An Evaluation of the Rapid Access Prescribing Service in Medway

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Authors: Axel Klein
          David Oshowale
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Acknowledgements

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1.1 Executive Summary

- Rapid Access Prescribing has impacted positively on clients in terms of (i) reducing drug use, (ii) offending behaviour (iii) social stability
- Most clients continue topping up scripts with street drugs, at far lower levels of regular use than at intake; a small number of clients were reported to be opiate abstinent
- Self reported crime has dropped by 73% after 4.5 weeks in treatment; reductions in terms of Estimated Value of Stolen Goods achieved by the clients completing treatment over a 12 week periods are in the region of some £ 135,205
- The Service has achieved an 80% client retention rate; 47 out of a total of 59 completed the programme
- Reductions in high risk behaviour – clients were reducing injecting, some ceased injecting and switched to smoking heroin, reported reduction in sharing paraphernalia
- The service is falling short of expected client numbers, partly because of rigid eligibility criteria
- Onward referral to pharmacy dispensing services inappropriate for some clients better suited to daily, supervised, on-site consumption
- Interviews with clients, focus groups and field work established that the Service has build up confidence among hard to reach users, including sex workers and serial offenders
- Good working relationships have been established over a short period of time with key partner agencies; other partner agencies need to be brought on board, e.g. prisons
RAPS has made other established agencies reflect on their practices and underlined the importance of supervised consumption.

1.2 Key Recommendations

- There are strong arguments for continuing a Rapid Access Prescribing service model. Maintaining a discrete prescribing service for a particular client group has advantages, but at considerable resource cost. These could be avoided if rapid access prescribing were rolled out across services by “bolting it on to existing services”
- Enhanced referral - it is suggested that alternative premises be found and a protocol be formulated allowing the police nurse and/or other arrest referral workers to conduct arrest referral outside the station.
- Widen eligibility criteria to allow for poly drug users
- The service has already taken on partners of sex workers. This policy should be widened further to take into account the need for support among vulnerable users.
- The range of substitute medication should be extended to provide clients with a choice between methadone and subutex – this is particularly important for clients coming out of prisons who have been using subutex

1.3 Background to the evaluation

The KIMHS evaluation team was tasked in January 2007 with the evaluation of the RAPS in Medway against a set of criteria. In the summer of 2006 KDAAT commissioned DTL with the running of RAPS pilot project for a 9 month period.

The findings reported below and the listed recommendations are intended as guidance for the DAAT on the future of rapid access prescribing services. They should also inform the service provisions and planning of the next service provider holding the contract.

Objectives of evaluation
To evaluate the effectiveness of the Rapid Access Prescribing Service in Medway against five key areas for investigation of service outcomes

- Reduction in re-offending
- Retention/Engagement
- Reduction in use of illicit drugs
- Reduction in High Risk behaviour
- Referral and inter-agency cooperation

1.4 Methodology

In accordance with the Terms of Reference (TOR) five specified key areas of investigation of the project were evaluated. To meet the tight deadline and ensure maximal validity and reliability, a selection of research methods were used.

(i) Interviews with 14 current service users – structured questionnaire drawn up in consultation with KDAT and KCC; piloted in stage 2 and revised in stage 3
(ii) focus group with service users
(iii) interviews with service staff and management
(iv) interviews with key stakeholders
(v) analysis of DTMU- KDAAT client forms
(vi) participant observation and street work

At the core of the study, a series of interviews with service users were held and the findings triangulated with additional data from other sources. The interviews were held on the premises of RAPS, in a separate room where clients were assured of confidentiality and that neither their willingness to participate or not, nor their answers, would in any way impact on their client status at RAPS. Placing the experience of service users at the forefront of the evaluation provides an unusual angle in the evaluation of drug treatment services, as “the attitude of the addict has received very little attention in drug abuse research”3 It is also the

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1 Copy of questionnaire in appendix
2 List of people interviewed in the appendix
most effective research tool to generate data on to risky drug use and offending behaviour, which are key variables in the evaluation.

There have been a number of recent initiatives to promote the involvement of service users in assessment and referral of clients either in treatment or seeking to access treatment. This merges with an established tradition of measuring client satisfaction through questionnaires. Agencies like the NTA and World Health Organisation have developed tools for comprehensive service evaluations that encompasses service users.

In consultation with KDAAT, two questionnaires were developed for service users and stakeholders. Amended after the pilot phase, the service user questionnaire provided the instrument for interviews and data gathering. A number of questions relating to offending behaviour and substance use were arranged in a questionnaire matrix, and answers recorded on the matrix by the interviewer. Additional information was recorded by hand. The interviewer sought to engage the client in discussions beyond the questionnaire to explore wider issues and to generate background information on each point. Where possible, and only with the clients’ consent, the interviews were taped. The questionnaire prepared for stakeholders was discarded after the first interview with DTL officers. RAPS officers were interviewed repeatedly, without any questionnaires.

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4 Addaction, 2006. Collecting the evidence: clients’ views on drug services. Addaction. See also Turning Point
The matrix below provides an overview of the research modalities developed for each item in the TOR.

<table>
<thead>
<tr>
<th>TOR – key areas of investigation</th>
<th>Client Questionnaire</th>
<th>Other Key Informants</th>
<th>Other methods/sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduction in re-offending</td>
<td>Section 1</td>
<td>Police</td>
<td>1. Participant observation&lt;br&gt;2. Peers</td>
</tr>
<tr>
<td>2. Retention/Engagement</td>
<td></td>
<td>RAPS Staff</td>
<td>1. RAPS project assessment and internal client feedback&lt;br&gt;2. Peers</td>
</tr>
<tr>
<td>5. Referral and inter-agency cooperation</td>
<td></td>
<td>1. Other drug services&lt;br&gt;2. Sexual Health Outreach team&lt;br&gt;3. DIP</td>
<td>1. DAAT</td>
</tr>
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</table>
Methodological Considerations in researching offending, drug use and high risk behaviour

(i) Interviews with current service users

There is an established tradition of research using self reports to establish patterns and prevalence levels of offending behaviour. The emergent consensus about the self-report method is that it provides a reasonable - but far from perfect - measure of criminal involvement, at least for the more 'trivial' crimes that are free of intense social stigma.

Research into self reported offending and high risk drug use behaviour suffers from a number of factors, including the attempt by some respondents to manipulate the interviewer in the hope to obtain positive outcomes especially when they surmise – rightly or wrongly – that their continued access to a particular treatment service depends on the nature of their response. Other respondents are prone to downplay or exaggerate their offending career. Often respondents simply cannot remember, or they are concerned about protecting co-offenders, or themselves from the possible consequences of disclosing the culpability of co-offenders; they may wish to improve their self image by downplaying or exaggerating their offending career.

