Rough Sleeping Drug and Alcohol Treatment Grant

Final evaluation report
July 2025

Carmela Carrea, Akshay Choudhary, Catherine Crick, Michael Lawrie, Taisie Lewis, Richard Lloyd and Laura Tuhou (Ipsos)
Dan Bleksley and Stephan Morrison (Groundswell)
Dr Stephen Green (Sheffield Hallam University)

Office for Health Improvement & Disparities

Ipsos

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1 Executive summary

This is the final report of an evaluation of the Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG), delivered by Ipsos with Groundswell and Dr Stephen Green of Sheffield Hallam University.

1.1 Aims and rationale for RSDATG

RSDATG comprised £262m of funding, given to 83 local authorities in England over 2021-25, to improve drug and alcohol treatment and recovery services for people experiencing rough sleeping or at risk of doing so. The funding was first announced in 2020 and allocated in three phases in 2020, 2021 and 2022. It was allocated to the local authorities with the highest levels of rough sleeping at the time.

RSDATG was seen as a key element of the Government's goal to end rough sleeping by 2024. The Government launched several other funding programmes at around the same time to address rough sleeping and to support its Drug Strategy. However, RSDATG was distinctive in that it focused on people affected by both of these issues.

RSDATG had three aims: to improve drug and alcohol treatment outcomes for people experiencing rough sleeping or at risk, to reduce rough sleeping, and to reduce deaths from drugs and alcohol amongst people experiencing rough sleeping or at risk.

The first phase of the grant focused on substance use support for people experiencing rough sleeping. In the second phase of the grant, eligibility was extended to support people at risk of rough sleeping: this was commonly defined as people living in temporary or hostel accommodation. The rationale for this change was to help avoid people in short-term accommodation experiencing or returning to rough sleeping, as it is often easier than intervening once someone is experiencing rough sleeping. By the end of RSDATG's fourth year, across all funded areas the majority of those supported (around 7 in 10) were in the 'at risk' group.

Other than the targeted focus, the funding was flexible: guidance to commissioners described the aims of the funding and points to consider when designing support, rather than requiring them to deliver specific interventions. This meant that local areas were able to spend the funding on what they thought would work best in their areas and work around existing services to fill gaps, something which they saw as a strength of the grant. There were no targets set for performance, for example for numbers of people engaged or people entering treatment, although areas were required to report to the Office for Health Improvement and Disparities (OHID) on a number of key performance indicators.

1.2 About the evaluation

The evaluation of RSDATG aimed to assess the impact of the funding on the grant's key objectives: as well as the three aims described above, these included further objectives such as

improvements in local services. The evaluation also sought to gather evidence on best practice for supporting people experiencing rough sleeping, or at risk, with substance use problems. It included process, impact and economic evaluation strands. The evaluation findings are based on 500 interviews covering nearly all of the funded local authorities, with service users, commissioners, staff involved in delivering RSDATG-funded services, and other professionals in funded areas with an important perspective on the implementation of services or their impact. This qualitative evidence was augmented by monitoring information and cost information submitted by funded areas, and an analysis of outcomes for service users based on data from the National Drug Treatment Monitoring System.

1.3 How funding has been used

RSDATG's focus and flexibility provided an opportunity for local authority commissioners to consider the needs of people experiencing rough sleeping, or at risk, who use drugs or alcohol, and provide services which meet these needs. They saw this as a relatively rare opportunity to work intensively with people who were the very "hardest to reach", with no pressure to focus on people who are able to make progress more quickly. Consequently, users of RSDATG-funded services tended to be people facing severe and multiple disadvantages in addition to homelessness and substance use. This included contact with the criminal justice system, experience of abuse, poor physical and mental health, and brain injury leading to cognitive difficulties. Many had been using drugs or alcohol from a very young age, and often had a long history of interacting with services for support with substance use, but had not found services able to meet their needs.

Commissioners most often described their priority for the funding as supporting these individuals to engage with drug or alcohol treatment, by addressing the reasons they had not engaged previously. They did so in the following three ways:

Making services more accessible so people could begin engaging with them. This commonly included overcoming practical, motivational and trust barriers. Often this was about taking services to people through outreach (particularly at the early stages of engagement), or providing drop-in opportunities, rather than expecting people to come in for appointments. Many projects had used funding to make opioid substitute medication more accessible, for example by setting up drop-in clinics for same day prescribing, satellite clinics in hostels, mobile clinics on buses, or recruiting specialist prescribing staff who could conduct outreach to where service users were likely to be.

Keeping people engaged by developing good relationships. This was largely facilitated by staff having small caseloads (sometimes as low as 10 or 15, whereas workers in mainstream drug and alcohol services typically have 50 or more people on their caseload) and the person-centred working this allowed. Consistent staffing was important so that meaningful relationships could form, and where this had not been possible, effective handover practices were required. Engagement was also encouraged by offering social and creative activities, separate to treatment plans, which could help people envisage a life outside substance use and form new and more

positive relationships. Some areas funded lived experience roles or teams, who could provide additional, informal support (such as accompanying people to appointments or meeting up for a coffee or walk in the park) and give credible endorsement of the potential benefits of engaging with services.

Wrap-around support and supporting people to deal with issues such as health problems which needed to be addressed before they could engage effectively with drug and alcohol services. In particular, RSDATG-funded staff had a role in supporting:

- People to obtain housing – by helping them apply for housing, advocating for them and reassuring housing providers that their substance use was being managed; and,
- 'At risk' people to maintain existing tenancies, by stabilising their substance use, supporting them to develop life skills such as cleaning, and negotiating with providers if there was a threat of eviction.

This type of holistic support was possible because workers had more time to spend on each service user and on building links with other organisations. The existence of a specific funding stream for this group also created impetus for different organisations to improve the coordination of their support for this group, and establish systems for this.

There was no defined 'RSDATG intervention' or standard delivery model; rather, commissioners used the funding in a variety of ways to meet local needs and build on services already available in their area. For example, one commissioner used RSDATG to focus on initial engagement and funded subsequent treatment from the core public health grant, while another used the Supplementary Substance Misuse Treatment and Recovery Grant to recruit more drug and alcohol workers, and RSDATG to fund wraparound support.

1.4 Outcomes of the funding

In interviews with commissioners and funded services, the outcome from the funding most consistently identified was that people experiencing rough sleeping or at risk were engaging with drug and alcohol services when they were not previously able to. The majority of service users supported by RSDATG had engaged with drug and alcohol services in the past, but RSDATG support was seen as more effective at keeping them engaged.

RSDATG supported more people annually than anticipated, reaching over 19,500 people in the final year of funding. In terms of access to treatment, numbers of people supported by RSDATG and in treatment were higher than the number of **treatment starts** expected to be created by the grant in the business case, and the numbers of people in the RSDATG cohort entering detox and rehab grew over time to the level anticipated at the outset of the grant.

However, in the first 2.5 years of the funding it appeared to have limited impact on the overall numbers of people in housing need receiving treatment for substance use: these numbers increased in areas receiving RSDATG funding, but by no more than increases that were also seen in

non-funded areas (likely due to additional national funding relating to the Drug Strategy). This may be partly because around half of those supported by RSDATG and engaged with treatment were already in treatment before receiving support, and partly because local authorities may have struggled to expand capacity as fully and quickly as intended from the various streams of additional funding, due to workforce constraints. RSDATG enabled local authorities to shift the profile of those engaged with treatment services towards those with higher levels of need, but this may have 'crowded out' others who would have been engaged otherwise.

Around a quarter of those supported by RSDATG were women: this is a higher proportion of women than that estimated in the population of those experiencing rough sleeping (although there is acknowledgement that women are underrepresented in official statistics). This may, therefore, represent a positive aspect of the programme's reach.

The grant had a positive impact on services' ability to improve **sustained engagement** in treatment for people experiencing rough sleeping or at risk. Qualitative interviews strongly indicated that the funding allowed services to work more effectively with people with higher levels of need, and that people who had cycled in and out of treatment for decades were able to achieve greater stability and progress.

This increased engagement was reported to result in **reduction or stabilisation in drug and alcohol use**, people getting treatment for their physical health, people being better able to maintain tenancies or avoid eviction, a gradual build-up of trust in services, and fewer drug- and alcohol-related harms. For others more reluctant to engage in treatment on entry or facing particularly complex challenges, support needs could remain high, and the ability of RSDATG services to continue to provide intense support over a prolonged period was a further differentiating factor compared to mainstream services.

Overall numbers of drug-related deaths in the general population have risen each year since 2019,[1] and commissioners and staff in funded areas reported that there had been a recent rise in drug-related deaths among the RSDATG cohort in their area. Nevertheless, commissioners and staff consistently reported that **levels of drug-related death** would be even higher in the absence of RSDATG, and several service users interviewed for the evaluation believed that the support they received had helped to keep them alive.

At the outset of the funding programme, and set out in the business case, it was anticipated that 16% of people supported by RSDATG (projected to be around 770 individuals per year) would successfully **complete treatment and be in recovery** from substance use. This anticipated number was broadly achieved, despite rates of treatment completion being lower than predicted. NDTMS data from June 2025 shows that over the preceding year, around 740 people in this year had completed treatment after being supported by RSDATG to enter treatment. When considering

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations. Official statistics on drug- and alcohol-related deaths for the homeless population specifically have not been published since 2021; they had remained relatively constant for the five years before that.

all those supported by RSDATG (including those who had already been in treatment when engaged by RSDATG-funded services), 9% (1,273 people) had completed treatment and were no longer using substances problematically, and a further 19% (2,611) were still in treatment but had substantially reduced or stopped their use of problem substances.

Given that the original estimation was based on outcomes for users of mainstream drug and alcohol services, this gap is perhaps unsurprising in light of the more significant barriers faced by the RSDATG cohort. Service users who had had this experience expressed gratitude for the support they had received and the difference becoming substance free had made to their wellbeing, self-worth and relationships; and staff and service users drew a connection between the service improvements enabled by RSDATG and the ability of some individuals to access and complete treatment.

It is important to note that when asked about RSDATG service users completing treatment, RSDATG staff and commissioners commonly said that treatment completion was not a realistic expectation for a large proportion of the RSDATG cohort. Despite intensive and wraparound support, because the challenges faced by this group are very severe and intersecting, progress can take a very long time. External factors also inhibited progress. There were shortages of both general and specialist accommodation; service users commonly reported feeling unable to engage meaningfully or safely with drug and alcohol services without a stable place to live.

Alongside this, service users continued to find it difficult to **get support for their mental health**. Reports that people using substances were being turned away by mental health services were heard in almost every area, suggesting a possible lack of awareness of NICE guidelines on co-occurring conditions (sometimes known as 'dual diagnosis') as well as capacity pressures on mental health services. Interviewees (who tended to be from outside mental health services) described unwillingness among mental health services to support people with substance use needs. Whilst many areas had funded dual diagnosis workers specifically to address this issue, the scale of the challenge appears too great for these roles to have had a significant impact. Unmet mental health needs represented a barrier to service user recovery because of the relationship between substance use and trauma: for many people, trauma-informed approaches alone were insufficient without clinical support. Unmet mental health needs could also lead to people not being accepted into IPD/RR.

Numbers of people entering detox and rehab were relatively small, but this was broadly in line with expectations. Monitoring information shows that numbers grew over the lifetime of the funding as services matured and developed more effective pathways, and commissioners in many areas reported that the numbers represented an increase compared to their previous experiences of obtaining residential treatment for people experiencing rough sleeping or at risk. However, the effect of RSDATG on this is difficult to estimate in the context of rising demand for drug and alcohol treatment nationally.

Areas that had successfully addressed the challenge of finding move-on accommodation had been able to send people to residential treatment in relatively high numbers. Equally, areas that had struggled with this found it a significant barrier, since it was not considered safe or effective to send people to residential treatment without a suitable place to live afterwards and appropriate aftercare. This was particularly important since reducing or stopping substance use often meant people were confronted with trauma and difficult feelings they had previously been able to avoid; and because relapses after a period of detox were particularly dangerous due to reduced tolerance.

The original business case for RSDATG anticipated that it could reduce the **numbers of people experiencing rough sleeping** by around 600. Over the lifetime of the grant, the number of people experiencing rough sleeping increased by 9% across England, and by 10% within the funded areas: based on annual single-night counts, there are 288 more people experiencing rough sleeping in the RSDATG-funded areas than there were in 2019.[2] The most commonly perceived reason for this was widespread shortages of housing, in particular shortages of housing suitable for people with more complex needs or vulnerabilities, a factor which was outside the influence of grant-funded roles and services and prevented the grant from having greater impact.

