Manchester Metropolitan University

Change Grow Live's Manchester Rapid Prescription Service for Rough Sleepers

DRUGS, POLICY & SOCIAL CHANGE

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Change Grow Live

Contents

Executive Summary

This report presents the findings of an Innovate UK Accelerated Knowledge Transfer (AKT) project evaluating Change Grow Live's Rapid Prescription Service (RPS), originally developed within Manchester's Street Engagement Hub (SEH) to improve access to Opioid Substitution Treatment (OST) for people experiencing street-based homelessness ('rough sleeping') and dependent opioid use. The evaluation examined the effectiveness of the service in reducing barriers to treatment, improving engagement and retention, supporting harm reduction, and responding to the growing risks associated with Novel Synthetic Opioids (NSOs). The study was conducted between November 2025 and February 2026 and involved qualitative interviews with 21 participants, including Change Grow Live staff, partner agencies and service users.

The findings demonstrate that the RPS addresses many of the structural barriers associated with traditional prescribing pathways. Participants consistently reported that conventional OST systems often require multiple appointments over a period of several weeks before treatment can begin. For people experiencing homelessness, unstable housing, chaotic substance use, or complex health needs, these delays frequently result in missed appointments, disengagement and continued reliance on illicit opioid use. In contrast, the RPS enables service users to complete assessment, medical review and prescribing within the same day or the following day, significantly reducing the risk of losing individuals during the brief period in which they are motivated and ready to engage with treatment. The evaluation found that this immediacy is central to the effectiveness of the model and should be understood as a form of harm reduction in its own right.

A key strength of the Manchester model is the use of a streamlined and often jointly delivered assessment process. Rather than requiring service users to repeatedly recount personal histories and attend multiple appointments, key workers and prescribers frequently conduct integrated assessments that reduce duplication and accelerate access to treatment. Participants reported that this approach not only improves efficiency but also reduces anxiety, minimises the potential for re-traumatisation and creates a more person-centred and trauma-informed treatment experience. The findings suggest that this streamlined assessment model is an important component of the service's success and should be protected as the model expands.

The evaluation also found strong evidence that rapid prescribing functions as an important response to the emergence of NSOs, including nitazenes, within the illicit drug supply. Participants consistently viewed rapid access to OST as a critical intervention for reducing exposure to contaminated heroin and lowering overdose risk. By reducing dependence on illicit opioid markets, the service provides immediate protection against the unpredictable potency of NSOs while simultaneously supporting longer-term engagement in treatment. Change Grow Live's staff described the national expansion of rapid prescribing as a necessary and proportionate response to the changing risk environment and identified it as an important strategy for reducing drug-related deaths.

Alongside rapid prescribing, testing strips, naloxone provision and local drug intelligence systems were identified as important elements of Change Grow Live's wider harm reduction response. Service users demonstrated meaningful engagement with testing strips, and staff reported that their use often created opportunities for conversations about overdose risk and safer consumption practices. Although participants acknowledged limitations regarding reliability and interpretation of testing-strip results, the findings indicate that they contribute positively to risk awareness, early warning systems and intelligence gathering. These interventions complement rapid prescribing by helping services identify emerging threats and respond quickly to changes in local drug markets.

Beyond overdose prevention, the RPS was associated with a wide range of broader health and social benefits. Participants described rapid prescribing as providing immediate stabilisation, reducing withdrawal-related distress and creating opportunities for the development of routine and structure. Through daily pharmacy attendance and increased contact with services, individuals were able to access wider healthcare support, including physical health interventions, blood-borne virus testing and referrals to specialist services. Clients and staff also reported reductions in acquisitive crime, begging and other street-based survival behaviours, reflecting the reduced need to generate income to purchase illicit opioids. The evidence therefore suggests that the benefits of rapid prescribing extend beyond clinical outcomes and contribute to wider improvements in wellbeing, public safety and social inclusion.

The service was also found to play a significant role in supporting re-engagement and retention within treatment. Participants highlighted that relapse and treatment drop-out are common features of opioid dependence and emphasised the importance of rapid, non-punitive pathways back into treatment. By reducing barriers to re-entry, the service minimises the amount of time individuals spend outside treatment and therefore reduces periods of heightened overdose and harm risk. Trust, flexibility and a welcoming service culture were repeatedly identified as critical factors underpinning sustained engagement. The long-standing presence of the Street Engagement Hub has enabled it to become a trusted and recognised service within Manchester's rough sleeping community, with many service users learning about the service through peer recommendation.

While the findings strongly support the effectiveness of the RPS, participants identified several considerations for future development. These include protecting dedicated rapid prescribing capacity, maintaining fidelity to the joint assessment model, ensuring adequate workforce and administrative infrastructure, securing sustainable funding arrangements and strengthening systems for monitoring outcomes and emerging drug market threats. Participants also highlighted opportunities to explore wider rapid-access models for individuals experiencing harms associated with substances beyond opioids.

Overall, this evaluation demonstrates that Change Grow Live's RPS is an innovative, evidence-informed and highly effective model of engagement with the rough sleeping community, providing a range of harm reduction benefits. The findings show that rapid prescribing is considerably more than a faster route into treatment. It

is a person-centred intervention that improves access, reduces structural barriers, enhances engagement, responds to emerging drug threats and supports a broad range of positive health and social outcomes. The evidence presented in this report supports the continued protection, development and wider implementation of the model both within Manchester and across other Change Grow Live services.

1. Introduction

This Academic Knowledge Transfer (AKT) project was commissioned to evaluate the implementation and effectiveness of Change Grow Live's Rapid Prescription Service (RPS). This project ran for 13 weeks from November 2025 to February 2026 and was funded by Innovate UK (90%) and Change Grow Live (10%).

First introduced in 2019 as part of Manchester's Street Engagement Hub (SEH), the RPS has been expanded nationally since late 2024 in response to the growing presence of NSOs in the illicit heroin supply. The RPS aims to reduce drug-related harm by improving access to Opioid Substitution Treatment (OST), removing barriers to treatment entry, and reducing exposure to NSO-contaminated substances. By streamlining prescribing processes, the service seeks to engage individuals who may not access traditional treatment pathways. Change Grow Live's rapid prescribing offer was initially created with the aim of engaging rough sleepers in central Manchester into drug treatment, as this cohort will typically experience more treatment barriers than people who use opiates and are housed.

This study evaluates the rollout of the RPS across central Manchester services, focusing on how effectively it addresses barriers within conventional OST provision, while identifying any remaining challenges for service users. It also explores how increased access to OST supports harm reduction behaviours, including drug testing and improved data-sharing with Local Drug Information Systems (LDIS), contributing to more responsive interventions and reduced harm at both individual and population levels. This research found that the RPS is successful in its aims to remove barriers for access for people who use heroin, and there are clear indicators that this has increased engagement with services and has resulted in some service users adopting the use of test strips in order to reduce risk of overdose caused by NSOs contamination.

2. Background & Context

There were 329,646 adults in drug and alcohol treatment in England in 2024/2025, this is the highest reported numbers of individuals in treatment since records began, and a 6% rise from the previous year (OHID, 2025). Almost half (44%) of those in treatment were seeking support regarding the use of opiates (OHID, 2025).

There is clear evidence that states that among people dependent on opioids, mortality rates are approximately twice as high during periods when individuals are not receiving OST compared with periods when they are engaged in treatment (Cornish et al., 2010, ONS, 2025). However, deaths in treatment still occur. 1.3% of all adults in drug and alcohol treatment died within the last year, and opiates users made up two thirds of this group at 63%, demonstrating the increased level of risk

among this cohort (OHID, 2025). People who use opiates are at a substantially higher risk of mortality than those who use other substances, with just under half of all drug poisoning deaths in 2024 (47.1%) involving an opiate/opioid (ONS, 2025).

OST has long been a well-established harm reduction method for people who use heroin. The National Drug Treatment Monitoring System (NDTMS) states that of those currently undergoing OST in England, 70% are prescribed methadone and 30% are prescribed buprenorphine (DHSC, 2024). OST reduces harm for people who use heroin by, reducing risks associated with injecting, contaminated street-heroin and overdose. The evidence supports this and highlights the relationship between opiate use and rough sleeping. For example, of those beginning treatment for opiate use from June 2023 to June 2024, 18% reported that they were at risk of homelessness and 39% reported having no home of their own (OHID, 2024).

The clear links between opiate use, mortality and homelessness demonstrate the complexity of supporting this cohort of service users. By Change Grow Live providing rapid access for people who use heroin, access to treatment becomes more realistic for a cohort of individuals who are historically difficult to engage in treatment and struggle to adhere to appointments. Change Grow Live's RPS attempts to break down remaining barriers for those wanting to access OST by significantly reducing wait times, increasing engagement and encouraging reintegration into treatment.

Change Grow Live's RPS was launched in 2019 as part of Manchester's Street Engagement Hub (SEH). The Street Engagement Hub is a multi-agency partnership that was formed in 2019 which included organisations such as: Change Grow Live, GMP, Riverside Housing, the Probation Service, Department Work and Pensions (DWP), Manchester Action on Street Health (MASH), Big Life, and local homeless charities such as Coffee4Craig. The SEH was developed to address the underlying causes of homelessness within Manchester city centre, with the initial aim to decrease anti-social behaviour (ASB) and break the cycles associated with crime and rough sleeping. Greater Manchester Police (GMP) had observed that problematic substance use was the main motivator for ASB and criminal activity for this cohort.

The aim of this partnership was to create a one stop shop for rough sleepers to access services that could support them to get into stable housing, reduce ASB and engage with a range of support services. Change Grow Live's role in this partnership was fundamental, and as part of their offer for the SEH, Change Grow Live introduced same-day rapid prescribing. The RPS was introduced to enable better engagement with a particularly vulnerable yet difficult to engage cohort. The RPS operated through drop-in sessions during the days that the SEH was open (Tuesday and Thursday), enabling service users to complete their triage, initial assessment, medical assessment and receive their OST prescription in the space of a couple of hours. This process typically took three to four weeks using the traditional OST pathway in core services. This wait time posed a major barrier for those seeking treatment as many rough sleepers face considerable instability, making it difficult for them to remember and attend multiple assessment appointments.

Since the original implementation within the SEH in 2019, Change Grow Live has extended its RPS to some core teams nationally in line with recommendations from the Department of Health & Social Care (2024). These updated recommendations are in response to the increased amount of NSOs being found in the illicit market and in drug related deaths. There was a sharp increase in the number of nitazene related deaths (195) in 2024, approximately four times higher than in 2023 (ONS, 2025). These statistics demonstrate a clear need for opioid users to rapidly access OST to reduce harm.

3. Methodology

3.1 Project Aim

This Accelerated Knowledge Transfer (AKT) project aimed to validate Change Grow Live's innovative RPS and explore its potential to reduce harm among people who use heroin, particularly in response to growing concerns regarding the rise in NSOs in the UK.