To a large extent many of these challenges to data quality can be met by an experienced and empathetic interviewer, and convincing assurances of confidentiality and objectivity. The location of the interview, in a neutral setting where respondents feel at ease to talk is also important. Given the experience of the team and the support of DTL and other services we are confident that the quality of the data obtained can be assured.

The research experience after some 40 years of self reporting into offending behaviour is that most convicted young males do admit their offences as well as drug use. The importance of drug use as predictor of and risk factor determining offending behaviour is a key assumption underlying the RAPS project. The evaluation of the service will therefore test not merely the quality of actual delivery but also the validity of the underlying assumptions.

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The baseline for the studies is formed by client attendance of the service. This information is available independent from the research, and provides a constant factor against which the other variables can be measured. These in turn will be established by interview, and then measured to see if a pattern emerged.

It is clear that in the absence of data on previous levels of offending by the respondents the outcome of this research exercise will be predominantly qualitative. It is hoped that it will be just the first in a series of exercises, and the beginning of a longitudinal database tracking the offending careers of problematic users and former users in the Medway area.

(ii) Focus group
It took two attempts to bring together enough clients (4) to run a small focus group on key issues around the service provision, offending behaviour and the use of and attitudes towards drugs. Getting service users to discuss and analyse questions was important, and also to get a closer understanding of perceptions of RAPS across the community of drug using offenders in the area.

(iii) Service Interviews
This aspect was the potentially most difficult part of the project as staff of any organisation that is being evaluated react defensively. In the event, staff were not only cooperative, but even proud to demonstrate their practice. The service providers were very supportive of the evaluation exercise, making information available, setting aside time to answer questions both formally and informally, accompanying researchers on off site visits, and organising clients to attend interviews.

(iv) Stakeholder Interviews
Key Informant interviews will be held with identified informants from different organisations, including KDAAT, DTL, the DIP team, MUST (East Kent Cyrenians), other treatment services in the area such as Manor Road, Addaction and KCA, service user organisations, outreach services like ISIS, and the police. These interviews provided primary data for the fifth evaluation objective, and supporting evidence for the other four.
(v) DTMU KDAAT – Substance Misuse Comprehensive Assessment

Information on the date when the client entered treatment, their substance use history, their medical assessment and offending behaviour were taken from the intake assessment. First, there was no need to duplicate information gathering and subject informants to ‘assessment fatigue.’ Secondly, client notes were extensive and well documented providing a useful point of reference. There is sufficient detail for future research on the significance of motivation, family history and employment states, which should become valuable with increasing data sets.

(vi) Participant observation

In addition to developing research instruments that are reliable and provide the framework for follow-up exercises in the future, the research has used a series of qualitative methods to triangulate and complement the findings. These include participant observation, with researchers spending time both on the premises of the service centre and by accompanying clients onto the streets. This helps to get a better understanding of the background and context of the key client group, and to understand the actual processes at work through perception of the clients. This method has contributed information on the significance of the service to actual and potential users. Researchers also accompanied outreach workers from ISIS, the sex workers group, to talk to actual and potential service users in their working environment.

RAPS has been set up to fast track targeted clients into opiate substitution treatment, specifically prescribing and dispensing on-site, in order to reduce the cycle of drug use related offending. Information of the service has spread across the scene of potential service users. The perception of RAPS among potential service users, or what we might call the latent clients, is important in order to understand impact of behaviour.

(vii) Research focus and follow-up

To ensure that clients do not suffer interview fatigue we pared down the number of structured questions in the questionnaire. Questions on health status, protective or risk factors, employment, education or living conditions were omitted, and taken from the assessment form used by the treatment service. We will, however, code our forms, so that only the research team have access to both sets of information. The coded forms will be kept securely at the University of Kent and will be available to researchers following up
RAPS clients any time in the future. It is important for the follow-up, however, to extend the questionnaire and include this information.

Confidentiality

One of the prerequisites for informant cooperation was the promise of confidentiality. We have therefore anonymized all citations from clients in this report, and have provided each client with a number, which is matched on the interview form. The originals are kept in a secure cupboard in a locked room, and are accessible only to members of the research team. This data will be made available for the purposes of follow up research.

Payment
Informants were remunerated in accordance with Department of Health principles of good practice. “Service users are not to be left out of pocket or put at risk of being financially worse off as a result of their involvement in service improvement.”7 To compensate informants for travel and time, all focus group participants received a £10 voucher. One to one interviews were conducted after clients had arrived at the clinic, and therefore did not impose a charge in either time or transport fares.

2. Contextualising Rapid Access Prescribing in Medway

The provision of methadone to chronic opiate users is a well established component in the range of drug treatment modalities available to service providers in the UK. It is based on the assumption that methadone as an opiate agonist suppresses the cravings triggered by the withdrawal from heroin, and therefore helps to stabilize the client. The regular administration of methadone should allow dependent users to function without recourse to street heroin and other illegal opiates.

One of the key assumptions in the current crime reduction strategy is that the medical stabilization of clients can achieve further changes in their offending behaviour. Because of their need for expensive, illicit drugs, often running in parallel with their declining engagement with the job market, dependent drug users are associated with a large proportion of property crime across the UK. Acquisition crime by dependent drug users is widely regarded as one of the key contributors to property crime across the UK, and particularly in areas where larger concentrations of problematic users consolidate into a ‘scene’. The government therefore hopes to break the “link between drugs and crime [by]…moving offenders out of the criminal justice system and into treatment.”

One of the defining characteristics of problematic drug dependency is the urgent need to use. Rapid access to treatment is critical, as drug users often fall through the gap between contacting a treatment centre, assessment and delays getting access to treatment. In deprived areas the problem is compounded by “a perception that drug treatment is hard to access.”

The disproportionate harm that the use and distribution of heroin/crack can cause to deprived communities is widely recognised. The Medway towns share the profile of ‘urban clusters’ of deprivation, drug use and crime. They contain the largest cluster of problematic drug users in Kent, with statistical models suggesting a population of an estimated 1,235 problematic users. Significantly, a 96% of these are predominantly opiate users. Setting up a rapid access methadone prescribing service in Gillingham was therefore a considered method for targeting this population and bringing them into treatment.

With the inception of RAPS, clients who met the eligibility criteria were referred by DIP to stabilise the client group before they moved on to Manor Road. RAPS has so far provided this service to 67 clients and claims an 80% success rate, in the sense of retaining clients in treatment for the contracted 12 week period before referring them on to the community prescribing service.