However, in case study areas, overall levels of rough sleeping and other insecure housing status had reduced somewhat amongst RSDATG service users. In these areas, around 40% of RSDATG service users in treatment who had been experiencing rough sleeping at the start of their engagement were no longer sleeping rough. There is also a large body of examples of positive housing outcomes from qualitative evidence. For example, in some areas staff reported that support from RSDATG had resulted in lower eviction rates in their area.

The grant also had **benefits for the array of services and organisations working with people experiencing rough sleeping.** It provided impetus to set up new systems for collaboration, such as multi-disciplinary meetings and information sharing agreements. Where these systems already existed, they were enhanced by RSDATG-funded staff having enough time to meaningfully engage with them and coordinate with others about the people they supported. RSDATG-funded teams helped increase understanding among other services about the complex needs of people in the RSDATG target cohort and what this means for working with them. This was achieved through a combination of increased exposure to the RSDATG cohort and experience of working directly to support them, and through awareness-raising and training activities with partner services.

The time-limited nature of the grant, with annual funding allocations that were sometimes confirmed with little notice, was challenging. This made it more difficult to recruit and retain staff, especially in regulated roles such as nursing or psychiatry. Some commissioners reported that it prevented them from implementing more innovative or radical solutions such as setting up specialist supported accommodation.

[2] https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024

1.5 Value for money

The overall value for money of RSDATG is uncertain because of the challenges in weighing up the actual and potential benefits of support (some of which will be realised over the longer term) against the costs of the funding and the ongoing costs associated with broadening access to treatment and other support.

RSDATG funding was largely spent on community treatment and wraparound and engagement services. Beyond the cost of the funding itself, RSDATG will have had additional costs, not all of which can be quantified, including costs of the central teams at OHID and the Ministry of Housing, Communities and Local Government (MHCLG), the need for additional administrative resource not covered by the grant, and increased use of other public services (GPs, hospitals, housing) stimulated by RSDATG.

RSDATG-funded services engaged over 19,500 people in the final year of funding covered by the evaluation, many of whom accessed drug and alcohol treatment and would not have been able to do so without the additional support from the funding. Positive outcomes include better-than-expected treatment retention rates given the complexity of the group, increased entry into detox and rehabilitation, and strong qualitative evidence of improved physical health and enhanced collaboration between services. The complex nature of drug and alcohol recovery and homelessness often necessitates prolonged periods of support to witness substantial, enduring change. Therefore, analysis may not have fully captured longer-term benefits such as improvements in well-being and societal reintegration (and in recognition of the timespan of the evaluation, this was not one of its objectives).

There is some evidence of displacement in the early years of the grant, and as individuals reaching drug and alcohol treatment via services funded through RSDATG had more acute needs and a lower likelihood of achieving a positive outcome, it is likely that this will have reduced the overall efficiency of drug and alcohol treatment services over the adjustment period. The positive effects in terms of equity of broadening access to treatment need to be considered against the implications for the overall value for money of drug and alcohol services of bringing people into treatment who were more costly to support and less likely to achieve positive outcomes. These displacement effects were temporary, but will have generated opportunity costs that create uncertainty as to whether the programme represented good value for money in overall terms.

1.6 Conclusions

RSDATG can be characterised as having provided intensive, specialist support for people with complex and high levels of need, often ultimately due to childhood and ongoing trauma, and who will continue to have significant levels of need in the medium and long term. This took place against a background of increased numbers of people experiencing rough sleeping and increased substance-related deaths amongst the general population. Much of the work funded by the grant was around keeping people safe and preventing problems from escalating. These outcomes were hugely valued by services and by service users themselves.

This was to some extent a departure from how the funding was conceived at the outset, which was as a time-limited boost to services to work through a high level of unmet need and then focus on prevention.[3] Instead, many commissioners and services described an ongoing need for this specialist support and said that they would struggle to support these vulnerable individuals without continued funding. The need for ongoing support, the lower-than-expected treatment completion rates and the role of the grant in connecting people to other services they need such as health and housing, implies a lower benefit-cost ratio than initially calculated.

RSDATG provides a strong evidence base for developing our understanding of people's lived experiences and making the case for more prevention activity. Given the mission focus of the current government on addressing rough sleeping, and the wider moral imperative for improving the lives of some of the most disadvantaged members of society, there is a strong argument for dedicated support for those with the most complex needs. The funding has been valuable for the people it supports, for local public services and for a compassionate society.

[3] From the year 1 strategic outline case: "The financial model included within this proposal increases year on year in order to eventually meet all of the unmet need, whilst taking into account workforce constraints. Whilst the evaluation team expects the unmet need to decrease over time, they expect there to remain a need (as new individuals develop substance use needs). The services will then become primarily a preventative measure to stop individuals ending up sleeping rough."

2 Introduction and methodology

Ipsos was commissioned to conduct an evaluation of the Rough Sleeping Drug and Alcohol Grant in partnership with Groundswell and with advisory support from Dr Stephen Green of Sheffield Hallam University. This is the final evaluation report, which presents findings from a period of scoping work in 2023, as well as three waves of fieldwork and qualitative and quantitative analysis conducted between February 2024 and May 2025. The report combines the process, impact and economic components of the evaluation.

This chapter introduces the RSDATG programme, summarises the aims and objectives of the evaluation, and sets out the report structure.

2.1 Summary of the RSDATG funding

RSDATG comprised £262m of funding, given to 83 local authorities in England, to improve drug and alcohol treatment and recovery services for people experiencing rough sleeping[4] or at risk of doing so[5]. Within this overall aim RSDATG had three primary objectives: to improve drug and alcohol treatment outcomes for people experiencing rough sleeping or at risk, to reduce rough sleeping, and to reduce deaths from drugs and alcohol amongst people experiencing rough sleeping or at risk.

RSDATG funding was first announced in 2020 and allocated in three phases: 43 areas were awarded funding in 2020 (Phase 1), 20 in 2021 (Phase 2) and 20 in 2022 (Phase 3). In all 83 areas, RSDATG funding ran until the end of the financial year 2024/5, at which time it was incorporated into the single drug and alcohol treatment and recovery improvement grant (DATRIG).

RSDATG was originally seen as a key element of the then Government's goal to end rough sleeping by 2024. The rationale for this was that substance use problems are both a cause and a consequence of rough sleeping; and that over the five years to 2020, spending on drug and alcohol treatment services had fallen by about a quarter[6]. The Government launched several other funding programmes around this time to address rough sleeping (such as the Rough Sleeping Initiative and the Rough Sleeping Accommodation Programme), and to support its Drug Strategy (such as funding for inpatient detox and the Supplemental Substance Misuse Treatment and Recovery

[4] The Ministry of Housing, Communities and Local Government (MHCLG) defines people experiencing rough sleeping as: "People sleeping, about to bed down (sitting on/in or standing next to their bedding) or actually bedded down in the open air (such as on the street, in tents, doorways, parks, bus shelters or encampments)"; and "People in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or 'bashes' which are makeshift shelters often comprised of cardboard boxes)." However, in practice, government policies and grants (including RSDATG) recognise that "people move in and out of periods of rough sleeping; rough sleeping can be a transitory state, and many experience a 'revolving door' cycle, moving in and out of short-term accommodation."

[5] The definition of 'at risk' was not precisely specified, but guidance to funded local authorities noted that "this may include, for example, people who are: in emergency accommodation set up to support people experiencing rough sleeping during the Covid-19 pandemic; in unstable or unsafe accommodation; sofa surfing; in other forms of short term or emergency accommodation and at risk of rough sleeping." This is different from MHCLG's definition of homelessness, which is: "households which meet specific criteria of priority need set out in legislation, and to whom a homelessness duty has been accepted by a local authority. Such households are rarely homeless in the literal sense of being without a roof over their heads, but are more likely to be threatened with the loss of, or are unable to continue with, their current accommodation."

[6] Quoted in RSDATG Year 1 Strategic Outline Case. The National Audit Office reported a 40% real-terms reduction in spending on adult drug and alcohol treatment between 2014/15 and 2021/22. https://www.nao.org.uk/reports/reducing-the-harm-from-illegal-drugs/

Grant). However, RSDATG is distinctive in that it focused on people affected by both of these issues.

Funding was allocated to the local authorities with the highest levels of rough sleeping at the time. The 83 local authorities awarded funding collectively accounted for around 70% of the population of people experiencing rough sleeping in England[7].

In Phase 2 of the grant, eligibility was extended to support people at risk of rough sleeping (in Phase 1 areas as well). This was commonly defined as people living in temporary or hostel accommodation. The rationale for this change was to help avoid people in short-term accommodation experiencing or returning to rough sleeping, as it is often easier than intervening once someone is experiencing rough sleeping. Evaluation participants also noted that many people experiencing rough sleeping cycle in and out of short-term accommodation. This suggests limiting support only to those currently rough sleeping could have been impractical. Even with this extended eligibility, RSDATG has a focus on a relatively small group of people. On average, there were around 60 people in each funded area experiencing rough sleeping with a drug or alcohol treatment need, but numbers varied widely between areas[8]. There were also around 350 'at risk' people with a drug or alcohol treatment need, though again the numbers reported by areas varied considerably, from 15 to 1,098.[9]

Other than the targeted focus, the funding was flexible: guidance to commissioners described the aims of the funding and points to consider when designing support, but did not present a menu of specific interventions. This has meant that local areas have been able to spend the funding on what they think will work best in their areas and work around existing services to fill gaps. There were no targets, for example for numbers of people engaged or people entering treatment. However, in the final business case for the funding (dated February 2022), it was anticipated to result in an additional 7,800 community treatment places and 900 residential treatment places each year (in other words, this number of people entering the treatment system who would not do so otherwise).[10]

[7] OHID analysis presented at RSDATG learning event, October 2024

[8] DHSC slides from October 2024 learning event – based on rough sleeping counts from March 2024 and prevalence of substance use needs taken from rough sleeping questionnaire – total of 5,270 divided by number of areas and rounded.

[9] Monitoring information submitted for Q1 21/22 – most recent figures available

[10] DHLUC, Rough Sleeping Drug and Alcohol Treatment Grant: Full Business Case (February 2022)

Treatment definitions: in this report, unless otherwise stated, 'treatment' refers to any treatment for a substance use problem from specialist drug and alcohol services. This may be a structured package of pharmacological and/or psychosocial interventions in a community setting (sometimes known as Tier 3 interventions), residential drug or alcohol treatment (inpatient detox and/or rehab, sometimes known as Tier 4 interventions), or both, as part of an overall treatment journey.

In the final year of funding covered by this evaluation (April 2024- March 2025), 19,614 people were supported by the RSDATG grant, of which 31% were experiencing rough sleeping and 69% were at risk. This was an average of 239 people per area, with significant variations between areas. The format of monitoring information means it is not possible to calculate the total number of people supported over the lifetime of the funding.[11]

2.2 Evaluation aims and objectives

The overall aim of the evaluation was to understand 'what works' across the RSDATG funded areas to improve access to drug and alcohol treatment, reduce dropout rates from treatment and improve recovery outcomes for people experiencing rough sleeping and at risk of rough sleeping. Within this, nine themes were set for the evaluation, as summarised in Table 2.1 below.

Table 2.1: Evaluation objectives and themes

Theme and objective	Where addressed in this report
Theme/objective 1: Impact on service user treatment outcomes – mechanisms and conditions - how RSDATG models and interventions interact with treatment outcomes; which are associated with positive treatment outcomes; what are the optimum conditions for service delivery; and what are the conditions and factors that interact with and influence this.	Chapters 4 and 5
Theme/objective 2: Economic impact and cost effectiveness - which interventions represent value for money and where/how is future investment likely to be most effective in improving access to sustained treatment and recovery outcomes.	Chapter 7
Theme/objective 3: The service user experience - understanding the drug and alcohol treatment journey of the cohort and sub-groups within it to identify what barriers remain in RSDATG funded areas (and for which sub-groups), and the factors associated with improved treatment outcomes	Chapters 4 and 5

[11] There are also some limitations to the grant monitoring information, described in section 2.3.6.