3.2 Project Objectives

- To develop increased engagement and a more effective treatment offer for rough sleepers who smoke or inject heroin via rapid prescribing.
- To establish a more efficient use of Change Grow Live's resources including reducing the cost of emergency interventions whilst enabling them to support more people across their services.
- To identify 'what works', informing Change Grow Live's resource allocation implementation across other Change Grow Live's sites.
- To scale up Change Grow Live's innovative harm reduction service.
- To reduce the scale of, and severity of need among people presenting with emergency health crises, overdoses, and long-term complications.
- To reduce drug related deaths.
- To enhance access to life-saving naloxone and new synthetic opioids test strips.
- To better protect rough sleepers from the increased risk of harm from new synthetic opioids.
- To help marginalised and vulnerable people who use heroin to engage when they are treatment ready, enabling people to be treated for drug dependency and addiction, and lead longer, healthier lives.

Ethical approval for the study was granted by the Arts and Humanities Faculty Research Ethics and Governance Committee at Manchester Metropolitan University (EthOS Reference Number: 82323).

A qualitative research design was adopted, using semi-structured interviews to collect data revealing the complexity of opioid substitution treatment (OST) from a

diverse range of perspectives - including Change Grow Live staff delivering the intervention and service users receiving treatment and non-Change Grow Live professional stakeholders.

Data collection took place between 26th November and 22nd January, during which a total of 21 interviews were conducted. To support recruitment of service users, the research team conducted 14 visits to the Street Engagement Hub, located at The Mustard Tree in Manchester, over the 13-week study period.

The research participants included 12 Change Grow Live staff members, four non-Change Grow Live professionals with experience of the RPS (a Commissioner, a Police Officer from Greater Manchester Police's Street Engagement Team, SEH Triage, and the Greater Manchester Early Drugs Warning System Coordinator), and five service users who had accessed the service via the Street Engagement Hub. The service users were all White British men from Greater Manchester, aged between 32 and 58 years. The small sample size of service users interviewed, and the lack of engagement with women or those from ethnically minoritised backgrounds, is a clear limitation. However, it does reflect the overwhelmingly middle-aged white male profile of Manchester's rough sleeping population. The 12 Change Grow Live staff participants included seven who were employed in homeless outreach services, three in core teams, and two harm reduction specialists.

In addition to this interview data, Change Grow Live provided monitoring data relating to the RPS. The report also presents four anonymised case studies illustrating the experiences of Change Grow Live service users who have accessed the RPS. These case studies were collected by the outreach team and subsequently anonymised by the Research Associate in line with ethical practice. Names have been replaced with pseudonyms.

All interviews were audio-recorded and transcribed verbatim. Data were analysed using thematic analysis, to identify key themes and sub-themes across the dataset. This approach was selected due to its theoretical flexibility (Braun and Clarke, 2008) and its suitability for exploring experiences, perspectives, and social processes in depth (Ahmed et al., 2025). The themes generated through this process are presented and discussed in the following section of the report.

4: Findings

4.1 Evaluation of the Rapid Prescription Service

4.1.1 Barriers within Traditional Pathways

Interview data consistently identified significant delays within the traditional opiate substitution treatment (OST) pathway. While initial triage was often described as timely, staff reported that individuals were then required to wait between three and five weeks for assessments, medical appointments, or prescribing clinics.

These waiting periods were widely described as incompatible with the lived realities of individuals who are rough sleeping or experiencing chaotic substance use. Change Grow Live staff emphasised that prolonged delays undermine engagement at the critical point when individuals are motivated to seek treatment.

As one Outreach Recovery Coordinator explained:

> *"And at that point, so let's just scenario this, you walk into a base (core team), you get triaged, that's good, same day, then you're given an appointment to come back for an assessment… turnaround was like three to four weeks, maybe five. The rough sleeping population would never, ever, ever be able to do that."* (Recovery Coordinator 1)

Another member of staff described the direct impact of delay on motivation:

> *"The kind of traditional prescribing process, people can be waiting, I don't know, three, four weeks to get into appointments. I guess the difference really is kind of the timeline because obviously a lot can happen in three weeks for people and they might lose their motivation."* (Recovery Coordinator 3)

These delays were not framed as minor administrative issues but as key structural barriers that directly undermine engagement. It was noted that the traditional pathway creates multiple points at which individuals can disengage before treatment even begins.

Staff consistently contrasted long wait times with the realities of unstructured lifestyles, particularly among those rough sleeping. Interviewees described how the structure of traditional appointment-based systems does not align with the circumstances of many individuals who are living street-based lifestyles and seeking OST.

One Outreach Recovery Coordinator reflected:

> *"you're asking someone who's woken up in a doorway on a really cold day like today, and rightly or wrongly, their priority is not, 'oh, I really need to get to that appointment at 10 o'clock'."* (Recovery Coordinator 1)

Similarly, a Team Leader described the impracticality of future-dated appointments:

> *"The traditional pathway, there's lots of room to not engage, yeah, there's a lot of room for you to just drop off or forget your appointment or DNA [do not attend] it or rearrange it or this, that and the other [. . .] we're working with the rough sleeping community, they very rarely have watches or phones and struggle to keep to any sort of un-chaotic life rules, so to say that 'I need you to come back a week on Thursday' to come to get a medical assessment and you'll get scripted... they don't know what a week on Thursday is."* (Team Leader 2)

The traditional pathway was further characterised as containing "lots of room to not engage":

Taken together, these accounts demonstrate that the structure of the traditional OST model is clearly misaligned with the needs of individuals experiencing homelessness and instability. A lack of engagement is not down to unwillingness, but due to systemic design that does not accommodate chaotic living conditions, and other barriers people who are rough sleeping face.

4.1.2 Same-Day Access and Motivation

In a randomised controlled trial, Ayres et al. (2014) found that participation in the 'script in a day' intervention enabled same-day access to methadone and reduced drug use. Notably, over half of participants were still receiving opioid substitution treatment (methadone or buprenorphine) at three-month follow-up. Similarly, accounts from the Street Engagement Hub staff demonstrates how rapid prescribing significantly reduces barriers for people who use heroin to access OST and maintain treatment support. By compressing assessments and prescribing into a single-day process, the Manchester outreach model captures individuals during a critical window of motivation, which traditional prescribing would be unable to achieve. Nine out of ten (89%) of people using opioids who presented to the service received opioid substitution treatment (OST), indicating that the rapid prescribing model effectively facilitated access to treatment for most service users, supporting its role in reducing barriers to care.

Change Grow Live staff members reported:

> *"Someone can walk into the street engagement hub, be triaged, assessed, and see a medic all in one day."* (Recovery Coordinator 1)

> *"Someone can leave with a prescription that starts that same day."* (Team Leader 1)

Change Grow Live staff emphasised that reducing waiting times from weeks to hours directly increases the likelihood of engagement, while reducing the barriers that are seen within the traditional system. One senior member of staff summarised the shift clearly:

> *"If you look at a base (core team) environment, it takes roughly about a month to get on a prescription, whereas we were doing it in an hour!"* (Team Leader 2)

The experiences recounted by service users provided further support for this claim:

> *"I just went in, went in, gave a urine sample, spoke to the lady and that, do you know what I mean? Told her what's going on and stuff and then she's got me scripted straight away."* (Early 50s, male, Salford)

The need for the provision of a rapid prescribing response is further underscored by the physical realities of withdrawal. As one Outreach Recovery Coordinator explained:

> *"Even an hour can be a long time. Because if they've come in and they've not had a hit that morning, or they've not had a drink that morning, they're heading into withdrawal, you know, their priorities change. It's like, 'I need to go, I need to go, I need to get well'."* (Recovery Coordinator 1)

This highlights how even short delays can result in disengagement due to the physiological impact of dependence and withdrawal. Rapid prescribing therefore functions not only as an efficiency measure, but as a harm reduction strategy aligned with the lived experience of service users.

The local Drug and Alcohol Commissioner also noted the benefits of the RPS in removing barriers:

> *"Removing wait periods, removing the traditional barriers."* (Drug and Alcohol Commissioner)

In summary, it was evident that the RPS provides an important direct response to the structural barriers that have been documented within the traditional treatment model. By reducing the time between help-seeking and treatment initiation, RPS captures motivation at the point it emerges, rather than allowing it to dissipate.

4.1.3 The Need for a Rapid Response

The importance of speed of access to treatment at the point of motivation was consistently emphasised across roles, regardless of the service users housing situation. As one Recovery Coordinator stated:

> *"When that person has made that step, that needs to be actioned in the quickest possible fashion."* (Recovery Coordinator 4)

This statement reinforces a central finding of this report: that hesitation or delay within the treatment pathway risks losing individuals altogether. For many service users, the decision to engage is momentary and influenced by complex and fluctuating circumstances. Rapid prescribing attempts to capture that moment before competing priorities, withdrawal, or instability intervene.

The significance of timely access to OST was also reinforced by other street engagement hub professionals:

> *"He'd been through our hands a couple of times, and we said to him, like, 'what would have made the biggest difference to you in all the time we've*

been dealing with you?' And he said, 'getting the script faster'." (Police Officer, Manchester Street Engagement Team)

Staff working within the SEH further linked rapid prescribing to broader recovery trajectories:

> "*They're on the streets because of addictions, rough sleeping, relationship breakdown. So, we need to get things put in place to get them off the street, and that's the first thing, is to get them on a script.*" (Triage, Street Engagement Hub)

Collectively, these findings validate the Manchester RPS model as an effective approach to improving treatment engagement for rough sleepers by aligning access to OST with the lived realities of this population.

4.1.4 Immediate Outcomes

There was strong agreement across participants that rapid prescribing delivers immediate and observable positive outcomes for individuals accessing treatment. These outcomes include increased engagement with services, reduced anxiety linked to withdrawal, and early stabilisation. Staff consistently linked these benefits directly to the speed of access provided through the Street Engagement Hub.

For individuals experiencing unstructured lifestyles, particularly those rough sleeping, the immediacy of access was described as critical. As one Police Officer observed:

> "*The chaotic people, if they can get really fast access to a script, you can have quick wins.*" (Police Officer, Manchester City Centre Street Engagement Team)

This highlights how rapid prescribing can interrupt cycles of drug-seeking behaviour and create opportunities for immediate stabilisation. These early "quick wins" can help build momentum for sustained engagement with treatment.

Service users also articulated the positive emotional impact of receiving same-day treatment:

> "*I mean, getting treated straight away, getting scripted and that. Man! Getting looked after and that, you know what I mean? Just getting the right service at the right time.*" (Early 50s, male, Salford)

This illustrates how rapid access not only addresses clinical need but also contributes to feelings of being valued and supported. This shift in perception is significant, as trust in services has historically been a barrier for this cohort.

Street Engagement Hub staff further highlighted the role that rapid access to scripts plays in reducing anxiety:

> "*The fear of withdrawal is such an added anxiety to people with an abundance of mental and physical health issues.*" (Triage, Street Engagement Hub)

By reducing the immediate fear of withdrawal, the RPS service reduces the urgency to obtain street drugs, thereby reducing exposure to contaminated supply (see section 4.2). In addition, the rapid provision of support can promote feelings of being looked after and help establish trust in services, increasing individuals' readiness to engage with workers and return for ongoing support. In this way, the immediate psychological impact of rapid prescribing also functions as harm reduction.