The high success rate of the scheme can be attributable to a number of factors. One of those normally cited is that a client in the RAPS programme usually gets his methadone within 48

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hours of referral. Clients have to attend RAPS daily and are thus constantly in touch with RAPS staff. This allows for personal relations to develop between staff and clients. It also provides the client a daily opportunity to seek counsel and advice. The low staff/client ratio gives the staff more time to provide more individual attention, as well as to provide personal assistance and drug education. “They have a good attitude and look at you as an individual.” Popular too was the attitude of staff towards their drug use: “they don’t try to reduce your script.”

Another factor seems to be that RAPS staff provided assistance in other areas, “they let you use the phone to call the DSS.”

Some of the staff were assisting clients in areas beyond the remit in areas like housing. One of the RAPS staff members with a background in housing helped clients to find temporary accommodation, outside his working hours. In other instances RAPS staff were doing outreach work to contact sex workers and provide information about the service in their private time.

2.2 RAPS – DTL the team.

Implementing the RAPS service was contracted out to Drug Treatment Limited, who developed the model to DAAT specifications, and in turn, engaged a team from Kaleidoscope to provide the service. The team comprised the Director, who is a specialised narcotics nurse, a second specialised narcotic nurse, and two drug counsellors. Much of the success with RAPs has to be attributed to its staff. It is arguable that client retention is not just a matter of providing methadone, but providing a service and an atmosphere that motivates clients to attend.

Clients interviewed stressed the dedication and commitment of the staff. Comments, like, “they treat you like a human being”, “they all remember your name” and “it feels like they care about you”, illustrate client views. At the focus group all participants agreed that they had good relationships with the RAPS team. These positive views were confirmed by
Amanda Heron, Co-coordinator of MUST who reported getting excellent feedback from her clients about the services and staff.  

RAPS staff also established good working relationships with other services. According to the Forensic Nurse Practitioner working as Enhanced Arrest Referral working with the RAPS/Kaleidoscope staff team was a “positive experience” and now that the project has finished, her role has lost some of its momentum. The good working relationship with RAPS staff was also commented on by Wayne Butcher, the Project Manager at Addaction.

The Drug Liaison Officer for Medway, wrote that: “the holistic manner in which individuals have been treated by the service is a credit to your practitioners.”

2.3 What is different about RAPS?

RAPS is, of course, a rapid access prescribing service. This means that once clients have been referred by the DIP they can obtain their methadone script within 24 hours.

Methadone consumption is supervised. This is regarded as an opportunity by staff. “You are alone with the client for about 10 minutes. You can ask them about what they have been using on top, you can take a look at their injection sites.”

The daily supervision of methadone consumption became the basis for a close relationship between clients and staff, something which was compared positively to the more formal and distant community prescribing service at Manor Road (MR). Often, it was clear

The attitude at RAPS was that the service was client centred, and that this helped build up their confidence. According to the RAPS manager, “we engage people in a non-judgemental way to help get them back on track.” Raising the clients’ self esteem was in turn seen as a prerequisite for successful recovery, and some of the staff had a low opinion of the more

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13 Interview with Amanda Herron Coordinator, 16th March - DO
14 Interview with Helen Crook, 04/03 – Andy Ashenhurst
15 Interview with Wayne Butcher 26th February – DO
16 Letter Bryan Ward, dated 04/01/07
17 Interview with RAPS manager Charlotte Coulson, 27/02/07
paternalistic approach at MR, where “all confidence is taken from them.” In interviews with two sex workers, they welcomed RAPS as the first service they would consider accessing because MR had such a long waiting list that it was not considered an option available to them.

Though RAPS staff claim that their approach is ‘client centred’ the conditions on the service user are strict. Daily attendance is required, which many clients find difficult at first. Yet, the requirement soon becomes a bonus, as clients begin to enjoy visiting the service, and possibly, to introduce a new structure to their lives. Client – staff relationships do not seem to be stressed by the drug testing process. RAPS staff are not using drug testing information punitively. Tests are conducted for opiates and methadone only.

The programme is intended to stabilize clients before referring them on to the community drugs service. RAPS is a special service, providing rapid access, close engagement with clients, and referral. Some informants suggest that the service has contributed to reducing the pressure on the community drug services.

2.4 The Clients’ experience

Unanimously among the 14 informants interviewed there was a positive response to RAPS. One client with a troubled history of care homes, young offender’s institutions and prisons expressed deep gratitude to the service and the team. After several years of abstinence, first in prison then a therapeutic community, he had just taken up injecting again when he succeeded in accessing RAPS, and managed to bring his opiate use under control: “They caught me when I was falling.”

The cases below are typical for the overall response during our survey, and provide some insight into the RAPS client group and the problems they are facing.

William is a 26 year old father of a 4 year old girl. He has a criminal history that stretches back to when he was 19, when he started taking drugs, since then he has been involved in shoplifting and car theft. On coming out of prison he was smoking £40.00 of heroin a day.

18 Interview with RAPS staff member
19 Interview with Addaction manager – RAPS provided the community service with a 12 week window to
William was employed up until 2002 as a printer, but didn’t enjoy the work and is contemplating work in a warehouse. He would like to stop his heroin use to clean himself up and stop his criminal lifestyle. He had been on methadone until his prescription was stopped by the service.

William has been on the programme now for 11 weeks and has been heroin clean for 7 of those weeks and was happy about having faced this challenge. His ability to stabilise his heroin has helped him drastically reduce intake of other drugs. He has smoked cannabis only once in the last month and eliminated his consumption of benzos. He was a serial shoplifter but has not committed this or any other crime in the last month. He is clean, bright and intelligent and looking forward to his detox and appeared confident empowered and positive.

(ii) Polly: 28
Polly is a 28 year old sex worker, who started taking cannabis at 13 and heroin and crack at 17. She has never had full time employment, and has been in prison 7 or 8 times. She had been involved in car theft and forgery in the past.

She used to take £60 of heroin and £60 of crack per day, as well as having taken benzos and amphetamines. Her main motivation for treatment was her desire to stop street working.

Polly has managed to considerably reduce her drug consumption. She used heroin once in the last week and only three times in the last month. Her crack use has declined significantly as she has taken it 3 times in the last month and about 12-16 times in the last month. She doesn’t drink but still continues to smoke cannabis regularly. She has also stopped in injecting since being on treatment, and uses tin foil.
She appeared stable and in control. She gets substantial support from her father and is re-adjusting. She felt RAPS had been essential to her recovery and the things she appreciated most was that the service provided was more client friendly, the staff had more time for their clients, and it provide her with the essential needs she required. She felt she had progressed much more with the RAPS scheme than when she had previously been at Manor Road.
(iii) Matthew: 29 years old.