Theme/objective 4: Improved access to/effectiveness of inpatient detox and residential rehab provision - in which LAs has access to/engagement in inpatient detox and residential rehab improved: where/how is positive change associated with RSDATG interventions; have the numbers completing residential rehab increased; what factors are associated with improvement/no change/reduction.	Sections 4.7, 5.2, 5.3 and 5.4
Theme/objective 5: Service users' accommodation statuses and treatment outcomes - what can be learned about the relationship between accommodation and treatment outcomes from the RSDATG, and how this varies between those experiencing rough sleeping and those at risk.	Sections 4.8 and 5.6
Theme/objective 6: Impacts of trauma informed and psychologically informed working on outcomes - how was trauma informed and psychologically informed working understood and operationalised, and how might understanding and practice affect outcomes.	Section 4.5 and 6.4
Theme/objective 7: RSDATG fit with local provision / alignment with other funding streams - in the context of multiple other funding streams received by the LAs, what was the added value to the system of the RSDATG.	Sections 3.3, 3.4 and 3.5; chapter 6
Theme/objective 8: Experience of staff recruitment and retention issues - what was the effect of recruitment and staff retention challenges on impact.	Section 3.6 and 3.7
Theme/objective 9: Lessons for the development and delivery of future policy - what future research questions were generated from the learning from the RSDATG.	Chapters 8, 9 and 10

The evaluation comprises three main components:

- **A process evaluation** – explored through the review of programme monitoring information (MI) to identify throughput and service user characteristics, and three waves of fieldwork across 26 case study local authority areas. This fieldwork comprised interviews with commissioners, service providers, local stakeholders and service users (with the service user interviews being conducted by Groundswell). Interviews were also conducted with commissioners from the LAs not chosen as case studies, to extend coverage.
- **A theory-driven impact evaluation** – drawing upon the programme MI to establish the outcomes achieved by service users and a comparative analysis exploring the counterfactual (what would have happened in the absence of the programme) using National Drug Treatment Monitoring System (NDTMS) data to establish a suitable comparison group. Data from the process evaluation has also informed the impact

evaluation: a contribution analysis has interpreted the impact findings and identified the internal and external factors leading to positive service user outcomes (or otherwise).

- **An economic evaluation** – using programme data to understand the costs, consequences and value for money associated with the RSDATG programme. This takes the form of a cost-consequence analysis (CCA) for each of 10 selected case studies based on the impact evaluation findings and the costs of delivering RSDATG.

2.3 Methodology

2.3.1 Case study approach

A case study approach was undertaken to understand in-depth how RSDATG has been delivered at a local authority level and its impact on key outcomes for service users and services. The case study research was designed to answer OHID's question of "what works for whom?" by bringing qualitative interview data together with the quantitative data gathered in respect of the ten impact evaluation sites.

During the evaluation scoping stage, a sampling process was carried out to select areas receiving RSDATG funding that would act as case studies in the evaluation. These Local Authorities (LAs) were selected following a survey conducted in 2023 which helped confirm their RSDATG-funded activities. These findings were triangulated with each area's funding applications to provide an overview of local design and delivery plans. LAs were selected for the evaluation as follows: to be representative of the regional allocation of RSDATG grants; those that were working with both people experiencing rough sleeping and those at risk; those which had higher levels of need (based on levels of rough sleeping per population in 2019); and to cover both urban and rural areas. Some areas could not participate in the evaluation as case studies, so were replaced with other areas with similar characteristics.

The case studies comprised up to four elements:

1. A desk review of local authority documentation and programme monitoring data – including project applications, financial information and in some cases other information provided by interviewees, to help prepare and set the context for each case study area.

2. In-depth qualitative consultations with local stakeholders: the composition of the sample for interviews reflected how funding was being used in each area and local partnership and multi-disciplinary team (MDT) arrangements.

3. In nine case study areas, in-depth consultations with service users in the area.

4. In ten case study areas, a quantitative analysis of outcomes achieved by people supported by RSDATG in that area, compared to a group of drug and alcohol service users with similar needs who were in treatment but not supported by RSDATG. This was based on NDTMS data.

2.3.2 Qualitative fieldwork

Data collection included three waves of qualitative fieldwork between February 2024 and May 2025.

- Wave 1 consisted of interviews with staff across 8 case study areas and service users in 7 of these areas.
- Wave 2 consisted of interviews with staff across 7 case study areas and service users in 2 of these areas.
- Wave 3 consisted of interviews with staff across 11 case study areas, interviews with commissioners in non-case study areas and revisiting 5 areas to interview service users.

The number of interviews per wave of fieldwork are displayed in Table 2.2.

Table 2.2: Overview of interview samples by fieldwork wave

Fieldwork wave	Total number of interview participants	Commissioners & project managers	Delivery partners & frontline staff	Other stakeholders	Service users	Commissioners in non-case-study funded areas	OHID & MHCLG stakeholders
Wave 1	169	23	50	42	43	-	11
Wave 2	152	18	59	36	27	-	12
Wave 3	212	22	93	24	19	44	10
TOTAL	533	63	202	102	89	44	33

In the later interviews, many of the themes raised by participants were similar to those raised in earlier waves. This provided useful confirmatory evidence and enabled findings to be triangulated between the areas.

Case study qualitative fieldwork

The Ipsos team conducted local stakeholder consultations, with each case study area allocated a lead researcher with support as required. As areas followed different delivery models, each case study began with an initial conversation with the local lead to identify key individuals and organisations to be interviewed to reflect the local system of services (both those funded by RSDATG and those interacting with RSDATG roles and services).

Ipsos developed topic guides for the case studies, to cover the overall evaluation themes while also focusing on the key areas of investigation for each research wave. The topic guides featured a series of core questions with tailoring to reflect different roles, with separate guides produced for local authority commissioners, organisations involved in the delivery of the project, frontline staff in roles funded by the grant, and wider stakeholders such as other local organisations working with

people experiencing rough sleeping.

Boxed text is used to indicate examples of best practice identified in the case studies.

Fieldwork with service users

Over the course of the evaluation, Groundswell conducted 89 interviews with a sample of service users across nine case study areas: Bournemouth, Christchurch and Poole; Cornwall; Haringey; Islington; Lincoln; Manchester; Nottingham; Southend; and Westminster. Interviewers had substantial experience of conducting research with people who have lived experience of homelessness and substance use. The aim of these interviews was to gain an in-depth understanding of the impact of RSDATG interventions on service users and to provide insights into service users' perceptions of:

- The effectiveness of RSDATG-funded services (including comparison with any previous experience of drug and alcohol services)
- Barriers and enablers to accessing RSDATG-funded services, including reasons for drop-out and ease of subsequent re-engagement
- Positive features of RSDATG-funded services, and areas for improvement
- How RSDATG-funded services have impacted them personally.

These interviews had originally been designed to be longitudinal, with service users participating in more than one interview over time. However, this was only possible in a small number of cases.

Fieldwork with commissioners

As part of the third wave of fieldwork, commissioners from 44 of the funded, non-case study, areas were interviewed. The purpose of these interviews was to gain an understanding of how the funding was being used and the impacts of the funding on service users across the whole programme. Findings from these interviews were triangulated with findings from the first two case study waves and were used to identify additional issues for investigation in the third round of case studies.

2.3.3 Qualitative analysis and contribution analysis

Each interview was recorded with the agreement of the interviewee, transcribed and coded to prepare for analysis. De-briefing and analysis sessions were held for members of the fieldwork team to discuss and identify key themes (which were reviewed by the Project Manager and Project Director), interpret and triangulate the findings between the two waves of research and prepare the concluding comments and recommendations (which were checked for accuracy and quality by the Project Manager and Project Director). When reporting these qualitative findings, focus is placed on the breadth of experiences and main themes rather than the number of people who have expressed an idea, so any proportions used should be considered indicative, rather than exact.

Findings from the qualitative research were analysed using a contribution analysis framework. This is a structured approach to gathering and analysing evidence to make a judgement about the contribution of certain activities to observed outcomes. Contribution analysis is appropriate because it is designed to address questions of attribution. It provided an opportunity to review the evidence collected in previous waves, and allows for the triangulation of different kinds of qualitative and quantitative evidence. Using the data collected, and reviewing it against the description of how the funding was intended to create positive impacts (the theory of change), the evaluation assembles a story that, based on the evidence, describes the ways in which the funding has contributed to the outcomes observed, and the strength of this contribution. To improve rigour, the evaluation has also looked for weaknesses in this story, including where the evidence is weaker and where the explanation given by the theory of change may be less credible. Where this is the case, alternative explanations for the observed outcomes are proposed. Together, this informs an assessment of the extent to which, and the ways in which, the funding has influenced key programme outcomes.

2.3.4 Quantitative comparative analysis

The quantitative comparative analysis was based on data from NDTMS. It comprised two analyses:

- An analysis of trends in the numbers of people in housing need starting treatment on a quarter-by-quarter basis, in all funded areas and in non-funded areas, both before and after funding.
- A comparison of the outcomes achieved by people in drug and alcohol treatment and supported by RSDATG, with outcomes achieved by a group of drug and alcohol service users with similar needs who were in treatment but not supported by RSDATG. This analysis was conducted separately for ten case study areas. However, because of the limited appropriateness of the comparison group findings from this comparison have not been reported in detail in this report. They are available in Annexe 1.

2.3.5 Economic evaluation

The economic evaluation is a cost-consequence analysis. This presents the costs of implementing RSDATG (including the costs of the funding and how this was spent, as well as any additional costs resulting from delivery or implementation of the grant); and programme impacts (its 'consequences', as set out in the impact evaluation and evidenced from a range of sources). This has been conducted separately for 10 case study areas (those that were included in the comparative analysis).

2.3.6 Limitations

Case study approach

Some areas initially selected as case studies did not have capacity to take part, so these areas were replaced with other LAs with similar profiles according to the sampling framework produced

during the scoping stage. Where possible a single interview with the local drug and alcohol commissioner was carried out instead. The evaluation attempted to interview commissioners in all funded areas, but due to availability, 9 funded local authorities did not participate in the evaluation at all.

The case studies were designed to explore 'what works for whom' by bringing qualitative and quantitative data together in respect of the ten comparative analysis sites. However, it has been difficult to precisely identify the impact of specific interventions because the funding has not been used to deliver discrete, specific interventions; rather, local commissioners typically used it for a range of roles and interventions designed to reflect local need and fill gaps in existing services.

Qualitative fieldwork and analysis

The findings from the case study research and interviews with commissioners are based on qualitative evidence. This reveals the diversity and nuances of experiences and the reasons underlying them. However, the research was not designed to be statistically representative of the wider population. Therefore, it is not possible to provide a precise indication of the prevalence of a certain outcome or experience.

There were challenges around recruiting service users to take part in the evaluation. Availability of service staff who could help recruit participants for interview was limited due to their workload. In some cases, it was difficult for them to identify suitable RSDATG participants with the capacity and willingness to take part in interviews. It was also logistically challenging to arrange follow-up interviews with service users, again due to limited staff capacity. This meant that only four of the service user participants were interviewed more than once, so it has not been possible to track service user outcomes using this method.

The service users interviewed for the evaluation represented a range of ages, genders, and nationalities. They were living in a range of accommodation types (at the time of interview), and experienced (or had experienced) problems with a variety of substances. However, it is important to note that the participant sample may not be representative of the experiences of the overall service user population, as the nature of recruitment for the interviews meant there was an inherent bias towards those who were more engaged with services (and therefore who may have faced fewer barriers to engagement) and who were in the later stages of recovery.

Monitoring data

Monitoring data was reported by local authorities receiving the funding. Some local authorities did not provide data for every variable in every quarter and therefore in some cases the evaluation team has made use of estimates (for example, where an annual figure was not provided, using the highest quarterly figure from that year). There are also inconsistencies in how different LAs define what constitutes an RSDATG intervention. Some local areas, particularly where services are integrated, include everyone on their wider caseload. Others, by contrast, only count individuals

who have direct contact with the teams funded through RSDATG. This difference in interpretation impacts the reported figures and they should be understood with this caveat in mind.

Quantitative comparative analysis

A quantitative impact evaluation requires longitudinal data (before and after) on the outcomes of interest for all individuals engaged. For RSDATG this is not available: the best available dataset is the NDTMS dataset, but this does not include all individuals engaged by RSDATG, only those who have engaged in treatment. This means the evaluation cannot draw conclusions as to how far the funding has improved outcomes for its entire target population of people experiencing rough sleeping, or at risk, with drug or alcohol issues. However, the quantitative analysis has instead (a) looked at aggregate data to assess the impact of RSDATG on the volume of treatment starts; and (b) compared the outcomes achieved by RSDATG service users that engage with drug and alcohol treatment with other people in housing need and in treatment, not supported by RSDATG. When undertaking this second analysis the evaluation team encountered a number of significant limitations which are covered in detail in Annexe 1.

The analysis which compares treatment starts in funded and non-funded areas is limited to people recorded as having an 'acute housing problem'. This was intended to limit the analysis to people who would be in the target group for RSDATG, and used the only housing variable possible to do this (since other housing variables in the dataset changed their definitions over the period in question). However, this will not capture everyone who would be in the target group for RSDATG since some people who are 'at risk' of rough sleeping would not be classed as having an 'acute housing problem'.[12] This means the analysis may not provide the full picture of the effect of RSDATG funding on treatment starts. Specifically, it cannot show how treatment starts among the less acute, 'at risk' group compare between RSDATG and non-RSDATG areas. If RSDATG funding brought a lot of this group into treatment in a way that did not happen in non-funded areas, this would not appear in the analysis.