Collectively, these findings demonstrate that rapid prescribing does not simply accelerate administrative processes; it produces immediate clinical, psychological, and engagement-based benefits. The speed of access is central to these outcomes.

4.1.5 Streamlined Process

A further commonly reported benefit of Change Grow Live's RPS is the adaptation of the traditional triage–assessment–medical pathway into a single, joint assessment model. Rather than requiring service users to attend multiple appointments and repeat their personal histories, the outreach team frequently combines the key worker assessment and medical appointment into one session.

This modification is designed to reduce both time and emotional burden. In doing so, it not only accelerates access to OST but also reflects a more trauma-informed approach to care, while reducing the risk of service users disengaging before receiving their prescription.

As one Team Leader explained:

> "*The assessment and the medical gets done at the same time.*" (Team Leader 1)

This process was further explained and the benefits reinforced by Change Grow Live staff:

> "*A joint assessment, so it's the medic and a recovery worker, or a key worker, would be doing it together. So, you're not asking questions twice. Your personalised assessment, then the medical assessment just happens in the one space. And that just cuts everything down by half, basically.*" (Harm Reduction Worker 1)

> "*We'll do it all together, so me and the recovery worker will do the assessments together, so they'll take information from what I'm saying and asking and vice versa.*" (Non-Medical Prescriber)

These Change Grow Live staff accounts demonstrate how the streamlined model reduces duplication and shortens time to prescription. More importantly, it minimises the emotional impact of repeatedly recounting potentially traumatic experiences. For individuals with complex histories, being asked the same safeguarding or substance use questions multiple times can increase distress and reduce the likelihood of continued engagement.

These findings indicate that combining assessments not only increases efficiency but also enhances trauma-informed practice, supports engagement, and strengthens

early retention within treatment. This operational adjustment represents a key structural component of Manchester's RPS effectiveness.

However, this streamlined approach is not consistently implemented across all service areas. A Recovery Coordinator from the Manchester core team highlighted that in some services, rapid access appointments remain separated, which can negatively impact service users:

> *"So I have fed back that at times, I think for a rapid access appointment, it really should all take place at the same time. Quicker for the client, less painful because they don't have to keep repeating themselves, which can be traumatic and triggering."* (Recovery Coordinator 3)

This suggests that, although the joint assessment model is regarded as a key strength of the RPS pathway within the SEH, it is not consistently implemented across the wider service. As a result, a core component of the Manchester Rough Sleepers RPS model is applied inconsistently, potentially reducing its effectiveness.

4.2 Rapid Response to NSOs and Harm Reduction Approaches

4.2.1 Response to NSOs

In 2024, synthetic opioids (primarily fentanyl) accounted for 60% of all overdose deaths (48,000 people) in the United States (GAO, 2025). However, while fentanyl and its analogues continue to cause thousands of fatalities, detections of nitazenes, a class of synthetic opioids that are even more potent, have increased in the last five years. Since 2021, Europe has seen a higher number of new unique nitazenes than fentanyl analogues (UNODC, 2024). In the UK, the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) drug related deaths toxicology reports has identified more nitazenes than fentanyl analogues (2024).

Scotland's Rapid Action Drug Alerts and Response (RADAR) quarterly report, published in January 2026, reported that nitazenes were the most frequently detected new synthetic opioids in Scotland during 2025. However, the report also notes that following recent global controls on nitazenes, a new group of synthetic opioids, commonly referred to as orphines, has begun to emerge within the UK drug market. Between September and December 2025, orphines were identified in seven samples submitted to the WEDINOS drug checking service from England (RADAR, 2026). Identified substances include 5,6-dichloro desmethylchlorphine, N-propionitrile chlorphine (cychlorphine), spirochlorphine, and etodezitramide.

A Drug and Alcohol Commissioner emphasised that resource allocation must prioritise those at highest risk:

> *"For us it's around providing that additionality resource for people who are really poorly and need it most."* (Drug and Alcohol Commissioner)

As previously outlined (see Section 1), Change Grow Live has provided rapid access prescribing for street-based populations through the Street Engagement Hub since

2019. However, the emergence and proliferation of potent NSOs within the illicit drug supply has significantly increased levels of risk. Since first appearing in death registrations in 2020, deaths involving nitazenes have risen sharply. In 2024, 195 deaths involving nitazenes were registered, almost four times the number recorded in 2023 (52 deaths) (ONS, 2025). This trend underscores the need for rapid treatment responses to reduce the risks associated with NSO-contaminated drug supplies and facilitate timely access to opioid substitution treatment (OST).

In 2024, the Office for Health Improvement and Disparities (OHID) published updated guidance on methadone and buprenorphine prescribing, stating that: "*All appropriate patients in every locally commissioned drug treatment system should have access to rapid prescribing, including on their first day in the service*" (OHID, 2024).

As one Recovery Coordinator stated, the increased risk NSOs pose warrants a change to traditional prescribing models outside of the SEH:

> "*They brought in rapid prescribing next day (nationally), within the last year. And that came on the back of the fear and worry and expectation of a flood of nitazenes and xylazines [. . .] I think it's an understandable justified panic. Because if we did or do get a flood of fentanyl, nitazenes, xylazine, like if you look at what's happened in the States, like it is an epidemic.*" (Recovery Coordinator 1)

In response to increased threat of these new synthetic opioids, Change Grow Live has been pre-emptive in its service adaptation, widening the rapid prescribing offer nationally, including extending it to core teams in Manchester, beyond the rough sleeping cohort.

As this Project Manager explained:

> "*Previously, it'd be between four and six weeks from referral to somebody getting into treatment, so the base (core team) has never done any rapid prescribing at all until the nitazenes came on the scene.*" (Project Manager 1)

Reflecting on the awareness of the severe overdose crisis observed internationally, Change Grow Live staff unanimously viewed the level of concern surrounding synthetic opioids and the need to adapt as proportionate to the potential harm.

> "*You've got the nitazenes, then we've just got the general risk of somebody using drugs and injecting and overdose risk so that's why it was felt that it was a need.*" (Non-Medical Prescriber)

The expansion of rapid prescribing therefore functions as a preventative harm reduction measure, designed to reduce exposure to potentially contaminated street drugs by accelerating access to opioid substitution treatment.

While overdose risk is inherent in street opioid use, NSOs significantly heighten that risk due to their potency and unpredictability. Therefore, rapid prescribing was perceived as a critical intervention in mitigating this increased overdose potential.

> *"I think since the NSO outbreak, they are looking at rapid prescribing more to reduce drug related deaths, basically."* (Team Leader 1)

In summary, Change Grow Live's expansion of rapid prescribing was viewed as a necessary, proportionate and targeted response to an emergent threat within the local drug market. Rapid access prescribing was often positioned not simply as a service improvement, but as an important adaptive harm reduction strategy aligned with the evolving risk posed by NSOs.

4.2.2 Mortality Reduction

As noted above, Change Grow Live's expansion of rapid prescribing was positioned as a direct response to the growing threat posed by NSOs and as a strategy to reduce overdose mortality. Several members of Change Grow Live staff demonstrated a strong awareness of the heightened risks associated with synthetic opioids, particularly their potency relative to street heroin. In Manchester, heroin has reportedly tested at purity levels as low as 1-2% (GMTRENDS Street Drug Survey, 2026). Consequently, the presence of highly potent synthetic opioids within the drug supply substantially increases overdose risk due to their unpredictable strength and the low opioid tolerance that may result from sustained exposure to low-purity heroin.

Frontline staff described recent overdose incidents within the local context:

> *"We've had a couple of non-fatal overdoses, but we have sadly had a couple of fatal ones. So that's why we're pushing testing strips on everyone."* (Recovery Coordinator 6)

This demonstrates that service adaptations were grounded in experience of both fatal and non-fatal overdoses. Widespread provision of testing strips for synthetic opioids, distributed in services is an important harm reduction measure to mitigate these new risks.

One service user also discussed the protective function of rapid prescribing, noting how getting on a methadone script provides safety compared to using street heroin:

> *"That's (methadone) not going to kill me today, that's all it takes, but the heroin could do."* (Early 30s, male, Salford)

This reflects a clear perception amongst people that use heroin that prescribed OST reduces immediate overdose risk by reducing their reliance on an increasingly unpredictable heroin market. Rapid access to treatment can therefore limit exposure to contaminated substances and lower the risk of acute overdose.

Notably, risk was discussed not only in relation to overdose, but also in relation to the psychological impact of unmanaged withdrawal. The same SEH client described the severity of withdrawal-related distress:

> *"I couldn't afford to keep my habit under control, and it was making me feel like I needed to just kill myself just so I didn't have to feel that way all the time. Yeah, because the withdrawals are so extreme."* (Early 30s, male, Salford)

This account highlights an additional pathway to mortality. Withdrawal distress, particularly when combined with homelessness, trauma and poor mental health, may exacerbate suicidal ideation. Rapid prescribing therefore functions as both an overdose prevention mechanism and a stabilisation intervention for individuals experiencing psychological crisis.

The life-saving potential of rapid prescribing was reinforced by clinical staff. A Non-Medical Prescriber stated:

> *"I think it's probably one of the best things that's come into drug services to be honest, it's literally saving lives!"* (Non-Medical Prescriber)

Taken together, the research findings strongly suggest that Change Grow Live's RPS reduces mortality risk through multiple mechanisms:

- Reducing exposure to contaminated street drugs
- Lowering overdose risk
- Stabilising individuals during acute withdrawal
- Mitigating psychological distress linked to unmanaged dependence

4.2.3 Testing Strips: Engagement and Behavioural Impact

Alongside the national expansion of rapid prescribing, Change Grow Live has introduced testing strips as an additional harm reduction strategy. The distribution of NSO testing strips to people engaging with the service provides an additional layer of harm reduction and may further reduce the risk of fatal overdose. While rapid prescribing reduces reliance on the illicit drug supply, testing strips help individuals make more informed decisions about their substance use where illicit drug use continues.

The findings suggest that engagement with testing strips is relatively strong among Change Grow Live service users, particularly those who remain actively engaged with services:

> *"From my first-hand experience, they do want testing kits."* (Recovery Coordinator 4)

In addition to concerns about NSOs, it was suggested that the demand for testing strips is also partly driven by concerns around poor quality:

> *"They want to know what's in the heroin. I think a lot of that's probably to do with how poor the quality of heroin has been since the pandemic."* (Recovery Coordinator 4)

Awareness of low-potency heroin, reinforced through local and national drug alerts and reports of synthetic opioid contamination, appears to have increased both curiosity and caution among service users. Data provided by Change Grow Live indicate that, in 2025, 27% of service users completing structured treatment assessments were issued with NSO testing strips. This suggests that testing strips have

been incorporated as a meaningful component of the service's broader harm reduction response, supporting efforts to increase awareness of drug-related risks and reduce the potential for overdose.