Matthew has had a long criminal history starting from when he was 8 years old. Coupled with this he has been in care, foster homes and correctional facilities since then. He has been a prolific offender and has been arrested for crimes ranging from possession, shoplifting, car theft, robbery, burglary and handling stolen goods.

Matthew was a heroin addict and occasional drinker. Since being on RAPS, Matthew has been able to substantially reduce his heroin addiction. He wants to reduce his habit so he can experience life without drugs. He has had various manual jobs in the past and is looking forward to a drug free life.

Matthew had reduced his heroin consumption and had not taken heroin for the last 4 days, and had taken heroin only 4 or 5 times in the last month.

He drinks moderately, (3 cans in the past week), only 8 to 9 drinks last month and has taken crack only once in the last month.

Matthew feels he is very stable and in control of his problems. He hasn’t had to commit any crimes while with RAPS. He finds RAPS was effective because they were there when he needed them, and that RAPS is a vital service. He said ‘God knows where he would be without them- probably prison.'
Findings

1. Impact on offending

(i) The feedback from service users that were currently with RAPS was unequivocal: they all claimed to have scaled back their offending behaviour substantially since coming on to the scheme. Speaking on behalf of himself and his friend, who is also a RAPS service user, one Focus Group participant said:

“We would shoplift six times a day to do four bags. Now we only do it once.”

While criminal behaviour was reduced it was not totally eliminated. This informant echoed the views of others who had problems in the early morning, as they were coming off their methadone. There was a window before the service opened at 10:30 during which they felt most vulnerable to commit crime. One informant was describing how he would:

“shoplift in the morning before coming here. Just do a quick snatch, sweet, that’s £15.”

RAPS staff voiced their concern over the late openings of the service for number of reasons and proposed earlier opening times. This would help service users fighting with cravings in one of the most vulnerable periods, when crime was committed opportunistically. Early opening would help particularly rough sleepers, who are left in an unstructured limbo during this period.

(ii) Informants recognised that some offences were the product of almost compulsive behaviour, quite unrelated to the actual need for money. One informant said that he would continue to steal petty things like chocolate even when he had money in his pocket to pay for it. They reported enjoying the buzz from the thieving, which is an issue that needs to be addressed in the quest for sustainable behaviour change.
There is also a problem with filling the hours of the day for these clients with no responsibilities. Clients confirmed that the main reasons for becoming involved with drugs, was boredom and the lack of things to do. As they get sucked into the cycle of regular drug use, they are less able to generate alternative forms of interest. The intoxication and physical deterioration is increasingly debilitating, making it difficult to find work. One of the few open avenues is petty crime, particularly shoplifting. There are several reasons why shoplifting is so attractive to problem drug users. To the rough sleepers it provides an opportunity to find shelter in a warm, and ordered environment. Working through the aisles of supermarkets has the semblance of the ordinary activity of shopping, and also yields the same result – a basket of goods.

What is not quantifiable, but clearly important is the ‘connectivity’ both downward and upward facilitated by shoplifting and the income it generates. This enables drug users to participate as buyers in the drugs economy and maintain relations with dealers, as well as with other users. But the entrenched system of users ‘shoplifting to order’ ties the shoplifter into a social network of non users for whom they shoplift, which again, provides an appearance of normality. Taking orders from customers, delivering goods takes the form of a routine, and the semblance of a service industry. There are some indicators of an ideological undercurrent to this, with some informants pointing out that large companies being able to absorb petty losses. The collusive relationship with buyers of stolen good may be assisting chronic users in neutralise their own deviance, and possibly, to see their actions in terms of us/them. It is important to remember that the appreciation of clients is one of the few positive reinforcements that this client group receives, and their only form of integration into a ‘community’.

(iii) Informants were emphatic that they had joined the programme because they wanted to change their lives and their behaviour, but that this was not general among problematic drug users in the area. People outside the scheme were, according to one informant, “smackheads, with no morals.” The informant, by contrast said “I don’t steal from people, because someone has worked hard for that.”

Offending remains one of the routine behaviour patterns among problematic drug users. Though this may precede the onset of drug use, there seems to be a reinforcing pattern of drug use and offending.
(iv) For neighbourhood safety the implications of RAPS have been profound. Self reported offending data is not a precise instrument, but is generally accepted as a valuable indicator for overall trends. The measurement used here has been to multiply the daily drug spend by 2.5 to arrive at the estimated retail value of stolen goods. The rationale behind this figure is that shoplifted goods are sold on for between half and a third of the retail price. Informants had been in treatment by a mean of 4.64 weeks and achieved a mean drop in offending of 73%.

The changes in individual offending behaviour in table 1 illustrated below graphically illustrate the drop.

Table 1 Reductions in offending by 14 informants

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Estimated Value of Stolen Goods Pre-treatment</th>
<th>Estimated Value of Stolen Goods at Interview</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>3000.00</td>
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<td>2</td>
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<td>7</td>
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If averaged out, this means that by week 4.64 in their treatment, the total number of clients that were retained in treatment, would have achieved a saving of £52,283.08 in the Estimated Value of Stolen Goods (EVSG).
If these reductions are projected over the 12 week period in which clients were in treatment, we reach a reduction of £135,205.

Needless to say, these figures are not precise measures of the actual offending behaviour of the client group. Instead they assume that the data for the 13 informants at point of intake and interview were representative for the entire group, that the trends in crime reduction reported by them were paralleled by all RAPS clients, and provides a quantitative measure for reading this change.

Descriptive Statistics

<table>
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<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
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2. Retention and Engagement

At the outset there were concerns that the required daily attendance would be too onerous for some of the clients. It proved that after initial reluctance, most clients found the contact with RAPS staff, and the positive pattern of regularity and structure emerging in their lives a benefit.

As a result claimed retention rates of 80% completion have been achieved. There were a total of 59 clients of whom 47 completed the programme.

The overall numbers of clients seen fell short of expectations, for reasons discussed below. There is a clear understanding that the shortfall in the client case load was due to the eligibility criteria and the referral process. According to Julie Shannon, the service “did not meet the numbers but that was not their fault because of the strict eligibility criteria.”