The comparative analysis assessed outcomes for the RSDATG cohort relative to non-funded areas or non-supported people. Because there have been wider improvements to drug and alcohol services over the funded period, there is less relative difference between RSDATG and mainstream services. These wider improvements were partly due to other funding streams, but RSDATG itself has also had an influence on mainstream drug and alcohol services and other services more widely in the funded areas (see chapter 6).

Economic analysis

[12] In NDTMS, acute housing problem is defined as "Has client had an acute housing problem (been homeless) in previous 28 days?". Some of the 'at risk' group for RSDATG were living in hostels or temporary accommodation which would be sufficiently long-term to mean they might not fall into this category.

The detail on spending available in cost proformas has limited the ability to disaggregate expenditures into different categories, and there are some differences between local authorities in how costs are categorised. This has led to difficulty in standardising costs across areas.

In terms of cost per service user, it is challenging to isolate RSDATG costs from the costs borne by other services, and information on the latter is not consistently available. The cost per service user in each area cannot be applied more widely as funding was allocated, and delivery models varied, based on local needs and availability of existing services.

Several of the costs and consequences of RSDATG are not quantifiable, or not observable over the time period of the evaluation. This means the true costs arising from the funding are likely understated, and limited information is available on the scale and economic impact of some of the consequences (for example, the costs and benefits of supporting service users with their physical health).

These limitations are presented in more detail in section 7.3.

2.4 Structure of the report

The report is structured as follows. Broadly speaking, chapters 3 and 4 discuss how the funding was used, and what worked well and less well; while chapters 5 and 6 summarise the outcomes of the funding. This is a common format for evaluation reporting and is designed so the impact of the funding can be summarised in one place, whilst the process findings and lessons learned are discussed in another. However, this does mean that readers of the outcomes chapters (5 and 6) may need to refer back to the process chapters (3 and 4) for a full explanation of the reasons behind the outcome findings.

- The following two chapters cover the findings from the process evaluation:
  - Chapter 3 introduces the process evaluation, looking at how the programme was set up and implemented across areas
  - Chapter 4 discusses the RSDATG cohort, how services identified and engaged service users, and the different types of support being offered
- The next two chapters cover the findings from the impact evaluation:
  - Chapter 5 looks at the impact of the funding on service users
  - Chapter 6 explores the impact of RSDATG funding on services
- Chapter 7 presents the findings of the economic evaluation
- Chapter 8 looks at local commissioners' plans for the future and the sustainability of funded roles and services

- Chapter 9 presents the conclusions and implications of the evaluation
- Chapter 10 provides recommendations

There are also 4 annexes that accompany this report, as follows:

- Annexe 1: Full details of the quantitative comparative analysis and tables of results
- Annexe 2: Individual reports from the 11 Wave 3 case study areas
- Annexe 3: Detailed cost analysis for the 10 areas for which this was carried out
- Annexe 4: The theory of change for the RSDATG project

3 Process evaluation: set-up and implementation

This chapter addresses the evaluation questions relating to RSDATG's fit with local provision and alignment with other funding streams and national programmes. It sets the scene for the remainder of the report by describing how commissioners intended to use the funding and why (given their local context). It also covers process evaluation questions around the experience of recruiting, retaining and supporting staff, and other aspects of managing the funding that do not relate to working with service users directly.

3.1 Commissioners' aims for how to use the funding

Guidance issued to commissioners stated that the purpose of the RSDATG funding was:

- To support people experiencing, or at risk of, rough sleeping to access and engage in drug and alcohol treatment;
- To ensure that the engagement that people have had with drug and alcohol treatment services whilst sleeping rough or in emergency or temporary accommodation is maintained as they move into longer-term accommodation; and
- To build resilience and capacity in local drug and alcohol treatment systems to meet the needs of this population in future years.

RSDATG funding was first announced in the March 2020 Budget. Two weeks later, the Government asked local authorities in England to "get everyone in", ensuring that people experiencing rough sleeping or in accommodation where it was difficult to self-isolate (such as shelters) were safely accommodated to protect them, and the wider public, from the risks of Covid-19. Phase 1 of RSDATG funding took place in the context of this Everyone In initiative and focused on the needs of people who had been moved into emergency accommodation as a result, although by the time funded areas began delivering RSDATG, only around three in ten of those housed during Everyone In were still in emergency accommodation.[13] The experience of delivering Everyone In had revealed the level of need and highlighted the potential benefits of outreach and taking services to people (see section 3.5 for more detail).

Commissioners consistently described their priority for RSDATG funding as increasing the numbers of people entering drug and alcohol treatment, in particular the most vulnerable, entrenched and at-risk individuals. They sought to commission services that would do this by building relationships and undertaking preparatory work to prepare people for treatment; and by offering wraparound support that could resolve problems such as health issues that might have been preventing someone engaging with treatment. Enabling people to engage with other services

[13] https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2021/annex-a-support-for-people-sleeping-rough-in-england-2021-not-official-statistics

outside drug and alcohol services (such as registering with a GP) was therefore also a common priority.

Beyond this, commissioners' other common priorities were reducing harm and risk of harm from substance use; retaining people in treatment and supporting them to engage with this consistently; and helping people to obtain or stay in housing. In some areas this was described as helping people access housing so that they could engage in treatment, whereas in other areas it was envisaged that engaging in treatment would help people obtain or maintain housing (see section 4.8).

RSDATG provided commissioners with flexibility to respond to local knowledge of service provision and key issues. Therefore, in addition to commissioners' main aims, identified above, a wide range of other, more specific goals, were set. This included:

- Supporting more opiate dependant people through rapid access to prescribing
- Improving access to detox and residential rehab for this group
- Increasing the numbers of people successfully completing treatment
- Re-engaging people quickly if they relapsed or left treatment early
- Creating diversionary activities and helping people get involved positively with their community
- Reducing pressure on other services
- Improving joint working and relationships between services
- Improving understanding of this group among other services.

Commissioners' goals related to their perceptions of the strengths and weaknesses of existing drug and alcohol services for this group. For example, some sought to increase capacity if existing services were working well but facing high demand; others focused on supporting sustained engagement if there were a large number of service users in the area who were known to treatment services but struggled to stay engaged.

> **"A lot of the people who are eligible to get support through this funding have been around a long time in [town], bouncing in and out of services... Success would look like people from that cohort staying consistently engaged with workers and services."** – Commissioner

Some of the more experienced commissioners said they felt confident in their understanding of what was required in establishing RSDATG services, and how best to go about the set-up work. In contrast, commissioners with less experience (especially those who were setting up targeted services from scratch) mentioned that they could have benefited from additional guidance and

support from OHID. However, commissioners were also conscious that the OHID team was increasingly stretched throughout the implementation phase of the grant funding.

Some areas had conducted needs assessments or other research to inform their priorities for the funding, such as reviewing the findings of drug and alcohol death reports. Priorities were also informed by an awareness of which services in the area were particularly under pressure, such as local authority homelessness departments.

3.2 How the funding was used

Local authorities typically used RSDATG funding for multiple interventions and a variety of roles rather than focusing on one, or a small handful of distinct activities / interventions. In a survey conducted in 2023, more than 4 in 5 commissioners selected the majority of the 18 options available when asked what kinds of interventions they were funding. 9 out of 10 participants stated that they had used the funding to offer harm reduction activities, improve access to detox and rehab, and fund specialist teams.

Assigning funding to create (or sometimes expand) specialist teams of drug and alcohol workers was a particularly strong theme. Most commissioners interviewed had chosen to commission these specialist teams from the same organisation that delivered drug and alcohol services for the general population in their area. Commissioners' reasoning for this was that it would allow better continuity of care for people moving into mainstream services once their housing and/or substance use was more stable, and conversely to identify and respond more quickly to people using the mainstream service who became at risk of rough sleeping and might need support from the specialist team. Other reasons were that existing treatment services already knew some of the relevant service users, and had relationships with other local services as well; that it would avoid duplication; and to avoid stigma that a differently-branded service might attract. As well as this, it was thought to be a more practical option in that it would allow the team to be set up more quickly, be better equipped to build upon existing local relationships and because the opportunity was thought unlikely to appeal to a new provider in light of the annual funding and the costs involved in setting up a new service.

Many areas set up a virtual team of people across a range of organisations including (for example) their local treatment provider, the local NHS mental health trust and the local authority itself. This approach was intended to ensure links to a wider range of services and draw on multiple perspectives. It was also thought to prevent bottlenecks that might arise by increasing capacity in only one part of the system, when people in the target cohort would need to be supported by multiple services. In particular, funding a role within mental health services was thought to improve access to mental health treatment for service users; likewise, areas where drug or alcohol treatment was delivered by an NHS mental health trust thought this put them at an advantage in terms of accessing mental health support. Depending on the types of roles funded, a virtual team could also allow service users to choose to work with the worker or organisation they had the best relationship with, and access other services via this relationship.

A small number of areas chose to set up a separate service for people in the RSDATG target cohort, delivered by a different provider and operating under a different name. They argued that this reflected the different approach and culture that working with more complex individuals required, and that it helped to delineate responsibilities. Other areas commissioned a differently-branded and managed service from their existing provider for similar reasons.

> **"I'm from working in a street outreach background and it's a really different philosophy to working in the treatment service...That very much needs a specific management style to try and create that culture."** – Commissioner

However, in one area that set up a different team delivered by a different provider, some stakeholders had concerns about duplication, especially when both the RSDATG team and mainstream drug and alcohol services were conducting street outreach. There were also reports of delayed handovers between the RSDATG and mainstream teams which could risk service users disengaging from treatment, although the RSDATG projects commonly took steps to mitigate this including ensuring service users had continued access to prescribing.

The types of roles that were funded within these local teams included drug and alcohol workers (typically with outreach or in-reach making up all or part of their role); workers to conduct outreach with specific groups such as women; co-occurring conditions workers whose role was to advocate and coordinate support for people in the target group with mental health problems; peer supporters; specialist clinical staff such as outreach nurses and GPs, who could help service users get support for physical health needs; psychologists and psychiatrists (who worked with service users directly, and/or supported other staff); and social workers.

RSDATG-funded social workers

Some areas recruited a social worker in recognition that people in the RSDATG target group with social care needs can have difficulty being assessed and thus having their needs met. These workers undertook assessments to understand individuals' mental capacity and needs relating to brain injury, learning difficulties/disabilities, or neurodiversity, in a way that would be formally acknowledged by other organisations. They helped other service providers understand how to communicate more effectively with service users given these needs. Social workers also used legal powers - through the Care Act, Mental Capacity Act, and Human Rights Act – to advocate for more appropriate accommodation and support for service users.

Social workers explained that once these needs were identified and communicated, services were more likely to make reasonable adjustments for service users rather than attributing any negative behaviour to substance use, and accommodation providers were less likely to evict service users.

"When I did the [Care Act assessment], it was all about crime and him being a nasty person. And I said, in the group, 'Well, has anybody done a capacity assessment?' No. 'Has anybody done a frontal lobe battery test?' No. 'Do you think we could have it done?' ... They've looked at him. They've put him in the most appropriate place. He, himself has not

drunk for 6 weeks. So, where's the nasty person who everyone knew? Getting the right support." – Frontline worker

As well as funding staff to work with service users, the grant was used for staff time to set up collaboration processes (such as MDT meetings) and systems (such as data-sharing IT systems); to design new pathways into residential treatment for service users with specific needs; and for training for staff both in funded roles and in other services.

Funding was also used on non-staff costs: drugs and other equipment; places at inpatient detox and rehab centres (discussed in sections 4.7, 5.2 and 5.3); the costs of running venues/drop-in sessions where people could get advice and harm reduction or meet services; buses for mobile clinics; and personalised budgets (discussed in sections 4.2.2 and 4.8.2).

A small number of areas intended to use RSDATG funding to set up or maintain specialist supported accommodation for people in the target group; however, the evaluation did not identify any examples of this having been achieved successfully. The main reason for this was thought to be the short-term and uncertain nature of the funding which meant the opportunity was not attractive to potential accommodation providers (see section 4.8.3).

3.3 What is distinctive about RSDATG-funded services

Since, by definition, funded areas had significant numbers of people experiencing rough sleeping, several already had access to specialist drug and alcohol services for this group. The 2023 survey responses suggested that just under one-third of the local authorities receiving RSDATG funding had previously commissioned drug and alcohol treatment services specifically for people experiencing rough sleeping or at risk of doing so.

Several funded local authorities also described initiatives they had previously been involved with to support a similar cohort of people to RSDATG, including Making Every Adult Matter (MEAM), Fulfilling Lives, Changing Futures, and the Blue Light project. As well as this, the Rough Sleeping Initiative (which launched in 2018) and the experience of delivering the Everyone In policy during the Covid-19 pandemic had also already led services to consider how best to support people experiencing rough sleeping with drug or alcohol needs in most of the local authority areas in scope.

