



Evaluation of the Rapid Access Homeless Outreach Service

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Executive Summary

The Rapid Access Homeless Outreach Service (RAHOS) is a low threshold service commissioned to engage 'hard to reach' substance users in treatment, principally aimed at homeless drug users. The service is mainly located in The Whitechapel Centre, a day centre for homeless people, in Liverpool.

Since the RAHOS was established in March 2007 there has been a steady uptake of the service and 124 clients accessed the service between March and December 2007 (Section 3.1). The service attracted a higher percentage of women, younger people and those from ethnic minority backgrounds than is typically seen in drug treatment services in Liverpool. The clients have high levels of heroin and crack use (Section 3.1), criminality (Section 3.2.3), street sex workers (Section 3.3) and injecting (Section 3.2.4).

A high percentage of clients had been in contact with at least one other drugs service in the year prior to the establishment of the RAHOS (Section 3.2). Analysis of the outcomes of those in contact with both the RAHOS and other treatment services between March and December 2007 indicated that those in contact with structured treatment after RAHOS contact were more likely to have a positive treatment outcome (Section 3.2).

Interviews with clients, staff and stakeholders indicated that the RAHOS has been received positively by all involved and that the service is considered to be beneficial (Section 3.3). The majority of clients interviewed indicated that they were happy with the transition to treatment at Liverpool DDU and high levels of initial contact were recorded, however, high levels of attrition after the initial contact from Liverpool DDU were found. (Section 3.2.2).

In conclusion, based on the evidence presented in this report the RAHOS is achieving its main aim of engaging the 'hard to reach', vulnerable substance users in Liverpool. A number of recommendations to improve and further enhance the RAHOS are detailed in Section 6.

1. Introduction

The link between substance use and social exclusion has been well established (Eaton et al., 2007; HPA, 2007) and is so important that the first key message in *Shooting Up 2007 Update* (HPA, 2007) relates to the increased injecting risk and risk of infection among homeless drug users. There are many reasons why a person becomes homeless and it is rare that there is only one reason. Typically reasons for homelessness may include a combination of mental health problems, unemployment, financial difficulties, criminal behaviour, relationship problems, family breakdown and substance use (ODPM, 2005).

A study undertaken in 2002 found that 83% of homeless people interviewed had used a substance other than alcohol in the previous month and two-thirds indicated that they had begun to use at least one new drug since becoming homeless (Fountain and Howes, 2002). Partnership working between drug treatment services and homeless agencies has been highlighted as an important method to address the complex issues of this group and could have significant harm reduction effects (Edmonds et al., 2005).

Homelessness in Liverpool

Representatives of the Department of Communities and Local Government (DCLG) undertake annual counts of rough sleepers in all local authorities. The most recent figures for Liverpool, from a June 2007 count, found that there were 12 rough sleepers in the city (Communities and Local Government, 2007). The recorded number of rough sleepers in Liverpool was the highest in the North West region and the sixth highest in England. Research undertaken in Liverpool in 2007 by homeless outreach workers indicate that the number of rough sleepers reported by DCLG is a substantial underestimate and that the actual figure is around 50 (Gosling, 2007). Monitoring figures from The Whitechapel Centre in Liverpool show that in 2005/06 1,933 individuals engaged with the service. The high numbers of service users indicates that

the homeless problem in Liverpool is more significant than government estimates indicate.

1.1 The Rapid Access Homeless Outreach Clinic

The Rapid Access Homeless Outreach Service (RAHOS) was established by Mersey Care NHS Trust in March 2007. The RAHOS was initially located at The Whitechapel Centre and expanded to Armistead Street later in 2007. The RAHOS was commissioned in response to Liverpool DAAT's need to engage 'hard to reach' substance users in treatment. The service aimed to target homeless people, people dependent on hostel accommodation, street sex workers and pregnant drug users. The RAHOS is part of Liverpool Drug Dependency Unit (DDU) and was established to act as a gateway from a low threshold service to mainstream drug treatment service.

The initial 6 month pilot was completed at the end of September 2007. Based on a project review conducted by the Drugs and Alcohol Directorate of Mersey Care NHS Trust the pilot has been extended and the RAHOS will continue as a pilot until 31st March 2008. The pilot will continue to be financially supported until the end of March 2008.

Aims of the Rapid Access Homeless Outreach Service

1. To provide a service which could be accessed by users who are normally hard to reach, principally homeless people, by offering:-
 - Rapid easy access
 - Low threshold of prescribing – up to 40-50 mg methadone
 - Low expectation of the client/tolerance of high level of failure
 - Easy re-entry to service following lapse
 - Tolerance of risk

2. Reduce criminality
3. Reduce health damage from blood borne viruses
4. Increase vaccination levels
5. Improve access to physical and mental health care.

The Host Services

Services that work with homeless drug users in Liverpool are the host sites for RAHOS. The Whitechapel Centre was used to engage with a sample of homeless drug users in different accommodation situations i.e. rough sleeping, staying at hostels, staying with friends/relatives. Armistead Street was utilised for the researchers to observe the functionality of the clinic and interview the RAHOS staff.

The Whitechapel Centre

The Whitechapel Centre was set up in 1975 to tackle Liverpool's growing homeless problem in the inner city. The Whitechapel Centre works to deliver long term solutions to homelessness through the many programmes and facilities they offer including day centre services, hot meals, outreach, resettlement activities, supported housing services, laundry and washing facilities and education and training. The service is also the main host for the RAHOS which is held at the Whitechapel Centre three mornings a week.

Armistead Street

Armistead Street is a support service for female street sex workers which was established in 1995. Armistead street aims to; provide a confidential assertive outreach and support service to women involved in street sex work and support those wishing to exit, deliver a flexible accessible and quality harm reduction service, refer and actively support street sex workers to access health, drugs, social care services and training/employment services. Armistead Street is part of the Armistead Centre within Liverpool Primary Care Trust. The service is another host for the RAHOS which is held at

Armistead Street, one afternoon per week specifically for women involved in street sex work. N.B. We are acknowledging this element of RAHOS but this evaluation has focused on the element of the service at the Whitechapel Centre and the clients within that provision.

1.2 The Evaluation

The Centre for Public Health (CPH) undertook a multi-method independent evaluation of the RAHOS. The evaluation used a variety of methods including, desktop research, structured questionnaire (see Appendix 2), staff and stakeholder interviews and observation.

It is important to note that the remit of the evaluation was to focus on the homeless clientele accessing the RAHOS. At The Whitechapel Centre clients who access the RAHOS should be homeless, however the clinic at Armistead Street does not operate under the same criteria and is for street sex workers, homeless or not.

The primary aim of the evaluation was:

- To evaluate the effectiveness of the open access service at engaging 'hard to reach' substance users in treatment, specifically homeless drug and alcohol users.

Supplementary aims included:

- Assessment of the characteristics of the clientele accessing the RAHOS service and their appropriateness to this type of service;
- Analysis of the retention levels at the RAHOS and the clients outcomes;
- Investigation client retention and outcomes at Liverpool DDU.
- Assessment of the value placed on the service by the clients;
- Gathering of feedback from staff/stakeholders as to the value and delivery of the RAHOS;
- Identification of areas requiring development by utilising the information gathered in the aims above.

2. Methodology

The methodology for this evaluation is outlined below.

Desktop Research

Interrogation of three monitoring databases which hold information about drug users. Attributable data from the RAHOS clients were matched to the data from the 2006/07 and 2007/08 year to date to investigate the extent of contact that RAHOS clients had with other services.

Fieldwork

Short structured interviews were undertaken with a sample of service users at The Whitechapel Centre between November 2007 and January 2008. The interviews focussed on the RAHOS and the clients views about the service.

Staff /Stakeholder Interviews

The research team undertook informal interviews with staff and stakeholders of the RAHOS, including the doctor and nurse. Stakeholders included representatives of each Whitechapel Centre and The Basement.