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20 Interview with Julie Shannon, 14/03/07
Monitoring information for RAPS in Medway for period 29 August 2006 – 31 January 2007

<table>
<thead>
<tr>
<th>No: Referrals from DIP in Medway</th>
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<th>Jan ‘07</th>
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</tr>
<tr>
<td>No: Receiving methadone</td>
<td>49</td>
<td>9</td>
<td>58</td>
</tr>
<tr>
<td>No: Waiting time for 1st assessment</td>
<td>Within 1 working day</td>
<td>Within 1 working day</td>
<td></td>
</tr>
<tr>
<td>Rate of retention</td>
<td>80%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>No. Transferred to Manor Road</td>
<td>17</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>No: referred to Detox</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No: DRR</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No: Assessed but DNA doctor’s appt</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No: Dropped out of treatment</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>No: DNA as a result of going to prison</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

3. Reduction in Drug Use and Impact on Risky Drug Use

At intake all 14 informants were heroin injectors, with 12 reporting groin injection. Two had recently taken up injecting again after extended periods of abstinence. In addition, 10 were regular cocaine users, and 2 reported ‘speedballing’, injecting cocaine simultaneously with heroin. There were also reports of high risk injecting practice, including the sharing of filters and spoons.

At the point of interview only one client was opiate abstinent, and it seems that even at the point of referral to the community drug service the majority of clients continue ‘topping up’ with street drugs. Nevertheless, clients were making significant gains in reducing the overall amount of drugs they were using, and were becoming increasingly stable in their behaviour pattern. Most clients were, furthermore, reducing their high risk behaviour by
cutting down on sharing paraphernalia. Four informants had ceased injecting altogether and were now smoking heroin.

These self-reported health improvements were supported to some extent by drug tests, with most clients showing at least one negative result. RAPS staff also reported the positive improvements made by their clients, and were confident in referring them on to Manor Road.

<table>
<thead>
<tr>
<th>Drug test results – total 10*</th>
<th>All negative</th>
<th>1/3 and more negative</th>
<th>1 negative result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people reporting abstinence</td>
<td>1/14</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Number of people reporting switch to from injecting to smoking</td>
<td>4/14</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Number of people reporting reduction in injecting behaviour</td>
<td>6/14</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

* Drug test results for 10 informants only

4. **Inter-agency cooperation**

Most of the stakeholders interviewed agreed that relations between the services had been excellent. The fact that RAPS was located in the same building as DIP, Addaction (a non prescribing treatment service) and Service User Groups such as MUST[^21] was a strong point, as it added value to each of the other agencies, and allowed for many informal exchanges of information.

The commitment of RAPS staff to the project was also positively noted by other agencies. One RAPS worker would attend ISIS night projects to disseminate information among sex workers. The relationship between the sexual health outreach team and RAPS has been excellent.

[^21]: Medway Users Standing Tall
According to Julie Shannon, the RAPS project has been an “Excellent example of multi agency working.” Notwithstanding the overall positive feedback, there are opportunities for further enhancing the effectiveness of the rapid prescribing service.

(i) Inward referral

RAPS by definition was set up for drug misusing offenders. One of the main channels into the service, was therefore the police. Unfortunately police capacity was hampered by staff constraints, with only one police custody nurse taking on the workload. There is an obvious capacity issue here, and it is strongly recommended that resources are made available to expand the Arrest Referral team and the volume of client throughput. It was suggested that staff from RAPS could work in police custody suites.

The work by the custody nurse was hampered further by operational protocols. Offenders suspected of drug use were invited to an interview to discuss their drug using habits and treatment options. The location for this interview was the police station, where they were taken after arrest. Many offenders are extremely reluctant to return to the police station voluntarily.

(ii) DIP

Relationship between the DIP and RAPS were cordial and efficient. The DIP team is in the process of matching clients with treatment places according to a set range of criteria. There were suggestions that the skills of DIP staff in triaging and assessing clients with complex needs could be enhanced. According the Mike Cochrane, the manager of Manor Road some of the assessments were done too quickly.

Another issue raised was that an opportunity for delivering a tier 2 intervention was being missed. It is arguable that this is not the purpose of the DIP, which operates a triaging process. This points towards a need for clearer communication and understanding about the

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22 Interview with Julie Shannon, 14/03/07
23 interview Mike Cochrane manager Cornerstone/Manor Road 9.3.07, Andy Ashenhurst
respective roles of each partner agency. Alternatively, it may be useful to explore options for enhancing DIP services in this context.

Problems arose with the case of one client who was evidently unsuitable for RAPS prescribing because her primary problem substance was alcohol. While she should not have been referred to RAPS in the first instance, RAPS then compounded the error by taking her on and issuing a methadone script. The client clearly fell outside the eligibility criteria. RAPS staff claimed they were simply responding to a referral made to them by DIP. This happened shortly after the opening of the service and can partly be explained as a teething problem. RAPS certainly, stuck closely to the eligibility criteria when screening all subsequent clients. The incident was fully documented and reported to the KDAAT at that time.

The complexities experienced by the DIP team in running the triage and allocating clients to a suitable programme have also to be put into perspective, and the performance has to be regarded as an ongoing learning experience. The eligibility criteria are complex, and working partnerships with other organisations also entail a range of problems. It is important to try to understand the clients’ perspective in these processes. One case is cited here to illustrate the challenges with regard to exchanging information between agencies and drawing the appropriate inferences from information. The example suggests a tendency for triage workers to assume that at all reported consumption patterns as problematic, even though many clients can exercise control over their intake of some substances but not others.

Adapted from the Logbook of a MUST case worker

20th October 2006. My Client Tony had been released from prison 6 weeks previously and upon his release he had been offered an assessment for RAPS, but as he was no longer using heroin he refused this offer. He had intended to stay clean, but now 6 weeks later he found himself with a heroin habit and wanted help. When asked about any other drug use he said that he occasionally drunk alcohol. He had been to see DIP in regard to now going

\[24\text{ Medway Service Users Standing Tall – service user group based in the same building as RAPS}\]
into the RAPS system but had learnt that as he had now been out of the criminal justice system for over 6 weeks he was no longer eligible. RAPS referrals have to be made within 4 weeks of leaving any sort of custody, be it police, court or prison.

Tony felt that he was being penalised for not being in trouble with the legal system, and wanted to go through his options with us. We explained that as Manor Road the only tier 3 treatment provider was not taking on any new cases at the moment, his only option for getting clean was a community detox or an in patient detox at Bridgehouse. First, however, he would need to get a referral from a tier 2 service, so we arranged an appointment to get him triaged at Addaction four days later.