Nevertheless, interviewees believed there were widespread shortcomings in drug and alcohol services that existed prior to RSDATG, which meant they were not meeting the needs of people experiencing rough sleeping. The most common theme was a lack of outreach; that there was either no outreach capacity for this group from drug or alcohol services or that it was highly limited (for example a single worker). This effectively meant that people experiencing rough sleeping were expected to come into drug and alcohol services for appointments at fixed times and sit in waiting areas, an expectation which they could often not meet. This resulted in them not receiving support and, where engagement attempts were made, often being discharged for non-attendance. Other

reasons cited for services not being able to meet the needs of people experiencing rough sleeping were that:

- Workers had high caseloads (some staff reported caseloads of 90 or 100 people per worker in the mainstream service pre-RSDATG). This meant workers had very little time to spend with each person;
- Interventions were generic with limited ability to tailor to individual needs; and
- For these and other reasons, services were not operating in a trauma-informed way that took account of the difficulties people were experiencing.

In this context, commissioners saw RSDATG as an opportunity to focus on the drug and alcohol needs of people experiencing rough sleeping and to design dedicated services to meet the needs of this group. The fact that the funding was not target-driven meant there was less pressure to focus on 'easier' cases to increase numbers, and instead an opportunity to enhance service quality and to work with people who previously might have been considered too entrenched to respond to support.

The fact that the grant was intended as a response to multiple issues enabled it to be used for interventions addressing multiple needs (such as mental health support for people who were homeless with co-occurring conditions) which previously could have struggled to attract funding as they did not clearly fall within any one commissioner's responsibility.

The support provided by RSDATG-funded services and roles was most often not highly innovative (if this is defined as a novel approach with an emerging evidence base but limited experience of delivery). Rather, local authorities pursued approaches that they felt confident would be effective because of experience in the past or elsewhere. These approaches tended to include one or more of the following, made possible through funding additional staff:

- Having smaller caseloads to allow more flexible and intensive working and more time to develop relationships (in some areas caseloads were as low as 10, whereas in others they could be 30 or 40 but still half that of the mainstream service);
- The ability to conduct increased outreach, in particular to reach people who had not previously come into services;
- The ability to look at a wider range of needs and issues in a more holistic way;
- A more collaborative, multi-agency approach.

Staff and commissioners strongly valued the ability to take these approaches, which were often described as something they had 'always wanted to do' but not been able to afford. Being able to work more closely and flexibly with service users was seen as leading to increased feelings of job satisfaction for staff, as described in section 3.6.

> **"We found it quite difficult to engage people before, because, obviously, it's really quite a big ask for somebody who's got really bad leg wounds, got no roof over their head... I think we always wanted to go out to them, but it wasn't always practical, because the staff just wasn't there for it."** – Service manager

Some commissioners and senior staff at service providers commented that the funding had allowed the restoration of higher-quality ways of working following local authority funding cuts in the 2010s.

> **"In 2015, we had a reduction of probably about 30% from local authority funding, plus other funding streams that were also stopped around the same time... and that resulted in things like outreach teams and rough sleeper teams and things like that were no longer possible to commission at that time. So, from 2015, we hadn't had any rough sleeper-specific provision."** – Commissioner

This observation was reflected in the business case for RSDATG, which noted that between 2015 and 2020, spending on drug and alcohol treatment services fell by around a quarter, and that further funding would be needed to make up for this loss beyond the increase in spending associated with the Drug Strategy. In fact, DHSC funding for adult drug and alcohol treatment to local authorities fell by 40% in real terms between 2014-15 and 2021-22, with 42 unitary authorities seeing falls of 50% or more[14]. In some areas, commissioners noted that the grant allowed them to continue work for which funding from elsewhere was coming to an end (such as assertive outreach to drug hotspots funded by a police and crime commissioner).

Interviewees felt that RSDATG funding was not only expanding what drug and alcohol services could offer in this context, but also making up for stretched capacity in other services such as accommodation providers and the NHS. For example, RSDATG workers could attend appointments with service users or help them with paperwork tasks, when in the past hostel staff might have had capacity to support this.

> **"What they do is so person-centred and so dependent on the individual, it can be anything. You know, for one person, they can help to get a birth certificate, which doesn't necessarily benefit that person getting into treatment, but it then means that whoever was dealing with them -, and it might not be the rough sleeping team, it might've been somebody else that was trying to access DWP [benefits], can then do that."** – Commissioner

RSDATG funded workers or initiatives would also help to deliver health interventions not directly related to drugs and alcohol, such as vaccination and oral healthcare.

Beyond the overall approaches that local authorities used the grant for, interviewees identified other initiatives or ways of working funded by RSDATG which they saw as innovative in their areas, such as same-day prescribing of opioid substitute medication (see box in 5.3.1); a team providing

[14] National Audit Office, Reducing the harm from illegal drugs, October 2023

psychological support to prepare people to work with mental health services (see 5.8.1); and a 'detox house' for people who would be eligible to undertake detox in the community but had no suitable accommodation to stay in while they do so (see 5.6). RSDATG funded six pan-London projects that sought to address issues affecting the city as a whole, including improving pathways and coordination for people with co-occurring conditions and providing guidance and training on how to support people with no recourse to public funds. However, some commissioners lamented that the annual nature of the funding had discouraged them from exploring more innovative or systemic approaches.

> **"If I knew that we were going to get this funding for another three years, we would work with our housing colleagues to develop more longer-term system stuff. Definitely around options for detox. I think we could be a bit 'more cleverer' by using other contracts out there and flexing. But it's been very difficult on a year-to-year basis."** – Commissioner

3.4 How does RSDATG fit with other local provision?

In their application forms, commissioners set out how they intended to use RSDATG funding to fill gaps in existing services, for example by recruiting specialist outreach workers or setting up dedicated co-occurring mental health teams. This means support has to some extent been designed around what was already there (for example, the extent to which there were already specialist homeless GP and nursing services in the area).

Several other funding streams and initiatives launched at or around the same time as RSDATG. This included several funding initiatives intended to reduce rough sleeping, such as the Rough Sleeping Initiative, the Homelessness Prevention Grant and the Rough Sleeping Accommodation Programme. The Government's Drug Strategy resulted in additional funding for local authority drug and alcohol commissioning, which as well as RSDATG included the Supplemental Substance Misuse Treatment and Recovery Grant (SSMRTG), additional funding for inpatient detox, and Project ADDER (a Home Office-led initiative to tackle substance use in 13 areas in England and Wales). In total, this additional funding amounted to £903 million between 2022 and 2025, and by the end of 2023 had already resulted in 1,224 new drug and alcohol workers being recruited across England[15] and 21,648 more people in treatment in 2023/24 compared to 2021/22.[16]

The Rough Sleeping Initiative (RSI) was particularly relevant to RSDATG implementation. As it was already underway at the time RSDATG funding was announced and most RSDATG-funded areas have also received RSI funding, commissioners have needed to distinguish the roles of RSDATG and RSI teams as well as ensuring good working relationships and effective pathways between them. There were a range of views on this: some commissioners perceived the purposes of the two grants as very distinct with little risk of overlap, while others described ongoing discussion and negotiation with other commissioning teams within the local authority to avoid duplication, and in some instances to unofficially pool funds (for example to set up a role funded by several

[15] https://www.nao.org.uk/wp-content/uploads/2023/10/reducing-the-harm-from-illegal-drugs.pdf
[16] NDTMS data, accessed at https://www.ndtms.net/ViewIt/Adult

different grants). Many areas promoted joint working between RSI and RSDATG teams. Still other commissioners reported that they would have liked to see more of this type of collaboration between commissioning teams in their areas, but believed that the separate funding pots discouraged it.

Public health commissioners explained that they mitigated potential duplication between the various drug and alcohol-related funding streams by prioritising different areas of focus for each. For example, one area used RSDATG to focus on initial engagement and funded subsequent treatment from the core public health grant, with recovery services funded by SSMRTG; another used SSMRTG to recruit more drug and alcohol workers and thus reduce caseloads, and RSDATG to fund wraparound support. RSDATG tended to be seen as more flexible than other sources of funding, allowing commissioners to complement and fill gaps in existing provision and so avoid duplication, and design services tailored to specific local needs.

In some areas, particularly at the outset of the grant, this coordination between funding streams was not done effectively, leading to duplication and confusion. Interviewees from two areas reported that at one point there were seven different teams seeking to conduct outreach with people experiencing rough sleeping, all for slightly different purposes, and a commissioner in another area described how RSDATG and RSI teams had been undertaking similar in-reach work in hostels, resulting in confusion for accommodation providers and friction between the two teams. These problems were reported to have been resolved by discussion between services led by commissioners, ad-hoc problem-solving meetings and by instigating regular MDT meetings. Nevertheless, some interviewees felt that the time-limited nature of funding and the lack of a requirement to build on existing services was partly responsible for this kind of situation occurring, and that similar problems could recur in future if further changes were made to funding streams.

The issue of managing potential duplication is particularly salient for initiatives such as RSDATG which focus on multiple issues and so cut across different commissioning teams. For example, as mentioned in section 3.2, there may be an ongoing risk of duplication where more than one service is focused on the same vulnerable groups, but strategically sat within different departments at the local authority (for example, housing and public health). Other case study areas had tackled this issue by bringing teams from different 'multiple disadvantage' initiatives together into a network, or assigning responsibility for planning and avoiding duplication to one team.

More broadly, some RSDATG areas reported being heavily reliant on time-limited grant funding to provide specialist services for the RSDATG cohort, and that the availability of these services had therefore fluctuated over the years, making it difficult to provide consistent support and establish long-term solutions.

> **"I don't know if you know much about drug services, but they're always bust and boom. Lots of funding. They take the funding out, crime rate increases, drug death increases, so they put money back in. It's that kind of bust and boom."** – Frontline worker

The high number of distinct funding streams was also reported to have caused administrative burden, both in terms of separate reporting requirements and in terms of the need to coordinate what each grant was being used for and then confirm this with OHID.

> **"I was asked the question, 'Why have you not considered your inpatient detox need within this pot?' And I was saying, 'Because I'm considering it under my inpatient detox pot that OHID have already given me'... It creates a lot of work for us, and it creates a lot of questions for us about how we're going about integrating that at the local level and the interface between it."** – Commissioner

However, interviewees were optimistic that the combined DATRIG funding system would improve this.

3.5 Effect of wider system and context

The Everyone In initiative to house people experiencing rough sleeping during the Covid-19 pandemic had influenced RSDATG-related commissioning in three key ways. It had

- Revealed the level of need, in terms of the numbers of people experiencing rough sleeping in each area and the numbers of people within this group with problems relating to substance use (and mental health). Both of these were often higher than commissioners had realised.
- Highlighted the potential benefits of outreach and taking services to people. During Everyone In, people who had been previously experiencing rough sleeping were housed in a small number of hotels, often with the local drug and alcohol service running clinics on site. The demonstrable difference this in-reach had made to engagement and health outcomes had prompted commissioners to invest more in this type of approach.
- Prompted more joint working between different services, instilled a sense of achievement and pride among the workforce about what could be achieved by working in this way, and raised ambitions locally for what could be done to help address rough sleeping amongst individuals with a range of complex needs.

In some areas, there had been other previous initiatives to support the RSDATG cohort or people with multiple disadvantage more broadly, which had had similar effects. SSMTRG funding had also increased the capacity of mainstream drug and alcohol services. More generally, commissioners often found it difficult to distinguish the effects of multiple funding streams: many areas received funding from RSI, RSDATG, SSMTRG, Changing Futures and OHID's inpatient detoxification fund.

Some of these initiatives had preceded RSDATG and already led local services and commissioners to consider how they could work together more effectively to support people with multiple needs.

> **"I think the complex needs, the Changing Futures stuff, had already started people thinking in that way… one of the things we did with Changing Futures was create those strategic networks and system changes… Changing Futures gave us a really useful thing to hang our work on and our thinking on; that's been key."** – Commissioner

In particular, in many areas the Rough Sleeping Initiative had led to the establishment of multi-disciplinary team meetings to discuss how best to support individuals experiencing rough sleeping, and introduced more intensive ways of working with people experiencing rough sleeping. In one case study area, RSDATG was characterised as "largely a continuation of the RSI ethos but with an acute focus on substance use and offending behaviours". Likewise, areas which had received Project ADDER[17] funding reported similar effects on collaboration and redesigning services to be more intensive and flexible.

As well as this, commissioners in some areas (particularly large cities and inner London boroughs) referred to their long experience of working with people experiencing rough sleeping with substance use needs. In contrast, commissioners who referred to the influence of specific initiatives from the last ten years tended to be from outer London areas or towns.