However, not all staff were fully confident that testing would be used consistently or correctly, particularly among individuals living highly chaotic lifestyles. One Harm Reduction Worker stated:

> *"The idea that, you know, everyone's going to be at home being a little junior scientist and getting these tests, you know, done exactly right. I don't think that's realistic."* (Harm Reduction Worker 2)

This reflects practical concerns regarding correct use, environmental conditions, and the potential for human error, highlighting that the availability of test strips does not guarantee their consistent or accurate application. These concerns are supported by research conducted by Marland et al. (2025), who reported both false positive and false negative results when evaluating nitazene test strips using 28 seized heroin samples. False positives were attributed to the presence of caffeine and paracetamol, common heroin adulterants, while several nitazene compounds present at low concentrations were not detected. Although the strips successfully identified most nitazene compounds, the authors cautioned against their uncritical deployment and questioned their reliability as a standalone harm reduction intervention.

Despite these limitations, service user interviews indicate meaningful engagement with NSO testing strips. Three of the five (60%) service users interviewed reported having used strips provided by Change Grow Live. Of the two who had not, one had not used street heroin for two years, while the other had been disengaged from services for more than twelve months. These findings suggest that, among those actively using heroin and engaged with treatment, uptake of testing strips was relatively high.

However, as illustrated below, positive test strip results do not necessarily stop people from using heroin:

> *"I tested the heroin the other day. There's only three different ones there. There's five, really. And I tested positive for the five of them . . . still used it!"* (Early 50s, male, Withington)

While positive synthetic opioid test strip results do not necessarily prevent use, it creates an opportunity for behavioural modification and risk reduction. Frontline staff described how testing strips open space for harm reduction conversations.

Staff reported that in relation to positive test strip results, they advise not to use but that if a service user does decide to still use the drugs they have purchased, they encourage the adoption of safer consumption strategies such as reducing the amounts they use ('low and slow'), smoking rather than injecting, not using alone and ensuring that naloxone is on hand in case of overdose.

One Recovery Worker discussed how this advice was adopted by one of his service users:

> *"I had a client the other day tell me that he had some heroin tainted with fentanyl and the first thing he did was come in the next day and tell me. He was like, 'I'll be honest, I still used it, but I used a lot less because I knew it was in there'."* (Recovery Coordinator 6)

This provides evidence of behavioural adaptation in response to positive synthetic opioid test strip results. While heroin use continued, the individual reduced their consumption and notified the service, indicating increased awareness of overdose risk and the adoption of harm reduction strategies.

In summary, these findings suggest that synthetic opioid testing strips function not solely as diagnostic tools, but they create structured opportunities for harm reduction dialogue, promote risk-awareness, and in some cases influence safer consumption practices. While positive tests results may not always be accurate or bring about decisions to abstain from use, behavioural shifts such as dose reduction, increased naloxone use, and proactive reporting represent meaningful harm reduction outcomes.

4.2.4 Testing Strips as Tools: Practical Limitations and Considerations

Although the preceding section demonstrates that NSO testing strips function as a valuable harm reduction tool, the interviews with professionals highlighted several practical limitations that need to be taken into consideration. These include reliability concerns due to human error and false positives, and the complexities of issuing drug alerts based solely on test strip results.

The NSO testing strips currently used by Manchester's Change Grow Live's outreach service require people who use them to dissolve a portion of their substance in distilled water before applying a dip test. Initially, the practicalities of this process were not considered realistic for individuals living highly chaotic and/or street-based lifestyles. In response, the outreach team developed testing packs that in addition to test strips, contain distilled water vials, mixing dishes and instructions for use (see Figure 1 below).

> *"So we made like a little kit with all the different testing strips and with a spoon and everything that they need to do it to complete the test."* (Project Manager 1)

Figure 1 NSO Testing Pack

This demonstrates how practical barriers can be reduced to increase effective use of NSO test strips. However, even with improved testing packs and guidance, concerns remain amongst Change Grow Live staff regarding the reliability of positive results. As one Harm Reduction Worker stated:

> *"They're quite good in terms of saying we've had positive test strips here and there. But the test strips are not 100% reliable. Human error is the main one."* (Harm Reduction Worker 2)

This harm reduction worker perspective reflects the inherent limitations of drug-checking test strips. Previous research has shown that false positive results and incorrect use can lead to inaccurate conclusions regarding drug contamination (Halifax et al., 2024; Lockwood et al., 2021). As such, positive NSO test strip results should be interpreted with caution and cannot be regarded as definitive confirmation of contamination.

4.2.5 Early Warning Systems and Drug Alerts

Concerns about the reliability of these results were also raised by the Coordinator of the Greater Manchester Local Drugs Information Network who highlighted that caution was required when considering issuing drug alerts based on testing strip results:

> *"My view is yes, test strips are really good but they're unreliable."* (Greater Manchester Local Drug Information Service Coordinator)

Ideally, initial positive test strip results would be corroborated with more accurate and sensitive laboratory analysis[1] before issuing warnings. Furthermore, the messaging must be carefully considered:

> *"You have to be careful about the warning. [. . .] That balance between giving out generic harm reduction advice to people and realising that if you tell them that 'there's really potent heroin, possibly with this really strong opioid in it at the moment', that you might attract them to it. So we put out a generic warning without mentioning there's really strong drugs in the area, just saying 'the drug market is really dangerous'. This is harm reduction advice."* (Greater Manchester Local Drug Information Service Coordinator)

This highlights an important consideration for services. Publicly communicating the presence of highly potent substances may, for some individuals, inadvertently increase interest in seeking out these drugs rather than discouraging their use.

A Harm Reduction Worker reinforced this concern:

> *"What I don't want to do is what happens a lot in drug services over the years is that you get like an anecdotal report and half the people would just be like, 'where is it? I want some'!"* (Harm Reduction Worker 2)

This demonstrates the need for agreed evidential thresholds and controlled messaging within early warning systems.

As noted by the Recovery Coordinator below, alerts should be channelled through existing defined professional roles within this system:

> *"Let the people whose positions it is to be looking about patterns and sending information around to other organisations and reporting it nationally."* (Recovery Coordinator 4)

Taken together, the evidence indicates that while NSO testing strips provide valuable harm reduction benefits, there are known limitations. Their reliability is not perfect, and their use should form part of wider harm reduction measures. The results should not be used in isolation, rather, they should inform multi-source intelligence on emergent drug market threats. They require careful integration into wider reporting and drug alert systems.

The research has demonstrated that NSO testing strips do not solely function as isolated harm reduction tools but also act as components of a broader early

[1] In the local Manchester context, this would typically be by the MANDRAKE lab.

warning and intelligence system within Change Grow Live and beyond the service. In addition to test results, local intelligence is generated through frontline conversations, service user disclosure and pattern recognition. It was frequently recounted that NSO testing strips encourage increased reporting of unusual drug effects and non-fatal overdoses.

> *"I'd say it's less about us receiving the positive tests and more about more people reporting non-fatal overdoses or reporting differences in the drugs or 'this didn't feel quite right'."* (Recovery Coordinator 1)

Several frontline staff described the gathering of contextual information to support NSO test strip results:

> *"I don't need to know the name of your dealer, I don't want any of that information, just, 'Where did you get it? What did you pay for it?, What does it look like?' I then feed that back to our Harm Reduction Worker."* (Recovery Coordinator 1)

These reports function as early indicators of potential market changes, strengthening situational awareness even when confirmatory forensic analysis is limited.

Where positive tests are reported, a structured escalation pathway is followed:

> *"We have a nitazene pathway… if someone reports a positive test… we report it."* (Team Leader 1)

> *"If someone reports to us that they've tested and it's a positive test… we then report it to our harm reduction team."* (Recovery Coordinator 1)

Thus, intelligence does not remain at practitioner level but is formally escalated through designated Harm Reduction Workers. The Project Manager further described how multiple reports would trigger formal internal processes:

> *"If we all of a sudden had a situation where we had a few people phoning up, then obviously we'd filter it into our own internal reporting system."* (Project Manager 1)

Intelligence collected at service level is escalated to designated leads responsible for pattern recognition and wider dissemination, including national reporting mechanisms.

The findings illustrate that Change Grow Live operates a layered early warning system in which drug alerts, NSO testing strips, service user feedback, and rapid access prescribing work together to identify emerging risks, increase awareness of contamination, and reduce exposure to potentially harmful substances.

- Service users report unusual effects or positive tests
- Frontline staff gather contextual intelligence
- Reports are escalated through a defined nitazene pathway
- Thresholds determine whether further action is required

- Designated leads analyse patterns and communicate findings locally and nationally

Importantly, this intelligence system is directly connected to rapid prescribing. When emerging risks are identified, Change Grow Live service users can rapidly access OST, reducing exposure to potentially contaminated street drugs. Alongside the provision of NSO testing strips and naloxone, this creates a comprehensive harm reduction approach. As such, the rapid prescribing service operates as both an early warning system and a rapid response mechanism, linking surveillance with timely treatment intervention.

4.3 Harm Reduction Outcomes

Change Grow Live's RPS demonstrates harm reduction benefits that extend beyond responding to the current threat posed by NSOs. The findings indicate that rapid prescribing contributes to a range of positive outcomes, including stabilisation, reductions in criminal activity, improved health monitoring, and progress towards recovery and wider life improvements.

4.3.1 Immediate Stabilisation and Routine

One of the immediate outcomes for service users accessing rapid prescribing is increased stabilisation and the development of a more structured routine. For many opiate users, substance use dictates daily life, often resulting in the loss of routine and stability. As withdrawal can be physically and psychologically distressing, individuals' lives frequently revolve around securing finances to purchase street heroin in order to avoid becoming unwell (Simpson et al., 2024). This survival-focused pattern can create chaotic lifestyles with little opportunity for structure or focus on healthcare.

The introduction of the rapid prescribing services gives service users the opportunity to reduce or cease street heroin use without the immediate fear of withdrawal. As daily supervised pick-up is typically required during the early stages of opioid substitution treatment, service users are required to attend a pharmacy each day. This consistent contact introduces routine and accountability, contributing to increased stability.

As one Outreach Recovery Coordinator stated:

> "*. . . for this individual, picking up his prescription daily, that's massive, it's huge. What does that do for him? It affords him some stability. A bit of routine.*" (Recovery Coordinator 1)

The same Outreach Recovery Coordinator expanded on this by saying:

> "*If I'm waking up in a doorway and I'm on prescription, I might still commit crimes to make money or I might be begging. But in the morning, I'm going to wake up and I'm going to go and get my methadone so I'm not rattling.*" (Recovery Coordinator 1)

Additionally, one service user reflected on his own routine by stating:

> *"I'm not saying, I'm staying out of trouble do you know what I mean?... but always make it to the chemist"* (Early 50s, male, Salford)

This immediate shift in daily priorities once a service user begins OST is noteworthy. Rather than waking up solely focused on preventing withdrawal through purchasing drugs, the service user's first action becomes attending the pharmacy. Although engagement in survival behaviours may not cease immediately, the prescription provides physiological stabilisation, which in turn reduces risky behaviours driven by the urgency and desperation to generate money to buy drugs to stop withdrawal symptoms.

