treatment, the arrestee is given a leaflet and an appointment may be made to see an assessor. In mid 2008, MDTA assessors also took over responsibility for Arrest Referral assessments on a temporary basis until the vacancies for these posts are filled.

If the MDTA test is positive, the arrestee is required to attend an assessment. Towards the end of the pilot, due to a low number of referrals, assessors have operated a daily 'phone-in' policy to ascertain whether they are needed at the police station for an assessment. Assessments in the police station are carried out in the solicitors' interview rooms, with the custody within a secure booth so no contact can be made between the assessor and arrestee. If an assessment is required outwith working hours, arrestees are given an appointment at the assessor's office.

Assessments are carried out by assessors at Criminal Justice Social Work at Aberdeen City Council. The office is centrally located, on Gallowgate, Aberdeen. Assessments are carried out in a private room, with only the assessor and arrestee present.

If an arrestee is willing to undergo treatment, the assessor will refer them onto the appropriate agency – usually the local health board. When MDTA began in June 2007, there were problems with regard to the Health Board providing treatment, and treatment was not put in place until April 2008. A representative from the health board will undertake a further assessment and work on engaging the arrestee in treatment, and the assessor will usually accompany the arrestee to their first few appointments. On occasion, the assessors will undertake work with the arrestee themselves to develop their 'lifeskills', and help them to find accommodation, or put them in touch with other services if this is required.

Edinburgh

In Edinburgh, Turning Point Scotland conduct the initial assessment interview and also link individuals into appropriate treatment providers/services. Assessors are based in St Leonard's police station between 5pm and 9pm, Monday to Friday, and are available during these times if an arrestee has been drug tested and requires an assessment. Turning Point have monitored the times that arrestees have been tested and based their working arrangements around this, changing the times assessors are based in the police station to fit with the times that arrestees are most tested. Assessments in the police station are carried out in the nurse's room in St Leonard's, and comprise the arrestee and

an assessor. If the assessor is not in the station at the time of the test, the arrestee is required to attend an assessment appointment at the Turning Point office on Forrest Road, Edinburgh. The assessments are conducted in a private room within the building.

The treatment providers that Turning Point refer onto include SACRO, Cruz 2000, MidPoint, and Pilot 9. The main treatment provider is SACRO which has a fast-track methadone scheme of which the majority of arrestees who take up treatment are referred onto. On occasion, the assessors have attended the first treatment appointment with the arrestee, otherwise, the treatment provider will take over at this stage.

Glasgow

In Glasgow, assessments and treatment are both offered by Glasgow Addiction Services (GAS). The model of service delivery advocated by GAS allows people referred into MDTA to link into existing treatment and care structures in the area and into the wider addiction services offered in the city. MDTA assessors use a combination of the Single Shared Assessment (SSA) baseline tool and the development of an Interim Careplan, as well as the provision of harm reduction information and motivational work to encourage engagement with treatment. Based on assessed need identified by the SSA Baseline and Interim Careplan, arrestees may also receive full health and medical checks (physical and mental), follow-up medical treatment if required and links into medical services provided by the Community Addiction team which serves the area in which they live. The recruitment of two addiction nurses and one medic for MDTA also allows clients access to substitute prescription services.

GAS assessors also provide signposting into extensive relevant services with which they are already networked. Ongoing engagement with clients is used to carry out further assessment (a Comprehensive Assessment of Need) addressing wider social issues such as accommodation and employment needs.

Appendix G - Number of MDTA Referrals for Assessment by Area and Month

	Aberdeen	Edinburgh	Glasgow
June 2007	31	6	17
July 2007	38	16	23
August 2007	29	13	35
September 2007	13	14	16
October 2007	24	25	27
November 2007	17	28	21
December 2007	26	27	13
January 2008	20	21	20
February 2008	10	35	19
March 2008	18	30	19
April 2008	12	19	19
May 2008	12	27	17
June 2008	16	21	16
July 2008	13	23	9
August 2008	7	18	9
September 2008	14	14	6
October 2008	6	21	9
November 2008	4	23	6
Total	310	381	301

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