Observation

Direct observation of one client consultation was undertaken. Indirect observation techniques were utilised during all data collection sessions to provide the researchers with a good understanding of the overall working process of the clinic and an understanding of the individual assessment procedures, protocols and practices.

Box 1: Evaluation Limitations

Limited time and resources to undertake the evaluation affected the scope of the evaluation. As a result the aims of the evaluation focussed on the main aim of the service, to provide an open easy access service engaging 'hard to reach' substance users, and the subsequent treatment engagement of RAHOS clients.

As the focus of the evaluation was on homeless drug and alcohol users it does not make any specific conclusions or recommendations regarding the service provision at Armistead Street. However, it is important to note that the desktop analysis of the NDTMS data from the RAHOS does include Armistead Street clients as there is no variable to identify these clients and remove them from the data file. Some of the conclusions and recommendations from this evaluation are general and should be applied to the overall service.

3. Results

3.1 Desktop Research: Contact with RAHOS

Desktop research was conducted on the most recent available NDTMS submission from the RAHOS. The data contained monitoring information on all episodes of treatment with the clinic from 29th March 2007 to 31st December 2007. This file includes all clients who have accessed the RAHOS at The Whitechapel Centre and Armistead Street as there is no location identifier in the dataset.

Between March and December 2007 there were 139 episodes of treatment with 124 individuals at the RAHOS. Figure 1 shows the distribution of episodes triaged between March and December 2007. Figure 1 indicates that since the RAHOS was established the number of clients triaged each month has steadily increased between March and November 2007 (with the exception of August 2007). In December 2007 only four new episodes of treatment were triaged, however, there were 95 episodes of ongoing treatment in this month indicating continued high levels of treatment engagement. (Note the numbers of ongoing treatment episodes shown in Figure 1 may be artificially inflated due to problems with recording discharge information on clients who have left the RAHOS treatment, see Box 2 on Page 14 for more detail).

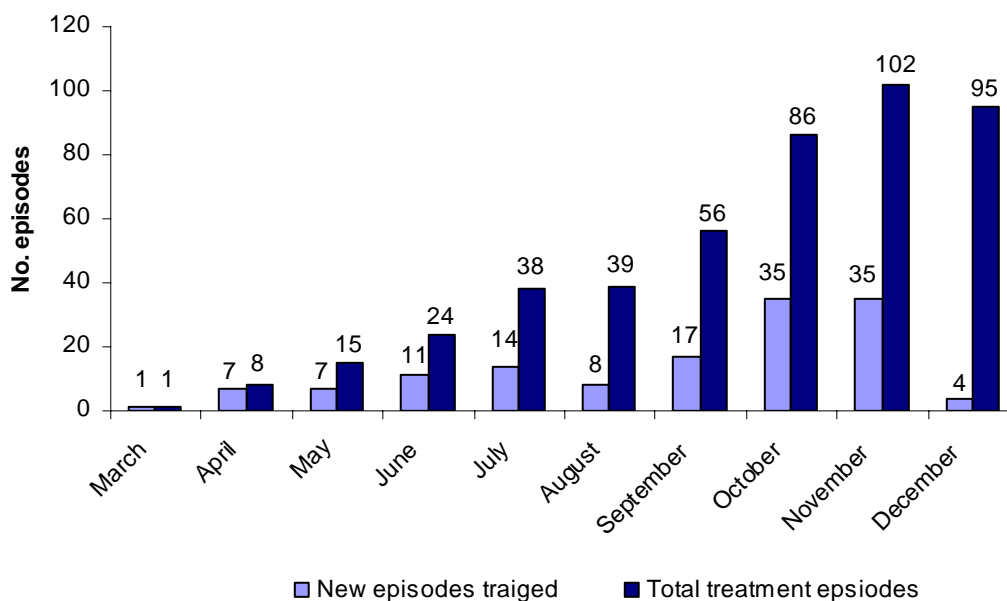


Figure 1: The total number of new and ongoing treatment episodes each month.

Of the 124 individuals in contact with the RAHOS, 54% (n=67) were male¹. The client's age ranged from 18 to 59 years with a mean age of 34.7 years. The vast majority reported their ethnicity as White British (n=109, 88%). Compared to the demographic profile of individuals in structured drug treatment in Liverpool DAAT in 2006/07, the RAHOS engaged a higher percentage of women, younger people and people from ethnic minority backgrounds.

The majority of clients reported their main problematic substance as heroin (n=120, 97%) and other primary substances reported were methadone and hallucinogens. Of those reporting heroin as their main problematic substance, 50% (n=60) reported that they usually smoked the drug and 48% (n=58) reported that they usually injected the drug.

Of the 118 clients who reported a secondary problematic substance, the majority reported crack (94.1%, n=111). The vast majority of clients who reported heroin as their main problematic substances reported crack as their

¹ This figure will be influenced by the clients accessing the RAHOS through Armistead Street and may not be representative of the demographic profile of The Whitechapel Centre service users. The majority of RAHOS users access the service via The Whitechapel Centre.

secondary problematic substance (95.7%, n=110). Alcohol was the most prevalent tertiary problematic substance among the 41 clients who reported a third drug (56.1%, n=23).

Thirty-nine clients exited treatment from the RAHOS between March and December 2007, of those discharged over two-thirds dropped out or left the service (69.2%, n=27). Figure 2 illustrates the variety of reasons for clients discharge (based on the client's last episode of treatment with RAHOS). Of the 12.8% (n=5) clients who were referred on from RAHOS only one client attended another agency within 2 weeks of RAHOS discharge.

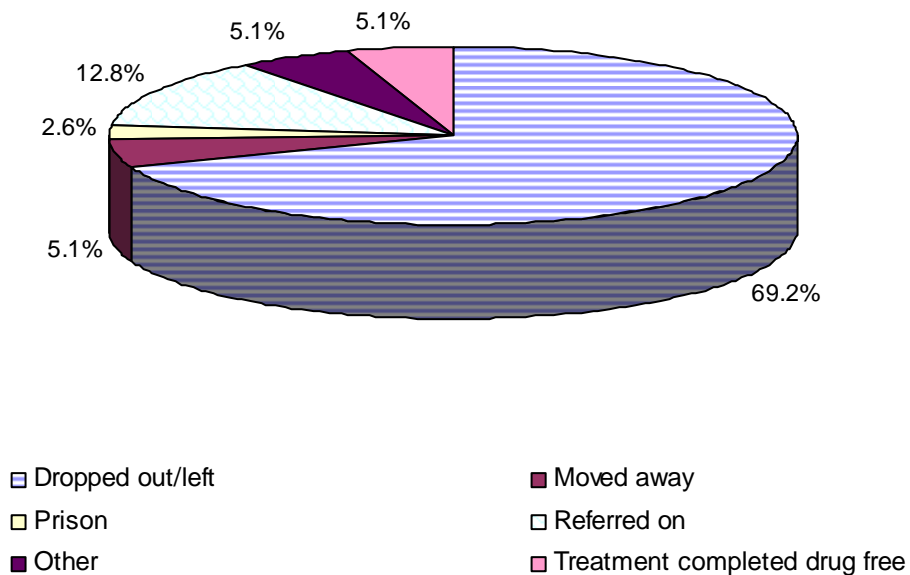


Figure 2: Reason for discharge.

Box 2: Exit Status of RAHOS Clients

The analysis of the 'discharge reason' reported to NDTMS from the RAHOS data and data matching with Liverpool DDU highlighted an important data issue. Although only 5 clients from the RAHOS were recorded as 'referred on', 26 clients who had attended the RAHOS attended Liverpool DDU after their RAHOS treatment. Four clients who were recorded as 'dropped out/left' on the RAHOS data attended Liverpool DDU on the same day as RAHOS treatment. The remaining clients who attended Liverpool DDU after RAHOS contact remained open in the RAHOS data.