26th October 2006. Tony came to the drop in to tell us that he had found out that he had a warrant out for his arrest in relation to unpaid fines. He was pleased about this as it meant that he could go into the criminal justice system again and so therefore be eligible for RAPS.

Tony asked if we could help him arrange to give himself up on the warrant and speak to the custody nurse in regard to referring him to RAPS, once he was in police custody. We spoke to the custody nurse, arranging for Tony to hand himself into police custody on Sunday pm when custody nurse would be there to do referral.

31st October 2006. Tony returned to drop in to explain that he had received a referral, but upon going to DIP for his assessment had been told that he was not eligible for treatment at RAPS. He had not been told why and asked us to begin an advocacy case on his behalf regarding this matter. I sent a letter to DIP asking for their reasons for his ineligibility.

6th November 2006. We received a letter from DIP stating that Tony is not eligible for treatment because of his alcohol abuse, as logged in his triage records from Addaction. Tony explained that he was asked at his triage appointment if he drunk alcohol and he said yes, but had meant occasionally as a social thing. He has no problem with alcohol abuse.

When this was pointed out to DIP they agreed to re-triage him on the 9th November 2006. Tony went to see the doctor on the following day for a script.
(iii) Onward Referral

Working relationships between RAPS and Manor Road, the community prescribing service in Medway were cordial and professional. Yet the relationship was not without tensions, as Manor Road was experiencing operational difficulties after key workers had left and their places were being filled with agency staff. It was reported by one informant that the service with an official capacity for looking after 200 clients had to look after 330, with individual staff members carrying a case load of 50 clients.25

It is reported that MR had closed their waiting list, as it was 3 months long, so were not taking on new clients. The arrival of RAPS therefore, as a well equipped rapid access service was both welcome and a cause for misgivings. According to one client “there were a lot of sour grapes when RAPS came along all singing and dancing.” Particularly as MR had to take on RAPS clients once they had been stabilized, which some of the non offending clients on MR waiting list saw as queue jumping.

The manager of Manor Road, did not admit to tensions, but said that the arrival of RAPS was unannounced among the wider service providers and that this led to RAPS development being retarded. Members from the Commissioning Team pointed out, however, that implementation days were held in which Manor Road staff participated.26

In the event, no clients were taken on prior to the termination of the 12 weeks. Even then, there were some problems with MR staff claiming that some of the clients had not been stabilized and that they were not equipped to deal with them. There was also a sense that clients were stable at RAPS under supervised consumption and daily contact, but would quickly lose motivation once they were moved on to pharmacy based dispensing. RAPS staff were acutely aware of the dilemma, as they saying “I feel guilty when people are leaving because we are setting the client up to fail.”

25 Interview with MR nurse speaking off the record
26 Mike Cochrane manager Cornerstone/Manor Road 9.3.07
This notwithstanding, RAPS staff were pro-active in establishing constructive working relationships. It was critical for the information exchange, as MR GP’s would prescribe to transferred clients without informing RAPS. As RAPS continued dispensing until receiving confirmation that the clients were now obtaining their methadone from pharmacies there was a risk of double scripting. A regular information exchanged was established by RAPS staff who reported that they were calling MR regularly to exchange prescribing information on clients who had been referred.

(iv) Law Enforcement Agencies

The Drugs Liaison (Police) Officer for Medway was convinced that RAPS had had a positive impact on crime reduction in the area, even though the volume was too small to register at this early stage. It being a rolling programme, he thought that in time it would reach a level of magnitude where the impact would be felt more widely. He thought that there were problems with the narrow eligibility criteria, as known but un convicted offenders were excluded. There were also some problems with regard to information sharing about clients, a sentiment echoed by other police officers. They wanted to know what drugs were being used by what clients for operational reasons.

RAPS staff were adamant that they did not want to share client information with the police. They welcomed the cooperation of the police but did not want them to become over-involved. Service clients repeatedly complained about police officers parking outside the service. At other times CCTV cameras normally directed at the High Street were redirected towards the entrance of RAPS. It remains essential that the police allow drug agencies ‘room to operate’ as to facilitate the establishment of trust and prevent clients being driven away.

3. Discussion

3.1 RAPS in the Context of Service Provision in Medway

There is a general sense among clients, staff and stakeholders, however, that RAPS achieved benefits over and above the gains predictable from the increase in inputs. It was the level of quality in service delivery, in client engagement, and in outreach that set a standard. According to stakeholders, RAPS did succeed in making other local service
providers reflect on their practice and highlighted the importance of supervised methadone consumption. Informants also thought that it succeeded in eliminating methadone leakage onto the street. 27

The two key issues arising for the planning of in Medway and across Kent is to what extent the model can be adopted for all clients, and not simply those ‘privileged’ by contact with the criminal justice system. The speed of accessing services is known as one of the main factors for client engagement, and reducing waiting times for drug treatment services has been one of the main performance targets for Drug Action Teams.

The second issue relates to the continuity of care. RAPS users have daily contact with service staff, and build up meaningful relationships – emergent therapeutic alliances – that are an important element on their road to recovery. Up to now the community prescribing service at Manor Road to which clients were referred on after the completion of their 12 week programme, could not deliver this level of care.

Most informants did support expanding a RAPS style programme to include non criminal justice clients, poly-drug users and those with complex needs. Ironically RAPS was popular to the extent that clients were allegedly asking police custody nurses for referrals, and the client discussed in the case study was pleased on hearing there was a warrant for his arrest which qualified him for RAPS. Supervised consumption was seen as necessary for all new and returning clients.

With regard to location, it was generally felt that Medway was strategically the right place for RAPS. A secondary non criminal justice filter was proposed as a way to widen access. A suggestion was that a RAPS type facility be operated alongside other tier 2 and tier 3 services, but with a pared down remit, referring clients with additional needs for other interventions nearby. To do this successfully eligibility criteria, staff training, interagency divisions of labour and referral protocols would need to be finer tuned.

The RAPS experience reaffirmed the need for wider access to prescribing services in Medway, which has many of the urban characteristics of an inner city. Whether the service is merited for other parts of the county, with a different drug use profile is questionable.

27 Mike Cochrane manager Cornerstone/Manor Road 9.3.07
3.1.2 Training and inter agency protocols

Because of the innovative nature of the RAPS pilot, the short notice given before it opened and the numbers of local agencies that were to become involved with the project, there were some concerns raised among local agency staff about how it would ‘fit’ with established practices. There were comments about a lack of dissemination of service level protocols among the participating agencies, and that operational links were developed on a piecemeal basis, with policy changes made on the hoof. While the front line staff of all the agencies involved did a good job in overcoming these shortcomings, it was clearly felt that these processes were flawed and handicapped the delivery of services.