3.6 Recruitment and retention of staff

Across most of the RSDATG projects, there have been issues with the retention and recruitment of staff, which interviewees attributed to the nature and intensity of the work combined with relatively short-term funding allocations creating job insecurity. This was especially marked in the early years of the grant and was reported to have improved over the lifetime of the funding.

> **"The funding is still very short term and that has caused problems. It's that uncertainty from year to year and you still don't know if there's going to be money next year. For the first time since the project started, we've got a stable staffing team and that has taken a good three years to get to that point."** – Commissioner

As the RSDATG funding is allocated annually, in most cases posts are funded one year at a time, which represented a barrier to recruitment as potential candidates may be hesitant to take on roles with limited job security. Some projects discussed posts taking months to fill and that during these times they did not have an adequate number of staff to deliver the service as intended. One case study area which was particularly affected by recruitment challenges described the RSDATG programme in their area as effectively "non-existent" at times.

Some noted recruitment challenges were more prevalent among staff in regulated roles such as nurses, psychologists and clinical prescribers, where RSDATG services are in competition with the

[17] A Home Office-led initiative that ran between Autumn 2020 and March 2025 in 13 areas, to establish and test whole-system response to combatting substance use.

NHS which typically offers better pay and job security. However, others reported challenges in all roles due to the work being emotionally and physically demanding. It was noted that many service users have faced multiple traumas which can make supporting them challenging. Some areas mentioned that this had led staff to go on long-term sick leave or in some cases, they had recruited staff who had found the role too difficult and were unable to stay in post.

> **"If you're working with a client, and they're smashing their heads against a wall and threatening suicide, and you make a referral to be told they're not suitable for mental health support because of their drug use, I often feel on my own and quite out of my depth."** – Frontline worker

In some cases, it was felt that recruiting for outreach RSDATG roles was more challenging than mainstream drug and alcohol service roles because peripatetic roles can be perceived to be more isolating and physically demanding than working from an office.

> **"I think because they're outreach based, I don't know how much contact they have together, or as a team, I think there's a risk there of staff maybe feeling isolated. I can imagine it would be quite isolating not to have a permanent base."** – Commissioner

However, others highlighted that RSDATG roles can be appealing to some professionals. In particular, frontline staff in RSDATG-funded roles had smaller caseloads than those working in other drug and alcohol services. This allows staff to provide more focused support, work flexibly with service users and use trauma-informed approaches which were noted to lead to strong feelings of job satisfaction. Additionally, staff appreciated being part of supportive teams and how rewarding it is to be able to help some of the most vulnerable people in society who are often excluded from mainstream services.

Some areas felt they were competing with inner-city opportunities which were seen to offer more competitive salaries and were in more desirable locations. Commissioners discussed how they struggled to recruit people to work in suburbs of major cities or in more rural areas. In some areas, outreach workers at other services were paid more than the RSDATG outreach workers which made recruitment more challenging.

One commissioner commented that as drug and alcohol services have been depleted over the years, so have the skill sets required for this work. In response to these challenges, some areas shifted their recruitment focus to prioritise values, empathy and a willingness to work with a challenging population; and (if needed) cultural links to key demographics within the cohort, rather than solely focusing on qualifications and previous experience.

> **"We were all competing for the same pool of staff. Nurses and complex needs workers have been really hard to recruit. Which is why we thought we'd rather just go to our local Romanian community organisation, recruit someone that has the right cultural skills, and then we can train them up in the substance misuse elements."** – Commissioner

Other areas worked on 'growing their own' staff through their peer mentor and volunteer training programme, which allow those who had gone through treatment to enter paid employment and support those currently accessing RSDATG services. These approaches can help to attract individuals who are passionate about the work and more likely to stay in the role.

However, recruiting in this way could mean that those who were recruited lacked the experience required for conducting this work and required a longer period of training and shadowing than would usually be expected. Interviews with stakeholders pointed to the importance of providing staff with adequate training, regular supervision and support to maintain their resilience and to help improve retention rates.

3.7 Support for staff

All areas provided psychological support to staff, as it was acknowledged as important for workforce resilience, to minimise staff turnover and to prevent burnout from the trauma that is likely to arise from working with this group.

> **"There is an expectation from staff to build a professional relationship with someone who is experiencing a lot of pain and trauma and self-destruction and who's very high risk of a lot of different things and that's going to take its toll on staff. They all have trauma and mental health issues, and we are not a mental health service."** – Frontline worker

Support varied between areas, and included:

- Supervision sessions, which could be conducted with a psychologist, psychiatrist or team leader, to allow recovery workers to discuss their caseload and any issues they are facing.
- Reflective practice, either individually or as part of whole-team sessions.
- Team leaders helped staff to manage their caseloads and where appropriate encourage them to transfer service users to the mainstream service, to ensure the caseloads of staff remain relatively low, and to mitigate burnout.
- Team building, to encourage staff to share their experiences with their colleagues. In addition, team leaders had open-door policies for staff to discuss their cases.

Fostering a culture where staff can discuss their service users and share pressures following specific events, alongside the interventions outlined above, ensure that staff are consistently supported.

Training was provided to staff on various topics, such as trauma-informed care and harm reduction. Additionally, training is also provided around personal resilience and well-being in recognition that frontline staff are prone to experiencing burnout and stress due to the intensity of their work.

3.8 Support from OHID to deliver RSDATG and effectiveness of this

Some areas reported that they had received useful support from OHID, most commonly in the early set-up stages of their projects and subsequently regarding re-profiling funding and to receive clarity on grant requirements. Interviews with members of the OHID Distributed Team noted that the size of their team has reduced which has impacted the level and nature of support they can provide to commissioners. Additionally, the remit of their work has changed as result of the introduction of DATRIG.

Some areas discussed having a good relationship with OHID. They had key contacts within the organisation and felt OHID were responsive when they had queries. Others described some level of flexibility in working with OHID when it came to re-profiling funding underspends. However, there were a handful of areas who reported challenges with OHID, including being required to frequently re-profile, which led to them feeling not trusted by OHID.

> **"We know now that OHID are quite happy that if it's along the same lines and it's not a huge amount of money, that we can [reprofile] without having to get approval from someone."** – Commissioner

3.9 Data collection and information-sharing requirements

Interviewees reported that setting up information-sharing arrangements between the organisations receiving RSDATG funding and their local partners had been very time-consuming due to the sensitive nature of the data and the difficulty in aligning different organisations' data policies. They reported that more support from OHID on this task, such as template data-sharing agreements, would have been very useful.

When asked about challenges around delivering the grant, many commissioners spontaneously mentioned the financial and data monitoring reports they were required to compile and return to OHID. These were reported as time-consuming to complete, as they required a considerable amount of information, which a number of staff across different services had to contribute to. Commissioners questioned whether the value of the data provided was proportionate to the time needed to collate it.

> **"We did resist a lot of the data entry for quite a long time because our model is one where recovery workers are seeing people, not filling in forms and not doing admin. You have to have the data to back up what we're doing, particularly when it's grant-funded, so we're absolutely not against that, [but] the volume of it and the complexity of it and the level of it is disproportionate to the amount of spend"** – Commissioner

Some believed that the metrics included in the reports do not reflect the value of the services provided. For example, whilst there were no targets set, areas are required to report on the number of people who had completed treatment. This was felt to be a crude measure as it did not accurately reflect all the work that took place in the lead up to and during the treatment process.

Some staff argued for the use of outcome measurement tools such as the Homeless Star to better capture gradual progress or distance travelled, while others were firmly against this as they believed this type of data collection would hinder taking a person-centred approach in interactions with service users.

The usefulness of the data was also queried: one commissioner mentioned that they were asked to self-define and record the numbers of those at risk of rough sleeping in their area, whether these people are working with services or not. They suspected that across local authorities this would be measured differently, which they thought would reduce the value of the data. This figure was later dropped from the data collection requirements.

> **"How many people [are the team] dealing with and what are the outcomes? It's a blunt thing, and we're worrying about all the other people who might be at risk of rough sleeping that this team isn't working with. We have wasted probably hundreds of hours of time amongst quite a lot of highly skilled professionals to attempt to fill out a spreadsheet that makes no sense."** – Commissioner

Additionally, commissioners mentioned that there was a lack of feedback on the quarterly monitoring data they provided to OHID and how this was being used. Many were keen to benchmark the performance of their services against those delivered in other RSDATG areas, so they could learn about effective approaches across the programme to inform improvements in local RSDATG delivery.

4 Process evaluation: working with service users

4.1 Introduction

This chapter explores how RSDATG services have engaged and worked with service users. This includes: the variety of pathways designed to support service users with different needs; the ways in which trauma-informed working is being implemented; how services provide harm reduction, stabilisation, detox and rehab spaces for their service users; and the support offered relating to the housing needs and health needs (mental and physical) of service users. The chapter draws on data from MI, interviews with staff and commissioners in funded areas, and interviews with service users. Groundswell conducted 89 interviews with service users across nine case study areas[18] to understand the impact of RSDATG interventions. These interviews provided insights into service users' perceptions of:

- The effectiveness of RSDATG-funded services (including comparison with any previous experience of drug and alcohol services)
- Barriers and enablers to accessing RSDATG-funded services, including reasons for drop-out and ease of subsequent re-engagement
- Positive features of RSDATG-funded services, and areas for improvement, and
- How RSDATG-funded services have impacted them personally.

To provide context, this chapter will first describe RSDATG's service user cohort (section 4.2). It will then discuss a series of key themes relating to the work of RSDATG projects:

- Recovery pathways that services have adopted (4.3)
- Engagement with service users (4.4)
- The nature of trauma-informed working within the RSDATG Programme (4.5)
- Harm reduction interventions (4.6)
- Access to detox and rehab (4.7)
- Support provided to access accommodation (4.8), and finally
- Support provided for mental and physical health (4.9).

[18] Service user interviews were carried out in nine of the evaluation's case study locations - Bournemouth, Christchurch and Poole, Cornwall, Haringey, Islington, Lincoln, Manchester, Nottingham, Southend, and Westminster.

4.2 The RSDATG service user cohort

4.2.1 Service user characteristics

People supported by RSDATG-funded roles and teams (service users) were characteristically White British, men, and aged between 30 and 50. Over the lifetime of the programme, 75% of service users were White British; 74% were men; and 70% were aged between 30 and 49. Ethnicity varied by geography; in some London boroughs, only 25% of service users were White British, whereas it was 99% in parts of North East England. In terms of gender, official estimates suggest that around 15% of the rough sleeping population are women[19], though there is acknowledgement that women are underrepresented in official statistics. That 26% of the RSDATG cohort are women may, therefore, represent a positive aspect of the programme's reach.

Some RSDATG staff observed that a minority of eligible service users differed in characteristics from the 'typical' cohort. It was not clear whether people from ethnic minority backgrounds and women were expanding as a proportion of the rough sleeping population, or simply becoming more visible (for example because of hidden groups, such as women who were 'sofa-surfing' being displaced during the Covid-19 pandemic). Staff reported that the RSDATG service user cohort included people from EU countries, people who speak English as a second or other language, neurodivergent people, and people who require referral to adult social care teams for assessments under the 2014 Care Act.

Staff reported that RSDATG service users tended to face severe and multiple disadvantages in addition to homelessness and substance use, including contact with the criminal justice system as a victim and/or perpetrator; experience of domestic, sexual, or other abuse; and poor physical health. Staff reported that RSDATG service users generally presented with co-occurring mental health conditions (though often un-diagnosed) and that there was increasing recognition of people living with a brain injury within the RSDATG cohort.

> **"What you've got with our clients is, they'll go and see other agencies. They'll say, 'Well, if they pack the drink and the drugs in, they'll be fine.' Most of my clients now, if you take their drink and drugs away, they won't be fine, they will need extra support. And I think that [for] 80% of the people we work with, if not more, that's the complexity."** – Frontline worker

4.2.2 History of drug and alcohol use, and engagement with services

Many people in the RSDATG cohort had a decades-long history of drug and alcohol use, and some had been using drugs or alcohol from a very young age. While polysubstance use was most common, there were also service users who used alcohol but not drugs.

Service users also often had a long history of interacting with services for support with substance use: OHID analysis of NDTMS data indicated that 51% of people supported by RSDATG were already

[19] https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024#demographics

in treatment when they first received an RSDATG-funded intervention, and four in five (82%) were not 'treatment naïve' - that is, they had engaged with drug and alcohol services in the area at some point in the past. When interviewed, service users described having engaged with different types of support in the past, including rehab, detox programmes, support groups, and substitute prescriptions. In some cases, this support had helped individuals stop using, sometimes for several years. However, single or multiple relapses were common. Some service users recalled negative experiences of services that had not suited their needs, and staff noted that these experiences could discourage people from seeking treatment again.