3.2 Desktop Research: Contact with other services

Client attributers (initials, date of birth and sex) were matched to three datasets to investigate client contact with other monitoring systems and therefore other services before and after attending the RAHOS. The other databases interrogated were:

- NDTMS (National Drug Treatment Monitoring System) is the official method of monitoring the extent and nature of structured drug treatment in England (tier 3 and 4 services).
- Drug Interventions Programme (DIP) aims to identify and engage with drug using offenders at every stage of the criminal justice system. All interactions with drug using offenders are monitored through the Drug Interventions Record within DIP.
- Syringe Exchange data from agencies and pharmacies is monitored as part of the Inter-Agency Database in Cheshire & Merseyside.

Data from 2006/07 and 2007/08 year-to-date was analysed, with the exception of Syringe Exchange as only April to September 2007 was available.

The results of the desktop analysis indicate that the majority of individuals who received treatment at the RAHOS had previous contact with other services as illustrated in the table below.

Table 1: Summary of contact of RAHOS clients with other services.

	2006/07	2007/08**
RAHOS*	-	124
NDTMS	69	89
DIP	50	60
SYRINGE EXCHANGE***	56	64
All services	19	29

*Figures quoted are from March 2007 to December 2007

** For NDTMS & DIP figures quoted are from April to December 2007

*** For Syringe exchange figures quoted are from April to September 2007

Almost one quarter (23.4%, n=29) of the individuals in contact with the RAHOS between March and December 2007 were also in contact with all three of the other services (NDTMS, DIP & Syringe Exchange) during the same period. As Syringe Exchange data was only available from April to September 2007 the number of clients in contact with all three services during 2007/08 may actually be larger.

Figure 3 (below) illustrates the recorded NDTMS outcome for the 29 clients who were in contact with all other services during 2007. The data has been split into contact with other services before contact with the RAHOS and contact with other services after contact with the RAHOS (this includes contact on the same day). The graph shows that those who were in contact with structured treatment services after contact with the RAHOS were more likely to be in treatment (ongoing on 31/12/2007) than those in contact with structured treatment before contact with the RAHOS (66.7% compared to 26.8%). Those in contact with NDTMS before RAHOS contact were more likely to be referred on to other services (n=5, 35.7%), as this analysis is based on latest episode of treatment these individuals had not accessed any other services since they were referred on indicating that they had fallen out of structured treatment.

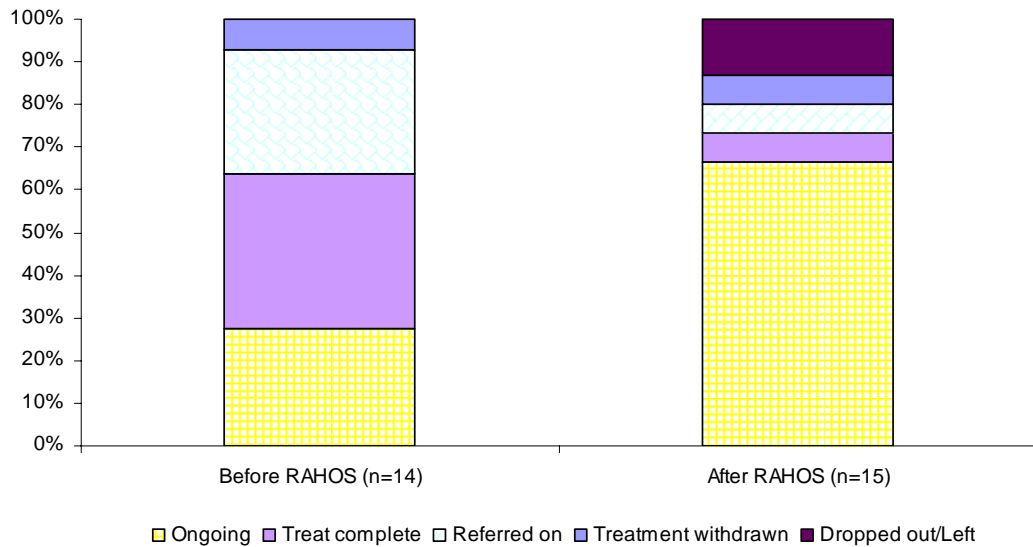


Figure 3: NDTMS outcomes of those in contact with RAHOS and recorded on all other services between April and December 2007.

3.2.1 Contact with Structured Treatment Service (NDTMS)

NDTMS 2006/07

Analysis of NDTMS 2006/07 indicated that 69 of the individuals in contact with RAHOS were in structured treatment during 2006/07 and they had a total of 120 episodes of treatment in this year.

Of the 69 individuals, the majority reported heroin as their main problematic substance (91.3%, n=63) and 60.9% (n=41) reported simultaneous use of heroin and crack.

Figure 4 illustrates the status of each client at the end of 2006/07 based on their last episode of treatment during the year. Over one third of the RAHOS clients in contact with NDTMS during 2006/07 were unsuccessfully discharged from treatment (34.8%, n=24) during this year (See Appendix 1 for definitions of successful completion, unplanned discharge and ongoing).

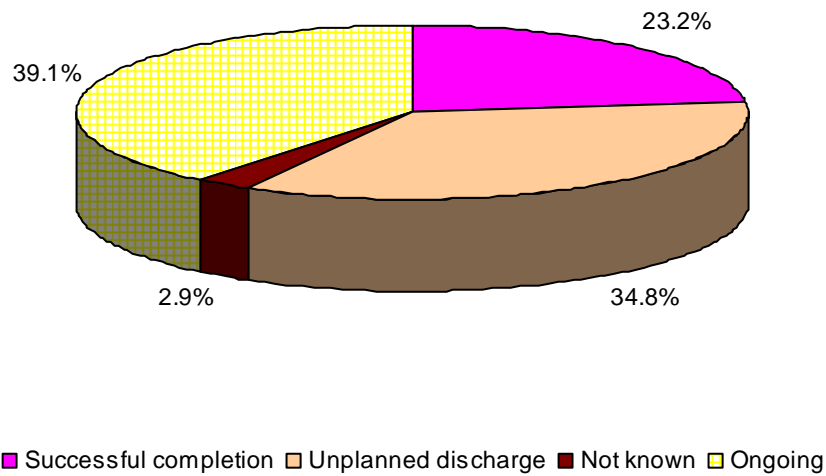


Figure 4: Client NDTMS status on 31/03/2007.

NDTMS 2007/08

Of the 124 individuals in contact with the RAHOS between March and December 2007, 89 were also in contact with other structured treatment services during this year (182 episodes of treatment). Of those in contact with other treatment services approximately one third had their latest treatment episode with NDTMS on the same day as their contact with the RAHOS (32.6%, n=29) and further analysis showed that all but one of these individuals were triaged at Liverpool DDU on the same day (the other individual was triaged at Hope Street Lighthouse Project).

Analysis of the NDTMS outcome of the latest episode of treatment of each individual in contact with both structured treatment (NDTMS) and the RAHOS between April and December 2007 is shown in Figure 5.

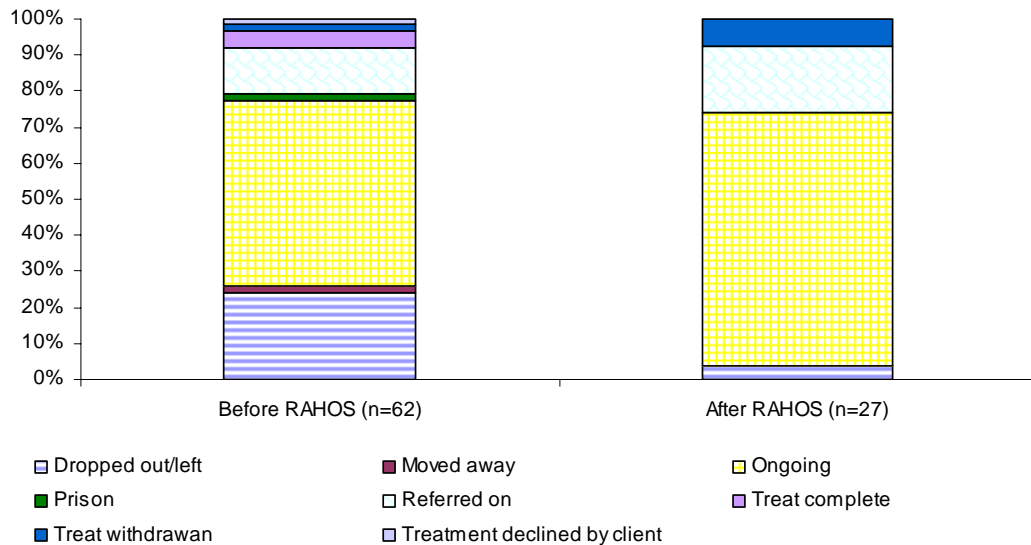


Figure 5: NDTMS outcomes of those in contact with RAHOS and structured treatment services between April and December 2007.