By removing the constant pressure of withdrawal, the RPS interrupts the daily cycle of crisis and introduces predictability, forming the foundation for further engagement and harm reduction outcomes.

4.3.2 Reduced Criminal Behaviour and Street-Based Survival Activity

The causal links between heroin dependency and survival-based criminal activity have been made since the first heroin outbreaks in the 1980s (Mott, 1986; MacGregor, 2000; Bennett and Holloway, 2009) and have underpinned the UK government's response since New Labour's Tough Choices and Drugs Intervention Programme (see Stimpson, 2000; Seddon et al., 2008). For many individuals experiencing rough sleeping or financial instability, income generation becomes directly tied to the need to avoid withdrawal. The distress and pain associated with heroin withdrawal can drive acquisitive crime, begging and other forms of anti-social behaviour (HM Government, 2022). In a Dutch cohort awaiting heroin-assisted treatment, 70% reported criminal activity and 50% acquisitive crime, occurring on average 20.5 days per month (3.1 offences daily). Shoplifting and bicycle theft predominated, and 63% reported offending to fund drug and alcohol use (Van Der Zanden et al., 2007).

The SEH was initially developed in partnership with Greater Manchester Police (GMP) with the aim of reducing street-based begging and anti-social behaviour among people experiencing homelessness. Rapid prescribing has been integral to this model. By enabling individuals to access OST quickly, the immediate pressure to generate income for street heroin is reduced.

One police officer from the Street Engagement Team described need for a RPS in the city centre to reduce acquisitive crime and anti-social behaviour:

> *"We wanted to try and break the cycle, and it turned out that every day for people was basically begging or stealing to fund their drug habit"* (GMP Street Engagement Team Police Officer)

Rapid prescribing disrupts this cycle by providing an alternative source of opioid stabilisation for people who lead street-based lifestyles.

The Triage team also identified wider community benefits associated with rapid prescribing, including reductions in begging and a diminished need for police involvement in the city centre:

> *"Because they've got a script in place, so they don't need to go out begging as much, so that reduces the police moving people on."* (Street Engagement Hub Triage)

These findings demonstrate both individual and community-level harm reduction. For the individual, reduced need to fund their drug use lessens the immediate need to engage in criminal or anti-social activities. For the wider community, reductions in visible street-based activity decrease police enforcement interactions and displacement.

This dynamic is reflected clearly in the account below:

> *"If they say to me, 'We can't script you for two weeks', I've got to find heroin for the next two weeks. It's as simple as that, mate. I've got to do criminal activity; I've got to do whatever!"* (Early 50s, male, Salford)

This narrative illustrates the accepted inevitability of criminal activity to fund drug dependency in the absence of timely treatment access. Where traditional pathways involve lengthy waiting periods, individuals describe having "no choice" but to pursue illicit income to avoid withdrawal. Rapid prescribing therefore functions not simply as a clinical intervention, but as a structural mechanism that reduces the conditions under which survival crime occurs.

Overall, the findings indicate that rapid access to OST reduces acquisitive crime, begging and repetitive street-based survival behaviours. The stabilising of individuals improves their personal health and wellbeing whilst also having a positive community-level impact.

4.3.3 Re-Engagement into Treatment

As previously discussed in section 4.1 rapid prescribing significantly reduces waiting times for service users seeking to begin opioid substitution treatment. The rapid prescribing offer has been particularly important in re-engaging individuals who have previously dropped out of treatment.

People who use heroin, particularly those experiencing homelessness or other forms of social instability, often face complex barriers to sustained engagement with treatment. As a result, many individuals cycle in and out of treatment services multiple times throughout their recovery journey (Gazzola et al, 2023). Rapid prescribing therefore functions not only as an initial entry pathway, but more commonly, as a fast-track re-engagement mechanism that removes barriers for those seeking to return to treatment.

Within the core teams, dedicated rapid restart appointments are available specifically for service users who require a medical restart. A Recovery Key Worker from the core team described this structure as follows:

> *"We have specific rapid access slots for people who are on restarts, so people who have dropped out of treatment and need to have a medical restart, we have specific slots for them but they're different to our rapid access slots."* (Recovery Coordinator 6)

This demonstrates that Change Grow Live has embedded flexibility within the model to recognise that relapse and disengagement are common within people who are opiate dependence, and that services must respond quickly when individuals are ready to return.

The model operates slightly differently within the outreach team at the Street Engagement Hub, where rapid access slots are allocated on a first-come, first-served basis and can be used for both new service users and those requiring restarts. One Non-Medical Prescriber reflected on the demand for these appointments:

> *"There's lots dropping off a script and wanting a restart so they will be blocking up the rapid slots to get back on the script but if you've only got so many a day, they're going to be gone quite easily."* (Non-Medical Prescriber)

This highlights the frequency with which service users re-present to treatment and reinforces the importance of maintaining rapid restart capacity.

From a service user perspective, the link between being prescribed and maintaining engagement is clear. One service user described the difference in their own attendance patterns:

> *"When you're on a script, I normally attend the appointments but when I'm not on it I don't really attend."* (Late 40s, male, Altringham)

This quote illustrates how access to OST can serve as an anchor for engagement, increasing the likelihood of continued attendance and contact with services.

Continued engagement with drug services is itself a significant harm reduction outcome. Through ongoing contact with key workers and clinicians, service users receive harm reduction advice, regular medical assessments, testing strips and naloxone kits. Rapid restart pathways therefore reduce the time individuals spend outside of treatment; minimising periods of heightened risk associated with relapse, overdose and disengagement.

4.3.4 Health Monitoring and Access to Healthcare Through Engagement with RPS

Individuals who use heroin and those who are rough sleeping often experience complex physical and mental health comorbidities (HM Government, 2021). Engagement with treatment therefore provides an entry point into wider healthcare pathways. A Non-Medical Prescriber highlighted this holistic element of the rapid prescribing model:

> *"it's not just about the prescription; we're doing a bit of a health check as well."* (Non-Medical Prescriber)

Mandatory medical assessments prior to commencing OST ensure treatment suitability and safety. In addition, clinicians offer blood-borne virus testing, ECG monitoring where clinically indicated, and referrals to specialist services. Therefore, rapid prescribing extends beyond medication provision. It functions as a gateway into broader healthcare engagement, reducing untreated morbidity and enabling earlier intervention for both physical and mental health concerns.

In addition to stabilisation and reduced street-based survival activity, engagement through rapid prescribing pathways creates increased opportunities for healthcare intervention. By bringing individuals into structured treatment, service users experience more frequent contact with medical professionals, not only through Change Grow Live clinicians but also through community pharmacists.

During the early stages of opioid substitution treatment, daily supervised consumption is common. As a result, individuals may have more consistent contact with pharmacists than with key workers. This increased professional visibility creates informal monitoring mechanisms that can identify physical health concerns at an earlier stage.

One Outreach Recovery Coordinator described how daily pharmacy attendance led to the identification of an untreated physical health issue:

> *"So, this individual now is being seen daily by a pharmacist… they probably see him more than we do. A while back, the pharmacist rang me and said, 'Oh, I've noticed that so-and-so is walking with a limp'. I went, 'okay, all right, that's interesting'. I then found that individual and found that they had leg ulcers."* (Recovery Coordinator 1)

The same Outreach Recovery Coordinator emphasised that this healthcare intervention was not incidental, but a direct outcome of engagement with rapid prescribing:

> *"Him getting his legs dressed and accessing healthcare is a byproduct. It's an offshoot of rapid access."* (Recovery Coordinator 1)

This evidence demonstrates that rapid prescribing facilitates secondary health monitoring to high-risk groups. Although the primary aim of the service is to initiate or restart opioid substitution treatment, the structured daily contact inherent within the model increases opportunities to identify and address unmet physical health needs.

The following case study highlights the critical role of flexible, low-threshold prescribing and outreach engagement. The street engagement hub enabled consistent contact at key moments, supporting not only Maggie's substance use recovery but also her physical and mental health, housing stability, and positive outcomes for both her and her child.

Case Study 1: 'Maggie'
Maggie first engaged with Change Grow Live in 2021 after presenting at the Street Engagement Hub following a move into the area. At the time, she required support for heroin and crack use and was experiencing significant instability, moving between Manchester and her previous area, alternating between rough

sleeping and staying with her father. Engagement was inconsistent, compounded by ongoing housing insecurity.

In 2023, Maggie accessed the rapid prescribing service on five occasions via the street engagement hub. A hospital visit revealed she was pregnant, triggering an immediate clinical response. She was prioritised for medical review with a Change Grow Live doctor, where her illicit use was assessed and her opiate substitution treatment (OST) safely continued in the community. As a precaution during pregnancy, her prescription was reduced from 80ml to 65ml of supervised daily physeptone. At the same time, she was supported into women-only temporary accommodation, preventing a return to rough sleeping.

Early engagement remained challenging. Maggie frequently missed pharmacy collections, requiring repeated rapid restarts of her medication. However, the flexibility of the Street Engagement Hub and rapid prescribing pathway ensured continuity of OST at critical points, reducing her risk during this unstable period.

From summer 2023, sustained multi-agency support began to shift outcomes. Maggie stabilised in her accommodation, attended all midwifery appointments, and demonstrated growing motivation to reduce illicit drug use. She identified stress and anxiety as key triggers and began using coping strategies, including music and structured activity. Engagement in mother and baby groups further supported her wellbeing and reduced relapse risk.

By late 2023, Maggie had progressed to a supported flat within a mother and baby unit. She was induced shortly afterwards and gave birth to a healthy baby. In 2026, she remains actively engaged with services and is no longer using heroin or crack.

Maggie had been diagnosed with Hepatitis C prior to pregnancy; treatment was deferred until postnatally. Following the birth, she initiated and successfully engaged with Hep C treatment.

4.3.5 Progression, Next Steps and Longer-Term Outcomes

Although rapid prescribing has immediate harm reduction benefits, it can also support longer-term progression for service users. Rapid access does not only prevent short-term harm but can act as the starting point for wider recovery pathways.

One Non-Medical Prescriber reflected on the positive outcomes that have followed engagement through the Street Engagement Hub, stating:

> *"We've had quite a few successes in the outreach team where they've come in through the hub got on a script gone on to detox, rehab and got on with their lives."* (Non-Medical Prescriber)

Without rapid access to treatment, these individuals may not have remained engaged long enough to reach this stage.

Similarly, one Outreach Recovery Coordinator described a noticeable shift in service users who had previously struggled to maintain treatment:

> *"I've had some service users that had really not ever maintained a script then suddenly were maintaining a script."* (Recovery Coordinator 3)

This suggests that by reducing barriers to access and allowing service users to begin treatment during their motivation window, rapid prescribing increases the likelihood of sustained engagement. For individuals who have historically cycled in and out of services, rapid access appears to provide a more stable entry point into long-term treatment.