> **"The engagement rates are actually pretty good for new arrivals. Where it gets interesting is, for individuals who've been in and around the systems for a while longer, perhaps they already know our treatment service and they've been there, and they didn't like it... the revolving door ones actually, sometimes, can be really hard to engage. So, you know, we find that's where things like [RSDATG] can make some really good links if they can identify people early, get out there before they've had a chance to almost get swayed by any other opinions. There might be other people who, sort of, say, 'Oh no, that service. No, it's crap, don't go there,' or something like that."** – Commissioner

Likewise, staff and commissioners described cases of individuals who had been cycling in and out of treatment from drug and alcohol services, and of rough sleeping, for 20 or 30 years. As a consequence, it was reported that local services may have developed a negative and outdated perception of some individuals, creating a barrier to support.

> **"Other agencies will have a strike 1, a strike 2, you're out. And, I can understand that to a point because there are bed spaces to consider and that kind of thing. But... you get exemptions for some people and not for others, and it's usually based upon a long history of narratives. 'Oh, but 10 years ago, blah blah'. Or, 'Five years ago...' And all this kind of stuff."** – Frontline worker

A shift away from 'three strikes and you're out' policies was seen as having been helpful for service users who had already been engaged with treatment before RSDATG, because it meant that services were better able to welcome service users back to treatment after drop-out, whenever they were ready. This meant that service users' chances of successfully completing treatment were improved because they could re-engage even after multiple 'failed' attempts.

> **"I think it is valuable for people just to know that services aren't going to give up on them and that they're still invested in them and they still want to work with them."** – Frontline worker

4.2.3 Housing circumstances

Service users reported prolonged instability in terms of their living situation. Many reported that they initially lost their accommodation following a relationship breakdown, due to fleeing domestic violence, financial difficulties, job loss, or cuckooing. Some individuals did not have

accommodation after they left prison or a prolonged stay in hospital. Following this, many service users resorted to sofa-surfing with friends or family, living in vehicles (vans, caravans, boats or motorhomes), sleeping rough, or moving in and out of temporary and emergency accommodation.

For RSDATG phase 2, funding was extended to support people *at risk* of rough sleeping. The business case for phase 2 anticipated that those 'at risk' would comprise less than 10% of those being supported into treatment by RSDATG. By the end of RSDATG's fourth year, across all funded areas more than 7 in 10 of those receiving support were in the 'at risk' group. This may be one reason why the overall number of those supported by RSDATG is higher than anticipated.

4.2.4 Multiple disadvantages faced

Service users faced multiple disadvantage and experienced complex, overlapping issues around trauma, mental health, physical health and substance use. Service users described adverse experiences during childhood and/or adulthood, of abuse, sexual assault, gender-based violence, bereavement, relationship breakdowns, and contact with the criminal justice system. Others described the trauma caused by their living situations – how sleeping rough was traumatic as well as the experience of losing their accommodation, for example due to financial difficulties or cuckooing. Individuals often directly attributed their drug and alcohol use and mental health issues to past and present trauma. Some service users spoke of their mental health issues and a few described being admitted to hospital due to a mental health episode or a suicide attempt.

Whilst some interviewees were receiving mental health support, many individuals spoke of difficulties in accessing help (see section 4.9.1). Some said they were reluctant to talk to mental health services because they did not want to discuss their past, or felt their trauma was too severe to be dealt with appropriately by the services they were offered. Others feared being sectioned and placed in inpatient psychiatric care. Of those who wanted to access mental health support, some described waiting a long time for referral into services.

Service users had wide-ranging physical health issues. Individuals commonly described having had injuries and illnesses related to substance use, exposure to weather, and lack of access to washing facilities. A few service users had contracted hepatitis C, and others had contracted HIV. Infections were common and some service users reported having had cellulitis, sepsis or pneumonia. Others described having had heart attacks or heart palpitations, strokes, blood clots, or issues with their liver. Some service users had suffered brain injuries which affected their cognitive abilities and (from their perspective) the ability to engage with treatment.

4.2.5 Implications for working with RSDATG service users

RSDATG staff explained that their service users are often mistrustful of services, having had poor experiences in the past. This extended to housing services, substance use services, and other services they had encountered. Service users described feeling stigmatised by:

- Being excluded from some services;

- Being treated differently from others using the same services;
- Being evicted;
- Being let down by a key worker;
- Having multiple changes of key worker (sometimes without any explanation);
- A perception that some healthcare staff had a poor understanding of drug or alcohol addiction.

Such mistrust and stigma were reported by staff to be a key challenge to overcome when engaging with service users. Staff also reflected that the flexibility of RSDATG-funded services was a clear benefit for engaging service users who felt stigmatised and mistrustful.

Service users often found it difficult to attend appointments at set times or adhere to treatment regimens. They could lack the means to know the time (such as a watch or mobile phone); be unable to transport themselves to a specific location due to the distance or a lack of funds; or they had a cognitive, neurological or mental health condition that made remembering or prioritising difficult. Staff reported also that service users often found it difficult to 'normalise' their behaviour, causing difficulties for a services' staff and its other users.

> **"There are a lot of people with unmet mental health needs who arrive at the service in a state of mental health crisis and can be quite aggressive."** – Service manager

> **"I've had clients set fire to the flat. I've had clients rip the pipes out the wall. I've had clients turn it into a crack den. I've had clients that reverted to rough sleeping, but they rent their property out, to other clients, and take the money off them to spend on drugs. So, it comes to a point, sometimes, you think, 'Well, you've exhausted everything.'"** – Frontline worker

While RSDATG services and others often frame themselves as 'recovery' services, some staff reported that this was a difficult concept for some service users to grasp. As one staff member reported, in cases where people have never known a happy, secure life, *"they've got nothing to recover to".* There is, therefore, an inherent challenge for services to help people envision and create for themselves a better future.

4.3 Bespoke pathways/journeys for service users

Service users with a wide variety of needs have benefitted from RSDATG. Interviews with stakeholders revealed that service users' life experiences and demographic characteristics influenced how they engaged with the programme. This section describes how RSDATG-funded services were tailored to an individual's needs.

4.3.1 Support for people experiencing rough sleeping in an 'entrenched' way, in comparison with those who are newer to the streets

Staff reported that there were differences in both the characteristics and needs of people described as experiencing 'entrenched' rough sleeping, as opposed to those who had less experience of sleeping rough.

Some areas reported higher numbers of people experiencing rough sleeping who were relatively new to the streets. This was common in areas with many transport links such as the inner London boroughs, and other major cities such as Manchester and Nottingham. Staff commented that service users who were newer to rough sleeping tended to have lower support needs compared with people experiencing rough sleeping in an entrenched way – for example, fewer needs around their physical health, such as wound care, which can increasingly become problematic for people who sleep rough for longer periods of time. People newer to rough sleeping, who had not been further traumatised by long-term experiences of homelessness, could often move on and settle into accommodation more quickly – with the right support.

In contrast, staff said that people who were experiencing longer-term, entrenched rough sleeping tended to require very intensive support over a longer period of time. This was critical to build up working relationships and overcome mistrust or ambivalence about engaging in treatment and preconceptions about the quality of support that might be available to them. More intensive support was also needed to address associated health conditions resulting from time spent living on the street. Staff reported that training in trauma-informed work was useful in helping them to understand how best to support service users, especially in terms of rethinking the way they approached people with a long history of rough sleeping, or people who displayed more challenging behaviours. In particular, staff mentioned the value of considering whether someone might have experienced a brain injury and/or trauma, and how that might impact on their ability to engage with services. This enabled staff to adapt ways of working to better meet service users' needs.

4.3.2 Services to meet the needs of specific groups

RSDATG funding provided an opportunity for services to focus on specific groups within the RSDATG cohort who were less well-served by mainstream drug and alcohol services, and many areas mentioned plans to do this in their applications. However, some areas did not do anything specific to reach particular demographic groups, and instead described adopting person-centred approaches tailored to each individual, which would include considerations of their personal characteristics and needs.

In order to provide support for service users, the first steps involve identifying the people who need support, and establishing mechanisms to most effectively reach and engage them. A theme emerged from staff interviews around the challenges of these initial steps of identifying and engaging certain groups. In some areas, services built on the service design work (see Chapter 3) to tailor provision to the needs of service users. This has involved setting up different pathways, roles, and services for different sub-groups within the RSDATG cohort. This is one of the

advantages of RSDATG, as the flexibility of the grant means that it can be (and has been) used to develop specialist pathways for service users in specific circumstances. The following paragraphs describe specialist pathways in place to meet the needs of some of these groups.

Support for women: Some areas reported their RSADTG-funded teams had achieved success with engaging women. Overall, around 3 in 10 of those supported by RSDATG were women: this is a higher proportion of women than that estimated in the population of those experiencing rough sleeping, and may represent a positive aspect of the programme's reach. Staff reported that women in this cohort were typically deeply traumatised, experienced multiple intersecting disadvantages, and required intensive, trauma-informed support. Women who were (or were at risk of) experiencing rough sleeping were more likely than men to also have experienced sexual exploitation and/or domestic violence according to staff, so feelings of physical and emotional safety with key workers were particularly important.

Some services have implemented pathways to address the specific needs of women, including appointing specialist women's workers, having a women-only space at set times each week, or holding women-only group sessions. Some services partnered with other organisations that support women sex workers and provide women with sexual health support including access to contraception, and sexually transmitted infection (STI) and blood-borne virus (BBV) testing. In addition, facilitating access to social services for support with children helped service users to feel more fully supported, and also upskilled staff in understanding the processes and terminology around child safeguarding. One service user described how the RSDATG team had worked in tandem with the local authority and her children's school to support her to regain (and maintain) custody of her children during and beyond her detox from alcohol.

> **"The police, my alcohol worker, my life skills coach, the school, the kids' nursery, the social worker [are all in conversation]. They all talk about how I'm getting on with my alcohol, how I'm getting on with my parenting, all stuff like that. So, they are all mixing together, which is good."** – Service user

However, staff noted that fear of having children removed by social care services was an important factor discouraging more women from seeking treatment.

Pathways for people from different cultural backgrounds, and/or who speak English as a second or other language: Actions included hiring staff who speak the same language as local service users, and who understand both the practical and cultural needs of service users from ethnic minority backgrounds. For example, people from some cultural backgrounds were likely to feel a great deal of shame around substance use, so relevant cultural understanding and tact were reported to be particularly important. However, for others, it was culturally appropriate to be more forthright than might be appropriate when working with white British service users, when discussing the risks of substance use and the benefits of engaging in treatment. These factors are a helpful reminder that 'trauma-informed' work requires an ethnic and cultural dimension.

Pathways for people who have no recourse to public funds (NRPF): In addition to the challenges outlined above, service users from other countries may not be entitled to access certain public resources such as social housing and rehab treatment. As a result, some RSDATG services have devised alternative ways of meeting these people's needs.

Pathways for prison leavers: In some areas, RSDATG staff worked with probation services to support those with no fixed abode upon leaving prison, or who wanted to get on a prescription to treat substance dependence. For example, in Manchester, the RSDATG team is co-located with the criminal justice team, to facilitate information-sharing and streamlining of services for service users. Close joint working between these teams has facilitated individuals to be supported by whichever team is most appropriate. This close working meant the two teams could effectively lever-in funding from different channels – for example, psychological support funded through RSDATG, and Buvidal and Nitazene tests funded via the criminal justice team. It also allowed each team to quickly get expert advice from the other.

> **"We worked out early on that there are quite a lot of homeless people being given court orders, so [our RSDATG] staff are co-located with probation... We've got a whole rounded picture for the people, so it works really well – a lot of sharing information... We can justify what's best for their health needs, rather than just by a criminal order."** – Service manager

In contrast, some staff reported finding it difficult to engage some prison leavers in services, due to the challenge of providing consistent support, especially where service users had a long history of imprisonment, release, and breach of bail resulting in re-imprisonment, without being able to access support services that could help them to avoid reoffending.

> **"We've seen a lot of, I suppose, revolving door cases. That come through and kind of say that prison is their life, they've been in and out for X amount of years, they depend on drugs and even though they engage with substance misuse services while they're in prison, they choose not to while they're outside. Because they're happy to just come back."** – Frontline worker

Likewise, service user interviewees who had spent time in prison tended to describe having had negative experiences of drug and alcohol treatment whilst in prison (especially in relation to a lack of support for withdrawals and side-effects, including sleep deprivation). As a result, having a positive experience of accessing treatment once they were released was particularly significant. Some service users reported having been sent to RSDATG services as a condition of their release, or by their probation officer, in the hope this would maximise their chances of remaining out of prison.