Figure 5 indicates that those who came into contact with structured treatment services after contact with the RAHOS were more likely to be in an ongoing treatment episode on 31/12/2007 (70.4% compared to 51.6%). Those who had their latest structured treatment episode before contact with the RAHOS were more likely to drop out or leave treatment compared to those in contact with structured services after RAHOS contact (24.2% compared to 3.7%).

3.2.2 Contact with Liverpool DDU

Twenty-six individuals who were in contact with the RAHOS attended Liverpool DDU within one week of their RAHOS contact, of which 24 attended the DDU on the same day as their RAHOS episode. However, of these clients on 31st December 2007 only 5 had a discharge date and reason in the RAHOS data although they were also in contact with Liverpool DDU. This indicates a problem in the data recording of clients discharged from Liverpool DDU and/or a problem in communication between the RAHOS and Liverpool DDU.

Half of the clients (n=13) who attended Liverpool DDU within one week of RAHOS contact were still in treatment on 31st December 2007. The discharge reasons for those discharged from Liverpool DDU are shown in Figure 6 below.

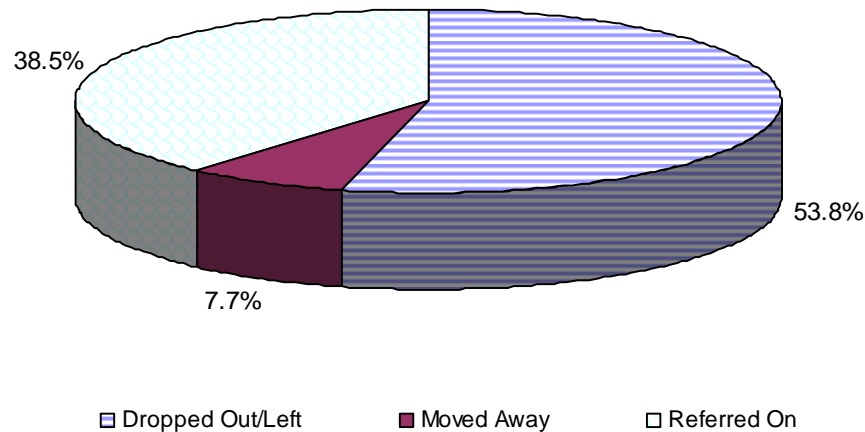


Figure 6: Discharge reasons recorded on NDTMS for clients discharged from Liverpool DDU after contact with the RAHOS.

Although a good rate of initial attendance at Liverpool DDU was found in clients previously in contact with the RAHOS, Figure 6 illustrates that the treatment outcome for clients who exited Liverpool DDU was not as positive. The majority of these clients dropped out or left service (n=7, 53.8%).

3.2.3 Contact with Drug Intervention Programme (DIP)

DIP 2006/07

Fifty individuals in contact with the RAHOS were assessed by DIP during 2006/07. A total of 102 assessments were carried out with the clients during this year with a range of number of assessments from 1 to 8 with an average of 2 assessments per individual. Of those assessed by DIP two-thirds were male (66%, n=33) and 90% (n=45) were White British. The age of these individuals ranged from 18 to 48 years with an average of 35.14 years. The

vast majority of individuals had used illicit drugs in the previous month (96%, n=48), with the majority of individuals reported use of crack (92%, n=46), and heroin (92%, n=46).

Figure 7 (below) illustrates the types of crime committed by the clients in assessed by DIP in 2006/07 based on all DIR contacts (n=100) (Note that two episodes of treatment were voluntary and therefore no crime was committed and these have not been included in the analysis below). The majority of contacts were initiated through shoplifting (36%, n=36) and begging (15%, n=15).

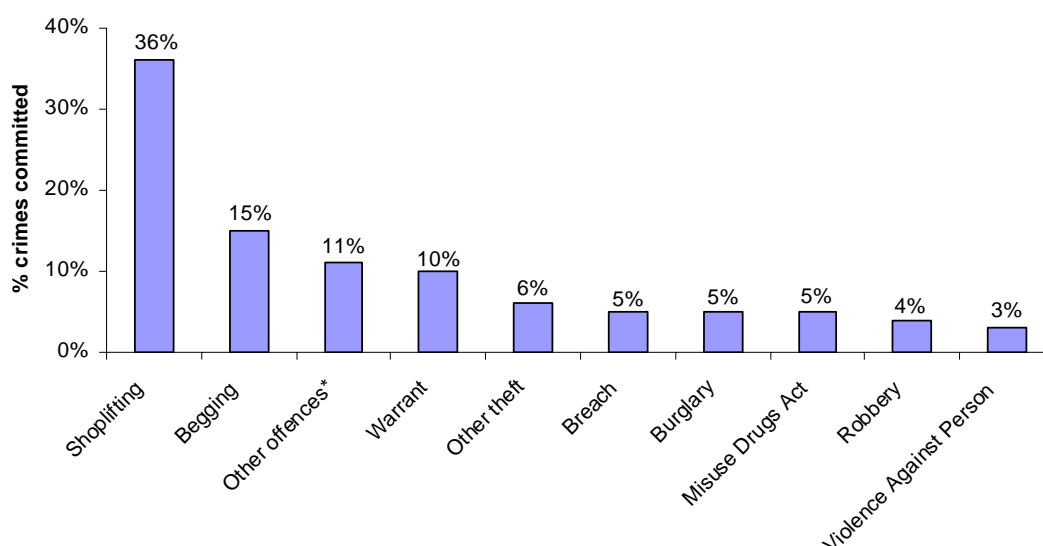


Figure 7: Crimes committed in 2006/07 (all contacts) by individuals in contact with RAHOS in 2007.

*'Other offences' included breach of peace, deception, soliciting, handling of stolen goods and failure to attend court.

DIP 2007/08

To date in 2007/08 there have been 126 DIP assessments with 60 individuals who also had contact with the RAHOS. Sixty-five percent of individuals were male (n=39) and 90% (n=54) had used illicit drugs in the previous month. The majority of individuals used heroin (91.7%, n=55) and crack (76.7%, n=46).

Figure 8 (below) illustrates the range of crimes committed by individuals in contact with both DIR and the RAHOS between April and December 2007 based on all DIR contacts (n=126). Similar patterns to 2006/07 were found with shoplifting (40%, n=50) and begging (10%, n=12) were among the most commonly committed crimes.