A number of informants commented on the skill level and preparedness of the DIP team to facilitate their roles in relation to the RAPS project. There was also some confusion around the role of the custody nurses and their relationship with would-be RAPS clients.

There was a consensus that some joint training or familiarisation sessions for all participating agency staff teams would have benefited all concerned.

3.2 Eligibility Criteria

From the outset there was a tension between setting up an effective rapid prescribing service targeted at the most vulnerable clients, working with available resource, and delivering quality care. Against the backdrop of waiting lists at the community drug prescribing service DAAT officers were concerned to protect the service from being swamped. The initial set of criteria were agreed upon at the stakeholders meeting, and have since been subject to minor amendment. The experience has found a number of problems which should be addressed:

(i) Many clients live with partners who are active users; it is difficult for one party to break out of a dependency on their own when their partner continues using. The problem is accentuated in the case of sex workers, some of whom have to continue working in order to provide for the drug habit of a partner.

Less obvious, but equally intractable is the case of young homeless men. Many of these are also in pairs or small groups that while not formalized provide the main social fabric in
their lives. It is difficult and possibly even counterproductive to work with only one member of such pairs or groups, as this threatens the only, or at least major social bond these individuals have. Two young men in the Focus Group said that they had entered together a few weeks after coming out of prison, but that their mate, who had also wanted to come along, had been refused – penalized for not having been convicted of a crime.

The service did respond to these arising needs, by making room for partners of sex workers. It should be widened further to take into account the social reality and the need for support among vulnerable users.

(ii) The focus of RAPS was on opiate users, including opiate users who were also using other substances such as alcohol. Yet in the event, most clients were using cocaine and cannabis in addition to, and sometimes in combination with opiates.28 It was suggested that this fact should be reflected in the terms of reference to allow people with other primary drug problems to access the programme. It was also suggested that people with alcohol problem should gain access to RAPS, though it was not clear to what extent methadone substitution would be of assistance to them.

Eligibility criteria should therefore be reformulated so as to allow access to poly-drug users where illicit opiate use is identified.

3.3 Access pathways

(i) Aimed at drug using offenders, RAPS depended on pro-active police referral mechanisms. Police resources were stretched, with only a single nurse working in the custody suites in Medway.

It is also suggested that the modalities of EAR be reviewed. When the police nurse is unable to see a client, an interview can be booked for him/her to return to the station at a later date. Conducting interviews in the police station is perfectly appropriate at the point of

28 Smith and Honor, 2004 say in their experience that heroin only users are a rarity
arrest. But many arrestees will refuse to return to the police station voluntarily to be interviewed about their illegal drug use. Instead of waiting for clients who fail to show up the police nurse’s time could be better spent by finding an alternative location for conducting interviews.

It is therefore suggested that alternative premises be found and a protocol be formulated allowing the police nurse and/or other arrest referral workers to conduct arrest referral outside the station.

(ii) Restricting access to clients passing through the criminal justice system is contentious as it excludes offenders who have not yet been caught. This has been particularly frustrating to (a) the Police Drug Liaison Officer when trying to enter an offender known to him onto the programme. The risk is that even prolific offenders who successfully avoid coming to the attention of the criminal justice system are excluded from treatment.

Secondly, the requirement of committing an offence is sending a false incentive to potential clients who feel that they need to commit a crime in order to access treatment – see the case study above.

There were, one the other hand, well placed concerns that providing clients with the opportunity to self-refer simply by claiming to have committed a crime would simply invite people to come and lie. Such claims were impossible to verify and may quickly overwhelm the service.

One way forward may be to extend partnership agreements to other designated stakeholders to refer clients to the DIP for screening.

3.4 Service Expansion

RAPS staff wanted to expand the programme to deliver many other services. There was a vision of setting up a one-stop-shop, particularly as RAPS shared offices with other organisations catering for drug users. There were two dimensions to the suggestions for service expansion – one was enhanced medical care, to include testing for Blood borne viruses, group work, acupuncture, vaccinations, wound cleaning and key work. This would
yield benefits further upstream, as at present clients were sent to hospitals to have wounds seen to.

The other dimension was to employ RAPS more pro-actively in adjacent fields, including arrest referral, as discussed above, harm reduction and outreach work. As local coverage was patchy with only one needle exchange in the area, RAPS could provide that service. As for outreach, some of the RAPS staff were already involved in some, but informally and in their own time. The idea was to reach vulnerable populations, particularly sex workers and provide them with information about RAPS. This work could have been stepped up, and possibly lead to an additional referral pathway.

A shortcoming commented on by most staff and service users, was the lack of prescribing alternatives. RAPS only prescribed and dispensed methadone, which did disappoint a number of clients particularly those coming out of the prison system, where subutex is prescribed.

It is therefore strongly suggested to broaden the range of substitute medication and provide clients with a choice between methadone, naltrexone and subutex.

**Research follow up.**

Given the closure of RAPS, our plans for a longitudinal project looking at its longer term efficacy have been frustrated. However if a similar facility is established we would welcome the opportunity to explore if such an intervention is beneficial to clients.
Annex I

Terms of Reference ‘Assessing the Rapid Access Prescribing Service in Medway’

DTL/RAPS Evaluation Survey

Background

The Rapid Access Prescribing Service (RAPS) pilot in Medway aims to provide a quick and accessible service to high-risk drug users, the majority of whom will be currently involved in the criminal justice system. The Service offers rapid access to daily supervised methadone treatment on site for a maximum period of twelve weeks, followed by transition into local Community Services. The pilot has been running since August 2006.

Key areas for investigation of service outcomes

- Reduction in re-offending
- Retention/Engagement
- Reduction in use of illicit drugs
- Reduction in High Risk behaviour

Brief: To evaluate the effectiveness of the Rapid Access Prescribing Service in Medway.