The findings indicate that rapid prescribing is not only reducing immediate harm but is also creating opportunities for progression. By stabilising service users quickly and keeping them engaged, Change Grow Live's RPS strengthens the foundations for longer-term recovery outcomes.

The following case study demonstrates the long-term impact of rapid access, assertive outreach, and integrated multi-agency support. Timely intervention through the street engagement hub enabled immediate stabilisation, while coordinated care across housing, healthcare, and psychological services supported sustained recovery and independence.

Case Study 2: 'Shaun'

Shaun has been known to Change Grow Live for over a decade. Following a period in custody, he re-presented in December 2022 seeking support for poly-drug use, including heroin, crack cocaine, pregabalin and benzodiazepines. After previously maintaining stability in abstinence-based housing, he was evicted following an incident with another resident. This led to street homelessness and a return to substance use.

Shaun re-engaged with Change Grow Live via the Street Engagement Hub. He was rapidly assessed, completed a same-day medical with a Non-Medical Prescriber, and commenced opioid substitution treatment immediately. Harm reduction interventions were delivered on the day, including take-home naloxone, blood-borne virus testing, and drug screening. His recent ECG results were also reviewed in light of a family history of cardiac issues, ensuring safe clinical management.

Engagement with the hub created a critical access point for wider support. Through partnership working with the Manchester Homeless Partnership, Shaun was quickly placed into temporary accommodation. Change Grow Live continued to provide coordinated, multi-agency support throughout.

Change Grow Live also played a key advocacy role in stabilising Shaun's access to primary care. Despite being outside the catchment area, the team successfully liaised with his previous GP to facilitate re-registration, alleviating Shaun's anxiety and enabling him to re-engage with physical health services.

Within weeks, Shaun was titrated to a therapeutic dose of physeptone and had ceased heroin use. By June 2024, he remained stable on treatment, with sustained engagement across services. He was referred to Housing First and offered his own tenancy, marking a significant step towards long-term stability.

Alongside this, Shaun engaged with Change Grow Live's psychology team to address underlying anxiety and PTSD. He continues to maintain his tenancy and reports feeling positive and optimistic about his recovery.

4.4 Engagement, Trust and Retention

Beyond demonstrating measurable harm reduction outcomes, the data collected during interviews highlight the significant impact that rapid prescribing has had on engagement, trust and retention within Change Grow Live services. While previous sections have explored structural barriers and immediate stabilisation, this section focuses more specifically on the relational and behavioural shifts that occur once barriers to access are reduced.

For many individuals experiencing rough sleeping and substance use, engagement with treatment services is not simply a matter of motivation, but is shaped by competing survival priorities, withdrawal, trauma histories and distrust of services. The findings suggest that rapid prescribing does more than reduce wait times; it alters the way individuals interact with treatment services. By responding quickly during the initial window of motivation, reducing punitive responses to drop-out, and embedding a flexible and trauma-informed approach, Change Grow Live has created a service model that encourages individuals to return even after periods of disengagement.

This section provides evidence of how rapid prescribing contributes to improved engagement through timely response, flexibility, trust-building and the creation of a non-judgemental environment. While retention is not guaranteed, the availability of rapid access increases the likelihood that individuals will re-present to services, remain in contact for longer periods and develop trust in the system over time.

4.4.1 Engagement Barriers and Survival Priorities

As discussed in section 4.1 long wait times create significant barriers to engagement. However, beyond delays in the traditional pathway, there are additional structural and behavioural barriers that impact engagement for people who use heroin. This section explores how survival priorities, withdrawal, instability and disengagement patterns influence service engagement, and how rapid prescribing attempts to respond to these realities.

For many people who are rough sleeping, attending scheduled appointments can be extremely challenging. Non-structured lifestyles, unstable accommodation,

survival-oriented behaviours, and limited access to communication devices can all affect engagement and attendance.

> *"We're working with a cohort who might not have phones, so they're not contactable, so they probably can't keep track of time, could show up late, might be out all night, obviously trying to survive."* (Recovery Coordinator 2)

These staff accounts highlight that engagement barriers are not solely about motivation, but about lived circumstances. Lack of phones, unstable sleeping arrangements, and survival-focused daily routines create practical obstacles to traditional models of care. Rapid prescribing attempts to respond to these realities by reducing delay and capitalising on moments of readiness before competing priorities intervene.

Change Grow Live staff frequently described instances in which service users disengaged from treatment after initially presenting for support, sometimes even during the same-day rapid access appointment at the Street Engagement Hub:

> *"We've had people that'll come in, yeah, they're ready to do it, they want to do it, and then they've disappeared again before they've left, before we've actually finished everything, but they'll come back."* (Project Manager)

This demonstrates how fragile the initial engagement window can be. Even when individuals are motivated, competing priorities can override intentions within a short space of time.

One key factor repeatedly referenced was withdrawal. For many service users, avoiding withdrawal becomes the dominant immediate priority, often superseding longer-term goals around treatment:

> *"Because if they've come and they've not had a hit that morning, or they've not had a drink that morning, they're heading into withdrawal, you know, their priorities change."* (Recovery Coordinator 1)

The following account from an RPS service user highlights the difficult choices between engaging with support services and meeting the immediate need to obtain drugs in order to feel well and avoid withdrawal symptoms:

> *"I woke up ill as fuck and I was like, 'I need to sort this out'. And I was like, 'but I need to get some heroin'."* (Early 30s, male, Salford)

Similarly, another RPS service user reported disengaging from conventional treatment pathways after triage, as the immediate need to use heroin to manage withdrawal symptoms took precedence over continued engagement with services:

> *"You can't afford to, you go, 'I'll come back a week on Wednesday. Yes.' You're not going to stay hurting until a week on fucking Wednesday!"* (Late 40s, male, Altringham)

This interview excerpt vividly demonstrates the mismatch between conventional OST prescribing processes and the realities of life for many people experiencing acute withdrawal. For some service users, waiting for treatment is simply not a viable

option, particularly when the physical and psychological demands of withdrawal require immediate relief.

The following case study illustrates the importance of persistence, flexibility, and system-wide collaboration in supporting individuals facing multiple disadvantage. Rapid prescribing, both on-street and through the SEH, played a pivotal role in maintaining engagement and stabilising Jason during periods of high risk. Crucially, coordinated action across housing, health, and social care removed entrenched barriers, enabling access to treatment and delivering a sustained pathway away from rough sleeping and substance dependence.

Case Study 3: 'Jason'

Jason has been known to Change Grow Live since 2018, with his most recent treatment episode beginning in January 2024. He re-engaged via the outreach team, seeking support for heroin and crack cocaine use, and accessed the Street Engagement Hub for a rapid prescribing review. He was restarted on opioid substitution treatment the same day.

Despite holding a tenancy, Jason was sleeping rough by choice, driven by low mood, isolation, and a preference to remain connected to his social network on the streets. Following the withdrawal of earlier housing support, his mental health deteriorated and his substance use escalated. At assessment, he reported daily use of heroin and crack cocaine. He received naloxone and targeted harm reduction advice.

Sustained outreach was critical. Change Grow Live workers engaged Jason at his bedding spot in the city centre, maintaining contact through periods of instability. His ability to stabilise on methadone was initially limited by the realities of rough sleeping, including difficulty attending daily pharmacy collections. Over the following 10 months, Jason's motivation fluctuated, requiring multiple rapid restarts of OST, delivered flexibly on-street and through the hub. This persistence ensured continued engagement during a high-risk period.

A significant structural barrier was Jason's ineligibility for housing support due to his existing tenancy. Through coordinated advocacy with Shelter and local authority partners, Change Grow Live supported Jason to relinquish his tenancy while avoiding an 'intentional homelessness' decision, unlocking access to more appropriate accommodation pathways. His case was escalated through multi-agency rough sleeper forums, leading to allocation of a social worker within the entrenched rough sleeper team.

As trust developed, Jason expressed readiness for detox and rehabilitation. However, co-dependency with another rough sleeper and reluctance to enter accommodation alone created challenges. Through intensive multi-agency planning, a tailored pathway was developed. Contingency housing arrangements were agreed to reduce risk if treatment was not completed, and

parallel treatment placements were secured for both individuals, removing a key barrier to engagement.

Change Grow Live facilitated preparatory engagement with the detox provider despite Jason's lack of stable accommodation, ensuring a flexible and realistic approach to pre-admission. In 2025, Jason successfully completed his detox and transitioned directly into residential rehabilitation. In early 2026, he remains in rehab, drug-free and making positive progress.

4.4.2 Re-Presentation, Non-Punitive Return and Retention

This section conceptualises RPS as a safety net rather than a one-off access model. A key benefit of rapid prescribing is that it facilitates re-engagement with treatment for individuals who have previously disengaged from services. As discussed earlier in this report, rapid access pathways remove many of the barriers that can prevent people from re-engaging with OST. However, even when these barriers are reduced, disengagement from treatment remains common due to the complex and often unstable circumstances faced by many service users.

The data presented in this section demonstrate how Change Grow Live's non-punitive and flexible approach supports repeated re-engagement with services. Rather than viewing treatment dropout as a failure, this model recognises that disengagement and re-engagement are often recurring features of recovery journeys, particularly within rough sleeping populations. By enabling people to return to treatment quickly and with minimal barriers, the service helps to reduce the length of time individuals who use heroin remain out of treatment, thereby reducing the risk of drug-related harm.

As the following Team Leader notes, people often disengage from drug services, but reducing the length of time they remain out of contact can help to minimise harm:

> *"They may not have stayed on script continuously, but rapid access to prescribing works in their favour by reducing the time they are out of treatment."* (Team Leader 2)

An Outreach Recovery Coordinator mentioned the importance of service users feeling welcomed back into services and not penalised:

> *"He was dropping out of scripts. 'All right, no problem. We'll get you back on'."* (Recovery Coordinator 1)

One of the Change Grow Live Non-Medical Prescribers supported this view by emphasising that it is common for service users to fall out of treatment, but rapid prescribing encourages them to return when they are ready:

> *"We might have our frequent drop out and back in, but they always come back."* (Non-Medical Prescriber)

4.4.3 Trust Development and Normalisation of the Hub

The Street Engagement Hub has been providing rapid prescribing since 2019, with the rest of the Change Grow Live service adopting the model nationally towards the end of 2024. Over the past six years, the SEH has had the opportunity to build a reputation grounded in reliability, accessibility and consistency. As a result, rapid prescribing has become embedded within the wider landscape of street-based support services in Manchester.

This normalisation of the RPS in Manchester was made evident in the comments of one Team Leader who stated:

> *"So, it took years, but now I feel like it's part of the furniture for people. So, they all just go to the hub. They know where it is."* (Team Leader 1)

Describing the SEH as "part of the furniture" reflects how the service has moved from being a new or experimental initiative to becoming an established and trusted fixture within the rough sleeping community.