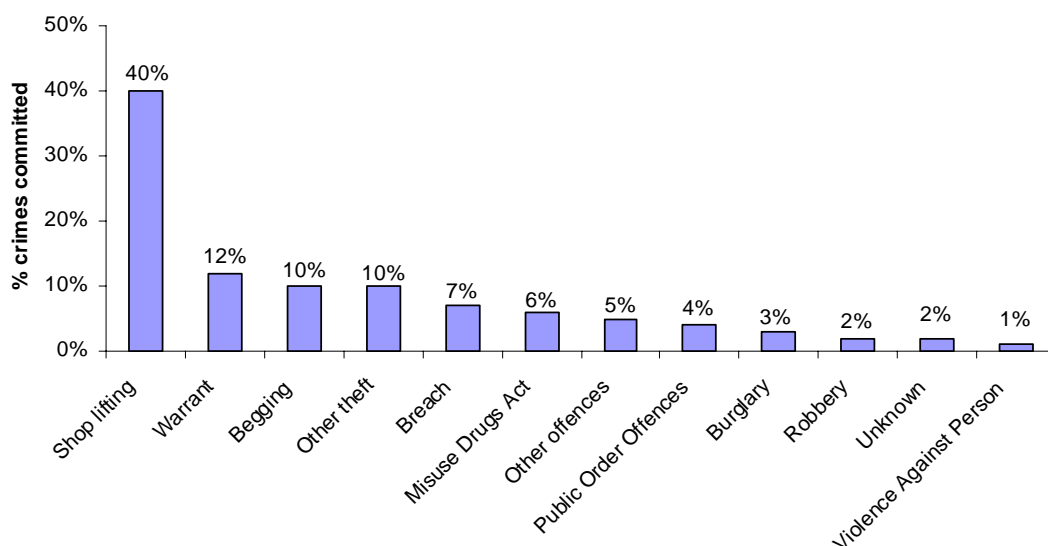


Figure 8: Crimes committed in 2007/08 to date (all contacts) by individuals in contact with RAHOS in 2007.

*'Other offences' includes soliciting for the purposes of prostitution, handling of stolen goods and failure to attend court.

3.2.4 Contact with Syringe Exchange Services

Syringe Exchange 2006/07

During 2006/07 56 clients who were in contact with the RAHOS in 2007 were also in contact with syringe exchange services in Cheshire and Merseyside. A total of 90 contacts were recorded during 2006/07. Two-thirds of those in contact with syringe exchange services and RAHOS were male (66.1%, n=37) and the average age was 34.75 years.

Syringe Exchange 2007/08

During the first half of 2007/08 (1st April – 30th September 2007), 64 individuals, who were also in contact with the RAHOS, made 160 contacts with syringe exchange services. Of these individuals, 53.1% (n=34) were male and the average age was 34.5 years.

3.3 Interviews with RAHOS clients

Short structured interviews were conducted with a sample of clients attending The Whitechapel Centre (See Appendix 2 for questionnaire). In total thirty-three participants completed the questionnaire, of which the breakdown of their awareness of the RAHOS is shown in Figure 9 below.

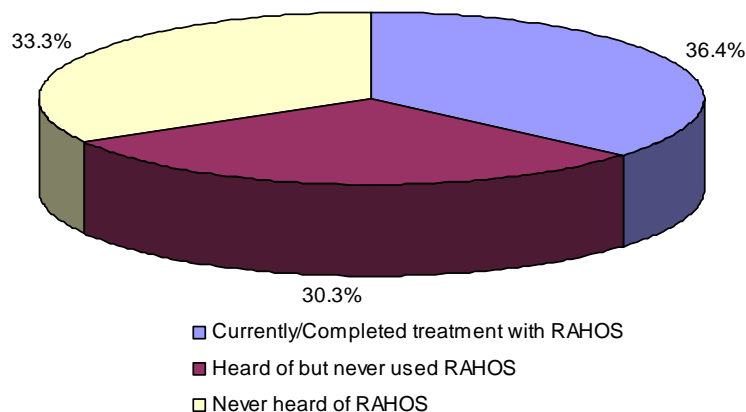


Figure 9: Participant responses when asked if they were aware of the RAHOS.

In order to evaluate the service only interviews with clients who had ever received treatment at the RAHOS were continued, therefore the following analysis is based on the 12 clients who were currently in or had completed treatment at the RAHOS.

Recruitment

Service users who attended The Whitechapel Centre on the days that the research was undertaken were invited to participate in the interview. Analysis of the participants recruited at the first data collection session indicated that

many had either never used or never heard of the RAHOS. In order to recruit participants who had used the service and therefore could give an evaluative opinion, staff at The Whitechapel Centre introduced the researchers to service users that they knew had had previous contact with the RAHOS.

Participant Demographics

Two-thirds of the clients were males (n=8, 66.7%). The average age of the clients was 34.33 years (range from 25 to 43 years). The majority of clients reported their ethnicity as White British (n=10, 83.3%) and the remaining clients indicated that they were White Irish (n=2, 16.7%). Two clients indicated that they were street sex workers (16.7%).

Four participants (33.3%) had completed their treatment at the RAHOS and the other eight clients (66.7%) were evenly split across the four weeks of treatment that each client received before moving into treatment at Liverpool DDU.

Housing Situation

All clients indicated that they had slept rough at some point and the majority indicated that they had slept rough on the previous night (n=9, 75%).

Referral into RAHOS

A breakdown of the routes of referrals into the RAHOS reported by clients is shown in Figure 10 below.

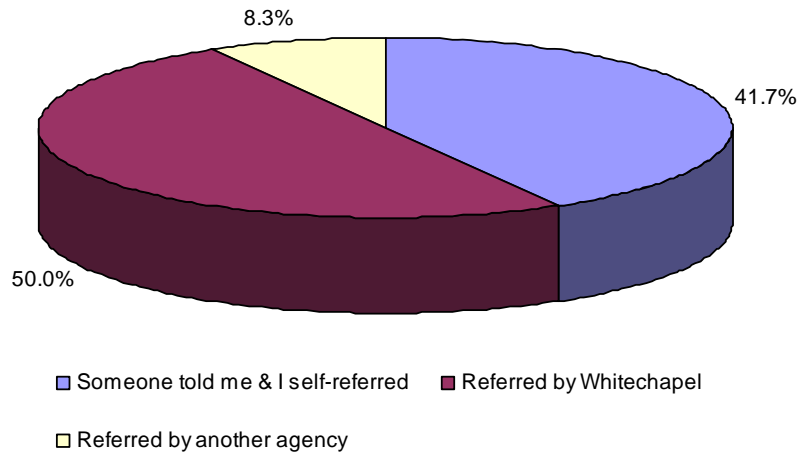


Figure 10: Route of referral into RAHOS.

Half of clients reported that they had been referred into the service by the staff at The Whitechapel Centre (n=6, 50%) and the majority of the remaining clients had self-referred after speaking to someone else (n=5, 41.7%). The client who indicated that they had been referred by another service reported that they had been referred by a prison staff member.

Services received at the RAHOS

Clients were asked about the purpose for which they used the RAHOS and presented with a list of services offered by the RAHOS. Figure 11 illustrates the client's responses. The vast majority of clients indicated that they used to RAHOS to obtain a methadone prescription (91.7%, n=11) and almost half of the clients used the service for referral to another service (41.7%, n=5). One client reported that they used the service to obtain a prescription for anti-depressants. (Note that as clients could give more than one response the graph total adds to more than 100%).

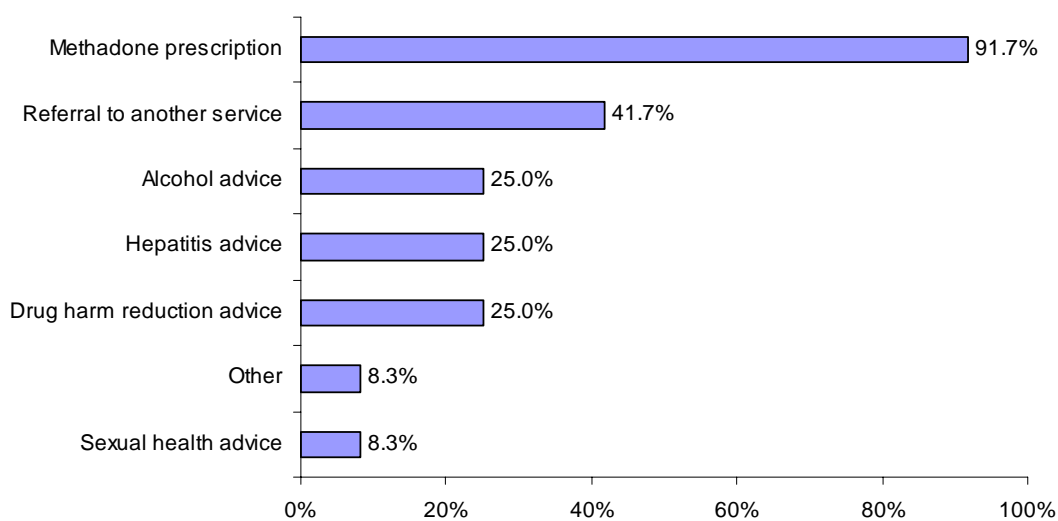


Figure 11: Purpose of use of the RAHOS

When asked if they were receiving treatment elsewhere, 41.7% (n=5) clients indicated that they were in treatment at another service, however, four of the five clients had completed their treatment at the RAHOS. All clients who were receiving drug treatment elsewhere reported that they were in contact with Liverpool DDU.