Assessment to be based on:

- snapshot interviews with service users and self reported offending behaviour and drug use
- 3 interviews of service provider on challenges to and achievement of project in delivering objectives
- 3 impact of project on clients and on the wider ‘scene’ - stakeholders

It is hoped that in the next financial year these clients could be followed up to assess the impact that this initial intervention has had on their lives. Therefore the research could form a baseline study for this.
Other issues for consideration in the survey:

Referral and inter-agency cooperation

Recommendations to be drawn from the survey
Report and recommendations delivered to KDAAT by March 16th 2007

Evaluation to be carried out by Axel Klein PhD, Kent Institute for Medicine and Health Sciences at the University of Kent
### Annex 2

**Question Matrix 2: Drug Use and Risk Behaviour**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Did you use any heroin</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Did you use any cocaine</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Did you use any other</td>
<td></td>
<td></td>
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<td>4. Did you drink any alcohol</td>
<td></td>
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<td></td>
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<tr>
<td>5. Did you inject</td>
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<td>6. Did you share the drugs</td>
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<td>7. Did you share any equipment</td>
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<td>8. Did you share the needle</td>
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<td>9. Did you have unprotected sex</td>
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</table>

1. Informant maybe reluctant to provide information, so it might be useful to repeat that this information is kept confidential. Also ensure that the informant is aware that s/he can choose not to answer any particular question.

**Question Matrix 1: Offending Behaviour**

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29 As people have real difficulty accurately recalling the last time they committed a given offence – particularly if it occurred some time ago responses could be adapted as follows: 0 = never, 1 = in the last week, 2 = in the last month, 3 = in the last 6 months, 4 = in the last 2 years, 5 = more than 2 years ago.
<table>
<thead>
<tr>
<th>Offence</th>
<th>Days committed last 6 months</th>
<th>Days committed last 30</th>
<th>Last time committed&lt;sup&gt;30&lt;/sup&gt;</th>
<th>Who did you usually do it with?&lt;sup&gt;31&lt;/sup&gt;</th>
<th>Why did you usually do it?&lt;sup&gt;32&lt;/sup&gt;</th>
<th>Did you use the proceeds to buy drugs?</th>
<th>Were you using drugs at the time?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud/forgery/deception</td>
<td></td>
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<tr>
<td>Shoplifting</td>
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<td>Burglary (residential/commercial)</td>
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<td></td>
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<tr>
<td>Robbery</td>
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<tr>
<td>Theft other</td>
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<tr>
<td>Theft from a vehicle</td>
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<tr>
<td>Theft of a vehicle (inc. TWOC)</td>
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<td>Handling stolen goods</td>
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<tr>
<td>Public order offences</td>
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<td></td>
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<tr>
<td>Firearm/weapons offences</td>
<td></td>
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<td></td>
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<tr>
<td>Other crimes (specify)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<sup>30</sup> As people have real difficulty accurately recalling the last time they committed a given offence – particularly if it occurred some time ago responses could be adapted as follows: 0 = never, 1 = in the last week, 2 = in the last month, 3 = in the last 6 months, 4 = in the last 2 years, 5 = more than 2 years ago.

<sup>31</sup> Responses could be coded as follows: 0 = alone, 1 = friend/acquaintance with drug/alcohol problem, 2 = friend/acquaintance without drug/alcohol problem, 3 = family member with drug/alcohol problem, 4 = family member without drug/alcohol problem, 5 = other, 6 = refused/not stated.

<sup>32</sup> Responses could be coded as follows: 1 = need for drugs, 2 = need for money, 3 = acceptance by peers, 4 = sensation seeking, 5 = in order to get treatment, 6 = other reason, 7 = refused/not stated.
**RAPS – DTL Evaluation**

**Staff Questionnaire**

1) In your opinion is the RAPS service performing to the best of its potential?
   
   yes: no:

   (i) If not, why not?

2) Does RAPS get the number of clients that were originally anticipated?

   (i) What are the problems with the referral system?
   
   (ii) Are there any particular bottlenecks?

3) How is the relationship with the key partners; could you specify what is working well/could be improved with regards to:

   (i) the courts
   
   (ii) the police
   
   (iii) the probation service
   
   (iv) ISIS
   
   (v) other

4) How is the relationship with the agencies involved in onward referral – Manor House/ what could be improved?

5) Do you believe that the eligibility criteria for clients referred onto RAPS is too narrow?

   (i) If so explain why?
   
   (ii) What could be done to expand it e.g. include poly drug users/alcohol users/non offenders?
   
   (iii) What benefits would this bring to clients and community?
   
   (iv) Would it reduce offending behaviour?
6) Is there a case for widening access to the scheme?
   (i) What other referral methods should there be, e.g. self referral, walk in?
   (ii) What benefits would this bring?
   (iii) Would it reduce offending behaviour?

7) Numbers
   (i) How many clients has RAPS taken in since starting out
   (ii) How many clients have completed their 12 weeks and been successfully referred
   (iii) How many of these remain in contact with Manor House/other
   (iv) How many clients are currently being cared for by RAPS
   (v) Is there potential for expanding clients numbers without increasing resources

8) Treatment
   could the range of treatment services be extended – HR interventions
   (ii) is there a case for providing Subutex from the RAPS experience
   (iii) what other services could RAPS provide

9) What other improvements could be made to the service to benefit clients?

10) What improvements can be made to the coordination between the different services?

11) How could RAPS become more pro-active in providing vital services – e.g. outreach, community work?

12) What do you see as the main benefits RAPS has achieved so far

13) What do you think RAPS was supposed to achieve?

14) What can be done to maximize intended and unintended benefits in the future?
Annex 3 RAPS Staff and Stakeholders Interview schedule

22nd Feb. 2007 Karen Edwards, Outreach Manager and Deborah Hornby, Sexual Health Outreach worker ISIS, (AK, DO)

22nd Feb. Field work in Chatham – interviewing sex workers. (AK, DO)

23rd Feb. Monique Tomlinson, Project manager, DTL (AA, AK, DO)

26th February Clay Woodden drug counsellor, Louise Godden drug counsellor and David Nash clinical nurse (DO)

26th February Wayne Butcher Addaction PM (DO)

27th Feb. Tony Gray Addaction and Charlotte Coulson, Julie (RAPS Project Manager) (AK, DO)

5th March. Brian Ward Medway DLO (AK)

7th March. Kate Tree, Peer Trainer SUST/East Kent Cyrenians (AA)

8th March. Ailish Geldenhuys, DAAT Coordinator Medway (AA)

8th March. Focus Group Service Users (AK, DO)

8th March Kim Flain, DIP Administrator (AK)

9th March. Mike Cochrane, Manager, NHS Manor Road. (AA)

13th March. Inspector Jerry Prodger DLO (AK)

13th March. Claire Begent, DIP Manager, KCA Swale. (AA)

14th March. Julie Shannon KDAAT (AK)

15th March. Rachel Enstone Acting Team Leader, Cranstoun for (DIP) Medway, and Joe Harris (Co-ordinator) (DO)

16th March Amanda Herron Coordinator MUST (DO)

4th April. Helen Crooke, Enhanced Arrest Referral Practitioner, Chatham Police Station. (AA)