This perception of trust was echoed by service users. All five service users interviewed reported hearing about the Street Engagement Hub through word of mouth. They specifically referenced peer recommendation as a key reason for attending:

> *"I've known about it for a little while, to be honest. Someone told me about it, a friend. He is rough sleeping and on a script."* (Early 30s, male, Salford)

Word-of-mouth endorsement within street-based communities suggests a level of credibility and trust that traditional treatment pathways and professional advice do not always achieve. Trust appears to be transmitted horizontally through peer networks, rather than solely vertically through professional authority.

The positive reputation of the service was further reinforced by another service user who described their experience as supportive and welcoming:

> *"The staff are very helpful, you know they're trying to help you as much as they can. Nice people, good place to come."* (Late 40s, male, Altringham)

These service user comments highlight that trust is not only built through access to medication, but through interpersonal interactions and how individuals are treated within the service environment.

Collectively, the service user perspectives demonstrate that trust plays a fundamental role in engagement and retention. The longevity of the Street Engagement Hub has allowed it to become a familiar, predictable and safe space for individuals who may otherwise avoid statutory services. Although rapid prescribing within core teams is still relatively new, the established reputation of the hub suggests that this trust-based model may continue to expand across the wider organisation as awareness increases among different populations accessing OST.

4.4.4 Flexibility and Adaptive Service Model

We have already discussed and highlighted how the unstructured lifestyle of people who use heroin, particularly those who live street-based lifestyles, can change priorities for service users as well as make it incredibly difficult for engagement with future appointments. Due to this, the outreach team has been incredibly flexible with their approach to rapid prescribing to break down barriers to engagement. As noted in section 4.1.5, this flexible approach includes combining the medical screening and key worker assessment into a one-hour dual-assessment which shortens the time service users are waiting considerably. This is also a more trauma-informed approach which reduces distress for service users accessing drug service. One Recovery Coordinator stated that this creates a positive first interaction with service users, stating:

> "*It's starting off on the right foot with service users.*" (Recovery Coordinator 5)

Other employees who work as part of the SEH Team support the idea that the rapid prescribing service at the SEH is flexible which in turn reduces harm for service users and encourages engagement.

> "*They're really good in the sense that they're quite flexible*." (Street Engagement Hub Triage)

This flexible approach is the only way to be able to reach certain cohorts of service users but for some a more traditional structured approach can be better:

> "*Some people will benefit from a structured approach… but for some service users there's just no point.*" (Harm Reduction Worker 2)

The below case study demonstrates the importance of rapid prescribing remaining flexible. Matthew faced several challenges accessing traditional treatment services, and through persistent effort and flexibility from the outreach team Matthew was able to stay engaged with OST and his keyworker. Without access to flexible rapid prescribing, Matthew would have been unlikely to engage with treatment or sustain a prescription through conventional pathways.

Case Study 4: 'Matthew'

Sporadically engaging with Change Grow Live since 2019, Matthew was re-engaged in June 2022 through persistent outreach, with a worker building trust over time through regular wellbeing checks. This consistent presence enabled Matthew to disclose his substance use and provide a urine sample in the community, marking a critical turning point in his engagement.

As Matthew was treatment naive, significant effort was placed on delivering tailored education around opioid substitution treatment and harm reduction. This was done in familiar, low-threshold settings where he felt safe and able to engage.

Frequent, consistent contact helped establish a strong therapeutic relationship. As trust developed, Matthew began collecting his prescription regularly and engaging

more consistently. He was gradually supported to attend the Street Engagement Hub at the Mustard Tree, where his prescription was safely titrated to a therapeutic dose. As a result, his illicit drug use reduced significantly, and he began carrying naloxone.

With improved stability, Matthew's mood and overall wellbeing began to improve. This enabled him to take initial steps towards maintaining accommodation. Engagement with Change Grow Live also highlighted unmet needs linked to autism and mental health, prompting wider multi-agency support to strengthen his care network.

4.5 Scalability and Sustainability of the Rapid Prescribing Model

While previous sections have demonstrated the clear benefits and harm reduction outcomes associated with Change Grow Live's Rapid Prescribing Service (RPS) for people experiencing rough sleeping in Manchester, this section considers the longer-term sustainability and potential scalability of the model. The findings suggest that rapid prescribing is highly effective; however, its continued success depends on maintaining protected capacity, appropriate staffing infrastructure, and strategic organisational commitment. Staff interviews highlighted the risk of 'model drift' if rapid access provision is not carefully safeguarded, while also raising important questions regarding future funding, governance arrangements, and the potential extension of the model beyond opiate use.

This section therefore examines the conditions required to preserve the integrity of rapid prescribing over the long term and considers the key challenges and opportunities associated with its wider implementation. In doing so, it explores what is needed not only to sustain the model's current success, but also to support its potential adaptation and expansion across different populations, substances, and service settings.

4.5.1 Protecting Rapid Capacity

One of the recurring themes to emerge during the thematic analysis was the importance of protecting rapid access and ensuring that appointment availability remains genuinely rapid. The Manchester outreach team has been delivering rapid prescribing since 2019 and, due to the disorganised lifestyles of many outreach service users, continues to operate a drop-in model where rapid access slots are allocated on a first-come, first-served basis.

In contrast, core teams within Manchester offer rapid prescribing appointments following initial triage, with reported wait times reaching up to two weeks. Although service users accessing core services may not experience all the same barriers as those who are rough sleeping, staff feedback suggests that structured booking

systems risk reintroducing the very barriers the RPS was designed to remove. If service users are required to wait up to two weeks to begin OST after initial engagement, the distinction between rapid prescribing and traditional pathways becomes blurred.

One member of the outreach team reflected on how core team booking systems can undermine the principle of rapid access:

> *"The base seems to have a booking system for rapid access which is another calendar that's just got clogged up, so just remove that, it's first come, first served. It would still maintain rapid access, rather than 'you're booked in two weeks on Thursday for a rapid access appointment', because it's not rapid!"* (Team Leader 2)

Similarly, an Outreach Recovery Coordinator emphasised that preserving rapid access requires protecting appointment capacity, warning that longer waiting times could compromise the effectiveness of the model and weaken its appeal to those most at risk of disengagement:

> *"You don't want to fall into the trap of going, 'all right, we've got a rapid access clinic, but actually you know, we've not got appointments now for three, four days.'"* (Recovery Coordinator 1)

These reflections highlight a central tension in discussions of sustainability and scale - expanding the model must not undermine the very features that make it effective. The defining strength of Change Grow Live's rough sleeper rapid prescribing service is its immediacy. If protected capacity is not maintained, the core principle of the model risks dilution, and the term 'rapid access' becomes compromised. In this sense, safeguarding immediacy is not simply an operational consideration but a prerequisite for maintaining the integrity of the intervention.

4.5.2 Workforce Infrastructure and Operational Requirements

Staff consistently identified that rapid prescribing is not simply about having a prescriber available; it requires coordinated workforce infrastructure to function effectively. For rapid prescribing to meet its intended aims, the Non-Medical Prescriber model must sit within a wider operational system that includes prescribing administration, key workers, pharmacy relationships and protected clinic capacity. While the Non-Medical Prescriber role is central, it cannot operate in isolation. Rapid prescribing remains rapid only when the surrounding infrastructure enables it to do so.

The Commissioner highlighted the strategic importance of the Non-Medical Prescriber model within this broader framework:

> *"If you think about the NMP model that's a really really key commissioning tool in how we would respond to an emergent threat."* (Commissioner)

However, frontline staff were clear that prescribing alone is insufficient without administrative support to operationalise it. As one Team Leader stated:

> *"Well, you'll definitely need a script admin."* (Team Leader 2)

This reinforces the finding that prescribing administration plays a pivotal role in ensuring same-day scripts can be printed, processed and dispensed efficiently. Without this function, clinical capacity alone cannot deliver rapid access.

There was also discussion regarding how roles should be structured within teams, particularly whether rapid prescribing should rely on designated specialists or be embedded more broadly across the workforce. One Outreach Recovery Coordinator reflected on this tension:

> *"On one side, if you have designated roles of staff, then you get consistency. But then the argument for every single staff member doing it is that then you're upskilling, and everyone then becomes an expert in it."* (Recovery Coordinator 1)

This highlights a sustainability question for Change Grow Live: *Is consistency through specialisation preferable to resilience through wider workforce skill distribution?*

Taken together, these findings indicate that the sustainability of rapid prescribing models depends not only on adequate funding but also on deliberate workforce planning and service design. Effective implementation requires protected clinical roles, sufficient administrative support, and clearly defined operational processes. In the absence of this infrastructure, delays may re-emerge, compromising the central principle of rapid access to treatment and increasing the risk of service user disengagement before treatment initiation.

4.5.3 Model Integrity and Safety

Scalability also raises important questions around governance, clinical safety and safeguarding. Staff were clear that while rapid access is essential, it must remain clinically robust. The content of assessments is critical to maintaining integrity; however, the way in which assessments are delivered can be adapted to reduce unnecessary delay without compromising safety.

As noted in section 4.1.5, a repeated theme during interviews was the value of combining the medical and key worker assessments into a single one-hour joint assessment, rather than two separate 45-minute appointments. This approach reduces repetition for service users, shortens waiting time, and maintains the defining speed of the rapid prescribing model while preserving clinical oversight.

The importance of maintaining structured but joint assessment standards was highlighted by one of the Harm Reduction Workers:

> *"That joint assessment would be key."* (Harm Reduction Worker 1)

Alongside this, there were reflections on increasing clinical thresholds to ensure safety remains central to the model. One Recovery Key Worker raised the importance of confirmation of street-opioid use before rapid prescribing takes place:

> *"I think rapid access should only take place after a positive six-mam[2] dip."* (Recovery Coordinator 4)

This perspective reflects the balance that must be maintained between accessibility and clinical assurance. As rapid prescribing expands, clear eligibility criteria and assessment standards help protect both service users and practitioners.

These findings demonstrate that scalability is not simply about increasing volume. Protecting the integrity of the model requires maintaining strong assessment standards, clear clinical thresholds and realistic expectations about engagement and outcomes. Without this balance, rapid access risks becoming either overly restrictive or clinically unsafe, both of which would undermine the model's long-term sustainability.

4.5.4 Scope Expansion

A significant theme to emerge from the staff interviews concerned whether rapid access pathways should remain focused on opioid use or be expanded to include other substances. Participants widely acknowledged the need for rapid access to treatment for people who use opioids, given the substantial mortality associated with heroin and other opioid use. In 2024, almost half (47%) of all drug-poisoning deaths involved an opiate or opioid (ONS, 2025). However, these risks should not obscure the harms experienced by people who use non-opioid substances. The same year saw 1,279 deaths related to cocaine, including crack cocaine, accounting for 14.4% of all drug-poisoning deaths (ONS, 2025). These figures highlight that significant drug-related harms extend beyond opioid use and raise important questions about the equity and scope of rapid access treatment models. While other substances including synthetic cannabinoids and prescription drugs are increasingly popular with street-based populations (Gray et al., 2021; GMTRENDS, 2021; 2026; Gaschino and Turnock, 2026).