A variety of responses were recorded when the clients were asked why they used or had used the RAHOS and not another service elsewhere, however, a number of themes emerged in the responses:

- Access to methadone prescription was easier than elsewhere;
- The RAHOS was easy to access at The Whitechapel Centre as clients would attend the service during the day anyway;
- Clients were more comfortable using the RAHOS in the familiar environment of The Whitechapel Centre than other services.

Previous contact with the RAHOS

Three clients (25%) reported that they had had previous contact with the RAHOS but had not completed the 4-week treatment programme. Two of the

clients indicated that this had only happened on one other occasion and one client reported 4 other occasions of contact with the RAHOS.

Reasons for a break in their previous treatment with the RAHOS included:

- Missed appointment;
- Prison;
- Moved back to family home, but has since left again.

Gateway into Liverpool DDU

The vast majority (91.7%, n=11) of clients reported that they intended to attend Liverpool DDU when they completed their treatment. The other client indicated that they felt they did not need to contact Liverpool DDU as they had their drug use under control and only required help for their mental health problems, which they were receiving elsewhere.

Clients were asked to rate on a scale of 1-10 how happy they felt about attending Liverpool DDU when they completed their treatment at the RAHOS. Figure 12, below, illustrates the clients responses. The findings indicate that the majority of clients (81.8%, n=9) felt happy about attending Liverpool DDU when their treatment was completed (based on a score of 7 and above).

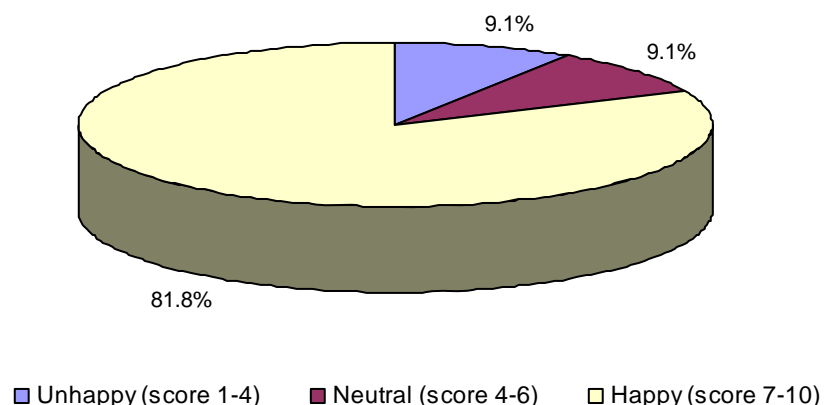


Figure 12: Client ratings of how happy they felt about attending Liverpool DDU once they had completed treatment at the RAHOS.

Evaluation of the RAHOS

Clients were asked to rate the RAHOS on a scale of 1 to 10, where 1 was very poor and 10 was very good. Three quarters of participants (75%, n=9) rated the service as good (based on a score of 7 and above) and the quarter rated the service as satisfactory (based on a score between 4 and 6). Almost half (41.7%, n=5) gave the RAHOS the top rating of 10.

Reasons for ratings scores included:

Satisfactory rating

- Lengthy wait to be seen;
- Difficulties explaining situation to RAHOS staff.

Good rating

- The doctor is very helpful;
- The RAHOS staff are there to help;
- Easy access to methadone script;
- Service is efficient.

Access to RAHOS

Clients were presented with another 10 point scale and asked to rate how easy they found the RAHOS to access, where 1 was very difficult and 10 was very easy. All clients rated the ease of access as 8 or above and 75% (n=9) gave the highest rating of 10.

Two clients (16.7%) reported that they had had problem accessing the service when they had wanted to. The problems reported were due to a previously missed appointment resulting in difficulties in accessing the service when they attended on another day without an appointment. One client reported that they had been turned away from the service once.

RAHOS Strengths and Weaknesses

The clients were asked open questions relating to the strengths and weaknesses of the RAHOS. The client's responses were coded according to themes. Figure 13 (below) illustrates that the majority of clients indicated that the easy access was the strength of the service (58.3%, n=7). (Note that the figures in the graph add to more than 100% as many clients gave more than one response).

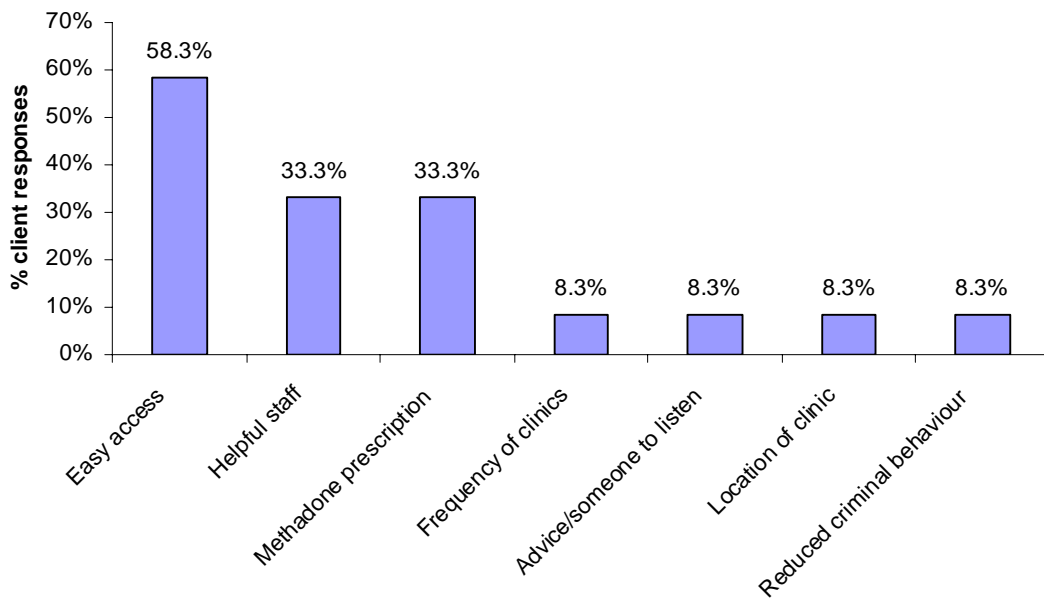


Figure 13: The strengths of the RAHOS.

When asked about the weaknesses of the service the majority of clients (83.3%, n=10) indicated that they did not think that the service had any weaknesses. Of those who did give a answer to the question, the responses included:

- Difficulties with access without an appointment;
- Inability to continue treatment at RAHOS for more than 4 weeks;
- Difficulties with RAHOS staff.

When asked what the benefits of the clinic had been for the clients three-quarters (75%, n=9) indicated that it was the methadone prescription and one quarter (25%, n=3) reported that the RAHOS had prompted their contact with Liverpool DDU. Other reported benefits included decreased drug use, reduced criminality and contact with the Kevin White Unit (inpatient detoxification service).

Additional comments

The client's responses when asked if they had any other comments are reported below.

"The (RAHOS) staff really go out of their way to help. There have been times when the clinics have run over in time just so that they can sort someone out."

"The service is a safety net."

"It has helped me a lot. It is a good service."

"They have always looked after me when I have needed it, whether I am early or late (for appointments)."

"Other places should have clinics like this because they are so good. The DDU is doing a good thing."

4. Additional Findings

Observation at The Whitechapel Centre and interviews with the RAHOS staff and stakeholders was undertaken in order to assess aspects of the RAHOS service that cannot be measured through data or client interviews.

Service users at The Whitechapel Centre have a good knowledge of the RAHOS service, however, there seems to be confusion among the clients regarding when the clinics are available. Some clients indicated that they expected the clinics to begin earlier and last longer (particularly when The Whitechapel Centre is open from 8 to 10am for rough sleepers only).

When clients attended The Whitechapel Centre without appointments for the RAHOS they were seen on a first-come-first-service basis. Clients were required to add their name to a list for the RAHOS if they wished to be seen at the service on that day. Typically, on each occasion that the clinic was in attendance at The Whitechapel Centre clients would attend who had missed their last appointment and wished to be seen. This potentially caused problems for the RAHOS staff and the clients as the demand outweighed the capacity of the clinic. No figures on the number of clients turned away on a monthly basis have been recorded.

Interviews with the staff at The Whitechapel Centre and other stakeholders (Basement & Armistead Street) indicated that the service is regarded as a positive step to engage homeless drug users in treatment. Staff at The Whitechapel Centre has been central in promoting the service among their service users. The RAHOS staff also agreed that the level of treatment engagement illustrated that there is a requirement for the service and it should continue to be funded on a permanent basis.

The RAHOS service at Armistead Street is run on one afternoon a week and in-house monitoring indicates that the service has improved the levels of

engagement with street sex workers with drug problems (Campbell, 2007). There has been a significant increase in the number of women involved in street sex work being assessed and accessing prescribed methadone treatment compared to before the RAHOS initiative was introduced.

Anecdotal findings to support the other aims of the clinic (i.e. aims 2-5, Page 7) were recorded. During client and staff interviews there was mention of reduced criminality, use of harm reduction advice, interest in further treatment and gaining drug free status and consideration of physical and mental well-being.

5. Conclusions

Treatment Engagement with RAHOS

Analysis of the data sources and observation at The Whitechapel Centre during the RAHOS clinics indicates that there has been a steady uptake in the service and that it is popular with clients. The location of the service within The Whitechapel Centre promotes engagement and is viewed positively by clients, staff and stakeholders.

Referrals into the RAHOS service are mainly initiated via staff at The Whitechapel Centre and word of mouth from other service users. The levels of treatment engagement with the RAHOS indicate that the RAHOS is achieving its main aim of providing access to service for the normally hard to reach homeless population in Liverpool. However, as the clinics did not always start and finish at the same time on each occasion there was confusion among clients regarding when they could and couldn't attend the service, particularly without an appointment.

The scope of this evaluation did not cover further effects of the clinic on the clients i.e. a more holistic analysis of the clients overall health, well-being and drug related behaviours. However, anecdotal information gained through discussion with clients, staff and stakeholders indicated that the other aims of the clinic are being addressed. Whilst the evaluation focused on clients who accessed via The Whitechapel Centre, monitoring data from Armistead Street showed an increase in street sex workers accessing methadone prescription (Campbell, 2007). A reduction in acquisitive crime, consideration of drug detoxification, reduction in the use of more risky methods of drug administration (i.e. injecting) and improved physical health were mentioned by clients and stakeholders.

Contact with Other Services

Analysis of three other data sources containing monitoring data indicated that the majority of the clients in contact with the RAHOS had contact with other services during 2006 and 2007. During 2006/07, the year before the RAHOS was established, over half of clients (55.6%, n=69) had been in structured treatment and 15.3% (n=19) had been in contact with syringe exchange, structured treatment and criminal justice services. The findings indicated that the majority of clients in contact with RAHOS had slipped through the net on at least one occasion, this is usually due to the chaotic nature and instability in their lifestyle.

Investigation of the NDTMS outcomes of those in contact with NDTMS and the RAHOS between March and December 2007 indicated that those in contact with structured treatment services after their RAHOS episode were more likely to have positive outcomes or be in an open episode on 31/12/2007.

Contact with Liverpool DDU

The RAHOS is the gateway for 'hard to reach' homeless drug users and women involved in street sex work from a low threshold open access service into mainstream structured drug treatment. Analysis of clients referred on from the RAHOS into other services indicated an initial level of engagement with other services was 100% and the majority of clients were referred on to Liverpool DDU. Further investigation of the client's outcomes when engaged with Liverpool DDU found that half of the clients were in ongoing treatment episodes on 31/12/2007, however, the majority of the other 50% of clients had an unplanned discharge.

The high levels of attrition of the RAHOS clients from Liverpool DDU indicate a significant problem with retention of this group in mainstream treatment services. Potentially, clients may be dropping out of treatment at Liverpool DDU due to their chaotic lifestyle and their inability to fit into a more traditional treatment system. Although the results indicate that this client group are less

likely to be retained in treatment, interpretation of these findings must be viewed with caution considering the low numbers of clients and the short time period for tracking the clients who had been referred on. Research indicates that the longer an individual spends in treatment and the more frequently they access drug treatment the more likely they are to have positive outcomes (Teesson et al., 2006), therefore although there is a high drop out rate from Liverpool DDU the access to treatment that the clients received should enhance the probability of a more positive outcome in the future.

Clients Views on The RAHOS

Interviews with a sample of the RAHOS clients at The Whitechapel Centre indicated that the service is well received by the clients, they feel that the consultations with the RAHOS staff have been beneficial and that they are happy to attend Liverpool DDU when their treatment is complete with the RAHOS. However, there some clients reported issues relating to confusion regarding when the clinic is available and problems re-accessing the service when they have missed appointments. The majority of clients interviewed rated the service highly.

Other Issues

Interrogation of the data source available from the RAHOS indicated that there may be an issue regarding discharge of clients on NDTMS. Only five clients in the RAHOS data extract had a discharge reason recorded as 'referred on', however, matching of the RAHOS clients to the overall NDTMS dataset indicated that 26 had left the RAHOS and attended Liverpool DDU. Further analysis of the 26 who had attended the RAHOS after contact with the RAHOS showed that in the RAHOS NDTMS data one client was discharged as 'referred on', 4 were discharged as 'dropped out/left' and the remaining clients were in an open treatment episode. The lack of discharge information on the RAHOS data may indicate a lack of communication between the RAHOS and Liverpool DDU which leads to problems with

accurate performance monitoring, evaluation and potentially clinical problems such as 'double scripting'.

Limitations of the Evaluation

Due to the limited scope of this evaluation only a small part of the client journey has been assessed. The additional issues for women involved in street sex work have not been considered. Further information on the client's treatment engagement pre and post-RAHOS would provide a richer picture of the overall impact of the RAHOS.

The focus of this evaluation has been on treatment engagement and retention in a short space of time, further research should investigate the economic cost of the RAHOS including unit costs, prevention of blood borne viruses, improvements in physical and mental health and reduction in drug related deaths among this vulnerable population.

6. Recommendations

Recommendations based on the evidence presented in this report are outlined below.

1. Further investigation on high levels of attrition from Liverpool DDU

Further analysis of why clients are dropping out of treatment from Liverpool DDU is required in order to promote retention among this client group.

2. Throughcare provision by RAHOS

In order to address the high attrition rates of the clients referred into Liverpool DDU an integrated delivery of treatment between the RAHOS and Liverpool DDU is recommended at the beginning of the clients mainstream treatment journey. In order to provide throughcare for all clients during their transition from the RAHOS to Liverpool DDU additional resources may be required on the RAHOS team. This recommendation should be considered as an additional aspect of Recommendation 1.