One Recovery Key Worker stressed the importance of universal rapid access:

> *"Rapid access should be for everyone. Not just people who are using opiates. Rapid response should be the gold standard for any person who wants to access support."* (Recovery Coordinator 4)

The practical implications of substance diversification were illustrated through evidence of contamination in crack cocaine. Although Change Grow Live's rapid prescribing service was originally nationalised in response to the emergence of NSOs in heroin supplies, data collected from the outreach team demonstrates that contamination is not exclusive to heroin:

[2] 6-Monoacetylmorphine (6-MAM), also known as 6-acetylmorphine (6-AM), is a metabolite stemming from heroin (diacetylmorphine). Upon heroin consumption, 6-MAM forms within the body, and is excreted in the urine. The detection of 6-MAM confirms recent heroin usage. The 6-MAM test facilitates rapid urine screening. A positive result indicates 6-MAM concentration in urine surpassing 10ng/mL.

> *"We're constantly offering tests, constantly having those harm reduction conversations, and this same service user tested a couple of different batches of crack and said that they found positives in both."* (Recovery Coordinator 2)

> *"I've had a couple of positives reported from crack."* (Non-Medical Prescriber)

Service user perspectives further challenge an opioid-only model. For some individuals, stabilisation on opioid substitute treatment does not eliminate wider substance use:

> *"But no, I'm not taking heroin (after being scripted). I'm just going to buy crack cocaine!"* (Early 30s, male, Salford)

The same service user added:

> *"Until I get a place to live, I'll not stop taking crack cocaine, simple as that. Because it keeps me warm, because if I've not got the heroin to keep me warm, then I'm going to have to use something to keep me warm."* (Early 30s, male, Salford)

Similarly, another service user reflected:

> *"So, in a way, it stops me from being ill, but I've spent more money on crack."* (Late 40s, male, Altringham)

Another service user described continued use of other substances while rough sleeping:

> *"When I get indoors, I'd give up spice like that [clicks fingers]. I'd give everything up like that."* (Early 50s, male, Salford)

There was also broader strategic reflection from staff regarding the purpose of rapid access itself:

> *"It shouldn't be in response to non-synthetic opioids. It should be in response in general to anyone who is suffering with any form of addiction."* (Recovery Coordinator 4)

These findings indicate that sustainability discussions must consider whether limiting rapid access to opiates creates inequity for other substance users experiencing comparable instability, environmental vulnerability and harm. While opioid mortality and rapid access to OST remains a key driver of the model, long-term scalability may require consideration of a broader, substance-inclusive rapid access framework. Recent NDTMS data further highlight the changing profile of treatment need. The proportion of adults in treatment for non-opioid problems, either alone or in combination with alcohol, increased from 21% in 2020 to 2021 to 28% in 2024 to 2025 (OHID, 2025). Similar trends are evident locally. For example, the Greater Manchester Street Drug Survey reported an increase in the proportion of street-based people who use drugs reporting crack cocaine use without concurrent heroin use (GMTRENDS, 2026). Collectively, these findings suggest that demand for treatment is becoming increasingly diverse, raising important questions about whether rapid

access models should continue to prioritise opioid use or evolve to meet the needs of a broader range of substance users.

4.5.5 Funding and Strategic Planning

Beyond workforce structure and operational capacity, the long-term sustainability of rapid prescribing is dependent on funding arrangements and strategic commissioning decisions. While staff overwhelmingly described the model as effective, there was recognition that its continuation and expansion is closely tied to financial resource, local priorities and wider policy landscapes.

One Team Leader reflected on the variability of service provision nationally, suggesting that access to rapid prescribing can be influenced by geography and resource allocation:

> *"[It will] Always be different depending on the person and different areas and what's accessible. I do think it is a postcode lottery and it's a resource and funding lottery, unfortunately."* (Team Leader 1)

This highlights that although the model has demonstrated success in Manchester's Street Engagement Hub, long-term replication elsewhere may be constrained by differences in funding streams, commissioning priorities and workforce capacity.

Similarly, the local Commissioner emphasised the complexity of balancing financial constraints with service need and national strategy:

> *"Have you got the financial budget for it? what are the local priorities? what are the national policies? You've got to balance it all but there are some things you just can't lose and you've got to provide; it's a delicate balance."* (Commissioner)

Sustainability is not simply a matter of demonstrating effectiveness, it also depends on embedding rapid prescribing within wider commissioning frameworks, national drug strategy priorities, and public health objectives. Although rapid prescribing has shown strong potential to reduce harm and improve engagement, its long-term viability relies on sustained investment and strategic commitment. Without secure funding and clear policy support, service capacity may diminish, waiting times may increase, and the core principle of the model, rapid and immediate access to treatment, may be compromised.

5. Conclusion

This evaluation provides compelling evidence that Change Grow Live's Rapid Prescription Service (RPS) represents an effective, evidence-informed harm reduction intervention for people who use heroin. The findings validate the Manchester model by demonstrating that reducing access to opioid substitution treatment from weeks to hours fundamentally changes how, when, and whether people engage with treatment. Rather than operating simply as an accelerated prescribing pathway, the service removes structural barriers embedded within traditional treatment systems and enables engagement at the critical moment when individuals are ready to seek support.

Through the thematic analysis, a consistent narrative emerged: rapid prescribing improves immediate access to treatment, but its benefits extend far beyond the initial prescription. Earlier engagement reduces reliance on street heroin, creates opportunities for stabilisation, increases contact with healthcare services, strengthens trust between service users and professionals, facilitates re-engagement following treatment drop-out, and supports wider harm reduction measures, including naloxone distribution, NSO testing, and drug market monitoring. Collectively, these findings demonstrate that rapid prescribing functions as a whole-system intervention rather than a discrete clinical innovation.

One of the most important contributions of this evaluation is the recognition that time should be understood as a determinant of harm. Conventional treatment pathways often assume that motivation to engage remains stable over periods of several weeks. However, participants consistently described motivation as fragile and time-sensitive, shaped by withdrawal, homelessness, trauma, deteriorating health, and competing survival demands. The effectiveness of rapid prescribing therefore lies not only in increasing service efficiency but in aligning treatment delivery with the realities of opioid dependence.

The findings also suggest that sustaining and expanding rapid prescribing requires more than evidence of effectiveness. Long-term success depends upon adequate workforce capacity, protected rapid-access appointments, integrated multidisciplinary working, and continued commissioning support. Without these foundations, there is a risk that delays re-emerge, capacity diminishes, and the immediacy that underpins the model's effectiveness is lost. Sustainability therefore depends not only on funding but on embedding rapid prescribing within wider commissioning frameworks, drug strategy priorities, and public health objectives.

While the evaluation strongly supports the continued prioritisation of rapid access for people using opioids, it also highlights broader questions regarding the future scope of the model. Rising levels of non-opioid treatment presentations and increasing harms associated with substances such as crack cocaine suggest that service providers and commissioners may need to consider how rapid-access principles can be adapted to meet a wider range of treatment needs. Further research is required to explore the feasibility, effectiveness, and equity implications of extending rapid intervention approaches beyond opioid use.

Overall, this evaluation demonstrates that rapid prescribing is considerably more than an administrative innovation. It represents a person-centred, trauma-informed, and highly responsive model of care that aligns treatment delivery with the lived realities of people who use heroin. By reducing structural barriers to treatment, responding quickly to emerging drug market threats, and creating opportunities for sustained engagement, the RPS provides a robust model for reducing drug-related harm. As drug markets become increasingly volatile and concerns surrounding NSOs continue to grow, services capable of responding rapidly, flexibly, and safely will become ever more important. The findings of this evaluation therefore support not only the continued delivery of rapid prescribing within Manchester, but its protection, sustained investment, and wider adoption as a core component of contemporary harm reduction policy and practice.

6. Recommendations

1. **Improve data recording for rapid prescribing**
   To accurately reflect the number of service users accessing the rapid prescribing service (RPS), clearer data-recording processes are required. This should include a shared understanding among all staff regarding how RPS data should be recorded and the rationale for accurate data collection.

2. **Standardise joint assessment models across RPS sites**
   The joint assessment principles currently used at Street Engagement Hub (SEH) should be implemented across all rapid prescribing sites, comprising a joint one-hour assessment with both a Non-Medical Prescriber (NMP) and a Recovery Coordinator, to promote consistency, efficiency, and a trauma-informed approach.

3. **Maintain RPS as a drop-in service**
   Where possible RPS should operate as a drop-in service (SEH model), minimising the risk of appointment slots becoming fully booked and therefore no longer meeting the intended purpose of being "rapid."

4. **Expand rapid access beyond opiates/opioids**
   Opportunities should be explored to engage with or introduce additional rapid access services, such as the provision of safer inhalation kits to engage people who use crack cocaine or rapid access alcohol assessments.

5. **Explore potential for in-reach delivery through partnership agencies**
   Explore the feasibility of Change Grow Live offering in-reach RPS services within partner organisations, such as temporary accommodation providers.

6. **Embed wider harm reduction within RPS offer**
   Rapid prescribing should not be delivered in isolation but as part of a broader harm reduction approach. Including, naloxone, drug testing kits (see figure 1, section 4.2.4) and accessible harm reduction information.

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Appendix A

Monitoring data for the Manchester Rapid Prescription Service (2021–2025).

		2021	2022	2023	2024	2025
Engagement	Total number of individuals engaged with	91	117	94	113	102
	New - Of those above, number still engaged at end of year	*N/A*	*N/A*	*N/A*	*N/A*	58
	Triage completed with individuals not accessing Treatment	68	82	70	105	100
	Structured Treatment Assessments	30	44	31	81	91
Harm Reduction	Number of Open Opiate S/U's issued with Naloxone	52	60	44	60	62
	New - Number with an RPS appointment	*N/A*	*N/A*	*N/A*	*N/A*	5
	New - Testing strips provided	*N/A*	*N/A*	*N/A*	*N/A*	28
	New - Testing strips results returned	*N/A*	*N/A*	*N/A*	*N/A*	1
	Number prescribed	46	60	58	86	55
	BBV Screening	7	28	50	44	43
	HEP C Positive	4	1	1	2	0
	HEP C Positve Referred to Treatment	6	3	6	4	0
Health & Wellbeing	Mental Health Need	51	63	63	59	70
	Accessing Mental Health Treatment	22	33	37	27	25
	Nurse Alcohol Assessments Completed	15	14	8	14	17
	Detox	0	0	0	0	4
	Rehab	0	0	0	0	2
Substance	Opiates only	15	16	7	19	16
	Opiates and Crack	62	70	61	67	46
	Crack only	4	9	10	7	4
	Alcohol	7	16	7	11	9
	Non Opiate	0	2	5	2	9
	Non Opiate & Alcohol	3	4	4	7	18
	New - Of the above, number of Spice users	N/R	N/R	N/R	N/R	8