3. Further analysis of how the RAHOS is performing against its other aims

Analysis of how the RAHOS is performing against aims 2 to 5 (Page 7) was not included in the scope of this report, however, anecdotal information indicates that the service is enhancing the overall health and well-being of the clients. Further investigation specifically aimed in these areas would provide a better overall picture of the RAHOS effectiveness.

4. Review of the RAHOS 'opening hours'

Confusion relating to when the RAHOS could be accessed was apparent among the client group. A review to assess if clients were aware of the clinic times and the most appropriate times to achieve high levels of penetration among the client group is required.

5. Recording of the number of clients turned away from the RAHOS

Collation of the number of clients turned away from the RAHOS on a monthly basis would provide the commissioners with a more accurate picture of demand and the resources required to achieve the highest possible levels of penetration.

6. Ongoing evaluation and monitoring of the RAHOS

A more detailed evaluation with a wider scope would provide a better picture of the effectiveness of the RAHOS. The evaluation should consider a cost-benefit analysis, a review of all the aims of the service, a holistic view of the client's treatment journey (pre and post-RAHOS contact), an examination of the particular issues for women involved in street sex work and further analysis of retention.

Box 3: Evaluation Summary

This evaluation has shown that the RAHOS is effective in achieving its main aim of engaging 'hard to reach' homeless substance users in treatment.

The RAHOS has:

- Attracted members of the most vulnerable group into treatment;
- Attracted groups under-represented in treatment (homeless, women, ethnic minorities);
- Enhanced the treatment outcomes for those who attend the RAHOS; and
- Promoted initial contact with mainstream treatment services within this group.

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Useful links

<http://www.armisteadcentre.co.uk/>

<http://www.whitechapelcentre.co.uk/index.htm>

<http://www.basementdropin.org.uk/>

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Appendix 1: Glossary

Definitions of Terminology

Successful Completion

A successful completion is defined as a person being discharged from treatment having completed the treatment or completed drug free or being referred on to another treatment service. Discharge reasons in the list below are considered by the NTA as successful completion:

- Treatment completed
- Treatment completed drug free
- Referred on

Unplanned discharge

Discharge reasons in the list below are considered by the NTA as unplanned discharge/unsuccessful discharge:

- Treatment withdrawn/Breach of contract
- No appropriate treatment available
- Dropped out/Left
- Moved away
- Prison
- Died
- Treatment declined by client
- Inappropriate referral

Ongoing

All clients in an open treatment episodes at the end of a reporting period.

- 2006/07 – in an open treatment episodes on 31st March 2007
- 2007/08 year-to-date – in an ongoing episode on 31st December 2007

Appendix 2: Structured Questionnaire

Rapid Access Outreach Service Evaluation Questions Participants

Section A: About You

This section asks questions about you.

A1. Initials

--	--

A2. Date of Birth

dd	mm	yyyy

Age (if DOB is not known)

A3. Gender

Male	Female
------	--------

A4. Looking at this card, which of the following best describes your Ethnicity? *(show list)*

--

A5. Where did you spend the majority of your life up to the age of 16? *(postcode if possible or area of city or town)*

--

A6. Are you currently employed?

Yes	No
-----	----

If yes, what kind of work do you do?

If No, when were you last employed (years/months) and what kind of work did you do?

Section B: Your Accommodation Status

Now I am going to ask you some questions about your homelessness

B1. What was the initial cause of your accommodation problems?

B2. Have you **ever** slept rough?

Yes	No (<i>Go to QB5</i>)
-----	-------------------------

B3. When did you last sleep rough?

<input type="text"/>	Nights/ weeks / months / years ago (<i>delete as appropriate</i>)
----------------------	---

B4. On the last occasion that you slept rough, why was it?

B5. Looking at this card, in which types of accommodation have you lived in the past 6 months? *(Tick all that apply)*

1	Council Tenancy	<input type="checkbox"/>
2	Hostel	<input type="checkbox"/>
3	Housing Association property (e.g. LHT, Riverside)	<input type="checkbox"/>
4	Bed and Breakfast	<input type="checkbox"/>
5	Staying with friend/relative	<input type="checkbox"/>
6	Sleeping Rough/Skippering	<input type="checkbox"/>
7	Didn't bed down	<input type="checkbox"/>
8	Prison cell/Police Cell	<input type="checkbox"/>
9	Hospital	<input type="checkbox"/>
10	Other accommodation (Please specify below)	<input type="checkbox"/>

B6. Looking at this card, where did you stay last night? *(show list – enter one code in box below)*

	If 'Other' please specify where.
--	----------------------------------

B7. How long have you been living in the above situation?

	Nights/ weeks / months / years <i>(delete as appropriate)</i>
--	---

B8. Have you ever been in prison?

Yes	No <i>(Go to Section C)</i>
-----	-----------------------------

B9. How many times have you been in prison....

	No. of times
On remand?	
Sentenced?	

1. Have you ever heard of the Rapid Access Homeless Outreach Service?

Yes (Go to Q2)

No (Go to Q5)

2. Have you ever used this Service?

Yes (Go to Q3)

No (Go to Q5)

3. How did you begin using the Service? *(tick one only)*

Someone told me about it & I self-referred

Referred by Whitechapel

Referred by Brownlow Practice

Referred by Armistead

Referred by another agency *(specify)*

Referred another way *(specify)*

4. For what purpose have you used the Service? *(tick all that apply)*

		Rate* (1-10)
Methadone prescription	<input type="checkbox"/>	
General harm reduction advice (drugs)	<input type="checkbox"/>	
Advice regarding Hepatitis	<input type="checkbox"/>	
Advice regarding alcohol (including detox)	<input type="checkbox"/>	
Referral to another drug service	<input type="checkbox"/>	
Sexual health advice	<input type="checkbox"/>	
Something else <i>(please specify below)</i>	<input type="checkbox"/>	

*Rate from 1 (very poor) to 10 (very good)

5. Are you currently in contact with any agencies/receiving treatment for drug

Yes Where & what for? →

No (Go to Q6)

(If client answered No to Q1 & Q2 go to Q19)

Go to Q7

6. Why do you use the Rapid Access Service and not somewhere else e.g. GP or DDU?

7. At what week of contact with the Service are you currently at? *(circle one response)*

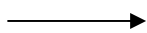
Week 1 Week 2 Week 3 Week 4 Don't know

8. Have you attended the Service on another occasion before this 4 week contact period? *(an occasion is any period of consecutive appointments)*

Yes (Go to Q9)

No (Go to Q10)

9. On how many occasions have you previously been in contact with the Service? *(an occasion is any period of consecutive appointments)*
(if the client has difficulty understanding this Q – ask them how many initial assessments they have undergone at the Service)



Why didn't you complete your last 4 week period of treatment?

10. Do you intend to attend the DDU for continued treatment when your 4 weeks with the Service is finished?

Yes (Go to Q11)

No

Don't know

Why? Do you intend to go somewhere else for treatment? If yes, where?

Go to Q12

11. How do you feel about attending the DDU when you finish your treatment with the Service? *(circle one response only)*

1 2 3 4 5 6 7 8 9 10
Very Very
unhappy happy

12. How would you rate the Service? (circle one response only)

1 2 3 4 5 6 7 8 9 10
Very poor Very good

Explain reason for response above

13. On the scale below please rate how easy the Service is to access compared with other services. (circle one response only)

1 2 3 4 5 6 7 8 9 10
Very difficult Very easy

14. Have you had any problems accessing the clinic when you have needed to?

Yes (Go to Q15)

No (Go to Q16)

15. What were the problems that you have had?

How many times have you been turned away from the clinic, if ever?

16. What do you think are the strengths of the Service?

17. What do you think are the weaknesses of the Service?

18. What have been the benefits of the clinic for you?

19. Do you work in the sex trade?

Yes

No

Don't want to answer

20. Are you pregnant?

Yes

No

Don't want to answer

Any other comments about the Service