4.4 Engagement with service users

This section discusses findings in relation to the ways in which RSDATG services engaged with people, what facilitated good engagement and what barriers existed to engagement for particular groups and individuals.

4.4.1 Ways of engagement

A repeated theme across interviews was the importance of taking services to where people are. This was reported to be especially important for initial engagement, and at the start of treatment journeys. It could typically be tapered off as people became more independent and able to engage more easily with in-reach or hub services.

Outreach was considered an essential way to initially identify and reach people, with many teams either conducting their own outreach or working alongside specialist homeless outreach services to identify those experiencing rough sleeping. In a few cases, projects reported working with organisations that serve specific groups to help build trust. For example, some projects worked alongside organisations that supported women or people who are engaged in sex work to better communicate available drug and alcohol services locally and to promote engagement.

> **"What we have commissioned is a service that can deliver all the provisions or interventions really that you would expect a core treatment service to be able to offer but in a more flexible way ... How proactive and assertive they are in terms of their outreach and engagement, sometimes it's 20 times they're trying to make those first initial appointments before they actually get the engagement so there's a persistence to that."** - Commissioner

Staff reported that assertive outreach could help to build relationships with potential service users. In many areas, staff visited locations known to be popular with this cohort - including hostels, soup kitchens, breakfast and dinner clubs - and had informal conversations to introduce and discuss the process of joining the service. Consistent and persistent interactions between service users and staff helped to develop and sustain relationships of trust, and staff suggested it could take many such visits before someone was willing to listen.

> **"If all you manage to do with a person is build a tiny speck of trust, you are rewriting that script that they've learnt that 'people don't care, that they don't want to support you, that they're not going to try their best'. Those 2-minute conversations, build up into trust, and into accessing and utilising support that turn into recovery."** - Frontline worker

Interviews with support workers emphasised the effectiveness of physical healthcare as a valuable starting point for engagement. While some may be reluctant to immediately tell their stories or receive support related to their substance use, support workers discussed some being willing to accept basic healthcare, which can be the first step to them engaging with the service.

"Wound care is a significant need for this cohort, and because it needs to be provided face-to-face which helps build up rapport and trust. This helps engage with people who are attending hospital frequently because of their alcohol or drug use and help engage them and connect them with longer-term support and care." - Commissioner

"If you start to engage with those basic issues, you're saying to that person, 'Actually, you've seen that we can do something. You see that we can resolve this for you, or at least ameliorate it in some way. So, what else do we think we can do together to get you into a different place?'" – Commissioner

RSDATG services were, in addition to outreach, promoted via existing services that interacted with people rough sleeping or being at risk of doing so. RSDATG teams received referrals via local homelessness teams or hostels, mental health teams, voluntary and community organisations and adult social care. Referrals were also made into the service by hospital liaison workers in emergency departments or hospital mental health teams, probation teams and GPs. Some of this activity was motivated by a desire to prevent people returning to the streets.

"We're not doing too much promotion in a sense; it's more about working in close partnership with other services and departments. We work closely with the housing providers and hostels as well to keep track of individuals as they're moving through the housing system or being discharged or released from prison custody back into community." - Commissioner

The RSDATG funding has funded several 'hubs', physical spaces where service users can access support. Service offer at these hubs varies. Some provide practical assistance, such as clothes, hot meals or laundry facilities, as well as staff available to offer rapid prescribing, basic physical healthcare or facilitate referrals to other services. It was noted that drop-ins work better than fixed appointments for this cohort, who may struggle with time keeping or with travelling to services. Some areas did not have permanent hubs but instead held drop-in events for people experiencing rough sleeping where they can be seen by many services in a single session. These types of interventions were felt to be particularly impactful because they allowed for immediate referrals between services. In particular, one area reported their drop-in event as being more effective than street outreach in terms of vaccination, GP registration and identifying long-term conditions. The events also helped build relationships between services. Staff in another area described in-reach being carried out by a range of different services in a winter night shelter, which enabled services to better understand the needs of these individuals and how to support them in a joined-up way.

However, staff recognised that hubs and other drop-in services presented challenges. For example, people avoided them if they were in dispute with other service users. In particular, it was felt that women, who could be vulnerable, could be uncomfortable attending a hub or may be coerced not to attend. Additionally, this model is also less likely to work in rural areas, where service users may have to travel a significant distance to reach the hub.

Some areas used outreach buses to provide a range of services and information for people who were sleeping rough. For example, one outreach bus service offered haircuts, oral health advice and referrals to dentists, essential everyday items such as clothes and toiletries, and digital and financial literacy training, such as support setting up a bank account.

> **"We make it like a welcoming environment for the client to come onboard. They might present with, 'I want to see the dentist,' or, 'I want a haircut.' By the time they're sitting in the chair, and you start talking, it's other things. It might be mental health, it might be that they lost housing, it might be that they've got a drug issue, and they don't know how to be linked into services, and at that point, we can start linking them in."** –Frontline worker

In-reach approaches were also used and involved staff actively engaging with service users in their accommodation or other settings they visited frequently. This enhanced engagement by bringing services directly to individuals who were reluctant to seek help and builds trust through consistent presence. As with a hub model, this also facilitated holistic support by addressing multiple needs at once, ultimately improving accessibility and integration with services. However, in-reach models were also reported to carry the risk of fostering dependency as service users could access everything from their accommodation without having to leave it, hindering their integration in the community. Additionally, this model was dependent on having sufficient staff resources to conduct in-reach.

In one area, interviewees agreed that the prescribing clinic at a day centre had been a major success: there was a perception that there were record numbers of people on opioid substitution treatment. The clinic is timed to take place in the early evening on the same day as the outreach workers' morning shifts, so the outreach team can advise people to attend the clinic that same day and capitalise on their motivation. Workers believed that because the clinic was in a venue already known to many people experiencing rough sleeping and which they attended for other reasons (such as to have a shower or do laundry) it was less daunting to attend, and people felt more comfortable there. Because it operated at multiple times, including in the evening, and operated on a simple first-come-first-served basis, it was accessible to a wider range of people. Interviewees reported that even people who were not in contact with outreach workers had attended the clinic after having heard about it from friends, which gave it more credibility. Around three in five people who attended the drop-in were reported to go on to take part in formal drug and alcohol treatment programmes.

In some cases, individuals could self-refer to the service, which was more common when the RSDATG team were located within the mainstream drug and alcohol service. There were also examples of people hearing about the service from other service users and presenting themselves to staff.

> **"Because of word of mouth, I think near enough everybody knows anyway, because it's an exchange as well, where you have to come and get your equipment, for users. They all know where it is."** – Service user

4.4.2Facilitators to engagement

Relationship building and trust were regarded as vital in enabling people to engage with and benefit from RSDATG services. Interviewees discussed the importance of staff building and maintaining relationships with potential and existing service users through tailored and focussed support. In part, this was enabled by smaller caseloads compared to mainstream drug and alcohol services which allows recovery workers to spend focussed time with service users. It was noted that RSDATG-funded workers often provided emotional support, and this was seen as critical for people who may not be in contact with friends and families. Therefore, their recovery workers were often relied upon to provide support, advocacy and friendship. Recovery workers with relatable lived experience were felt by both staff and service users themselves to be particularly well placed to provide support to this cohort and help them navigate the service.

> **"They know it all so you can't blag them. They've been heavy addicts, people who work here. Maybe a long time ago, but they've still been heavy addicts. It's nice to come in and say, 'I feel like this way,' and they go, 'I get it. I get it.' [Or,] 'I'm hurting because of this,' they go, 'Oh, I get it, I know, that's just the medicine.' Do you know what I mean? They get it."** – Service user

Support workers described service users, particularly those seen as deeply entrenched, as having been repeatedly failed by mainstream services in the past. This meant that when they accepted RSDATG support, it was crucial to ensure they had positive experiences. Recovery workers did this in the following ways.

- Ensuring that support related to their substance use can be accessed quickly. This may include helping them to access rapid prescribing or an alcohol assessment.
- Providing support or advocacy as they access other services, such as supporting them to attend the pharmacy to get their script or helping them register with a GP.
- Referring service users to other services, such as housing support, and supporting them to engage.
- Taking time to explain how systems and services 'work', what to expect, and what options there are.

Information sharing between services and establishing referral pathways were also noted as important. Joint work directly with service users, such as RSDATG-funded outreach workers accompanying other homelessness outreach services, brought a range of benefits, including drawing on each service's knowledge of people experiencing rough sleeping in their areas, bringing complementary skills (e.g. where RSDATG outreach nurses could offer treatment on the street), as well as minimising duplication of effort.

Consistent staffing enabled meaningful relationships to be built between service users and recovery workers, ensuring a continuity of care and limiting the number of times service users

must tell their story to new people, which could be annoying and sometimes re-traumatising. Some support workers described the lives of service users as being chaotic, and believed consistent staffing provided service users with some stability. Equally, service users highlighted that frequent changing of their recovery worker could be confusing, especially when they were experiencing memory problems from their substance use. They also stressed the importance of the positive relationships established with their recovery workers and reported a sense of loss if their recovery worker left their post. There were also examples of service users feeling that they had been 'dropped' when they were transferred between key workers. Therefore, good handover practices are required when support workers leave their posts, or cases are transferred, to mitigate service users being negatively impacted.

> **"People leave, people come, they change the way they're working, we've had 3 or 4, yes... I got a bit pissed off at one point, yes. You'd get close to someone, and they'd go, or they'd swap me, but it is what it is, I've just got to deal with it... it's why people don't let their guard down very often because, you know, next time you'll have to do it all again with somebody else."** – Service user

Staff commented that service users were not always committed to becoming substance free, and this may not be the most appropriate goal for some to work towards at the outset of their engagement. Instead, staff pointed to small wins or behaviour change outside of substance use as measures of success for service users, such as people reconnecting with their families or finding a hobby. Therefore, it was seen as important for recovery workers to focus and place emphasis on working with people to change their behaviour, through harm reduction and improving aspects of their lives as a requisite for drug and alcohol treatment.

Staff highlighted that offering social and creative activities can be an effective way to encourage people to begin accessing services. Staff shared examples of ensuring service users had opportunities to feel better about themselves, such as dental care, podiatry and haircuts. Other support included encouraging people to take up new hobbies like fishing or going to the gym. These activities reportedly allowed people to build a relationship with recovery workers and access further support at their own pace. This was evident in both staff and service user interviews, which emphasised that having a sense of agency helped with feeling understood and willing to engage. Activities also helped people to discover or rekindle interests and skills, helping them to consider a life outside of substance use. In some cases, these activities were funded by personalised budgets, which are used by service users to engage in meaningful and purposeful activities. The budget was also used to buy clothes, taxi fares to healthcare appointments or days out. This helped sustain engagement and provided positive diversionary activities for service users.

"Personalised budgets are really important for this cohort, you can't send somebody to residential treatment, they won't go if they've got no clothing, so some of that money goes onto buying them a couple of changes of clothes, so that they're confident enough to go. In terms of the relationship building that can happen because you've purchased somebody something that they view that they really need, that buys that engagement and that joint respect with their worker, that then helps to keep them engaged, so that's critically important with this group." - Commissioner

4.4.3 Barriers to engagement

As previously mentioned, staff reported that people had deep-seated mistrust of services, due mainly to previous bad experiences, and this was a key barrier to engagement. In addition, the evaluation identified other barriers to engagement.

The inability to promise decent accommodation was a major barrier to service users engaging in services. Some staff reported that service users considered access to accommodation an important initial reason to engage with the service. Where there lacked a guaranteed pathway to accommodation, this reportedly discouraged individuals from consistently engaging. Interviews with stakeholders also emphasised the importance of stable accommodation in allowing people to engage with structured treatment. This is discussed further in section 4.8.

Lack of knowledge about services and processes was another potential barrier to engagement. Some staff felt that people in the RSDATG target group lacked awareness of available services. Confusion about the specific services offered by different organisations, or services known by previous names, could further exacerbate this. This lack of awareness meant that individuals who were eligible for services were not aware of their existence.

Some groups were distant from any service or support. Among those people in-scope to receive support via RSDATG, there were reported to be distinctive groups who were far less conspicuous. This included women who are homeless and are less likely to receive support because services are difficult for them to access and not tailored to their needs. As a result, drug and alcohol services struggle to identify them. Other at-risk service users deemed 'hard to reach' or 'hard to engage' due to issues in identifying them, include people who sex work (especially those who are exploited online) and victims of cuckooing. In some cases, partnership working helped to identify people in this cohort when they presented at A&E, through social housing services or specialist service providers.

Some individuals required more support than RSDATG services had planned for. Several areas noted that their original programme design involved providing service users with intensive wraparound support for 12 weeks, before transferring them to mainstream services. Within the 12-week period, they aimed to help service users settle into accommodation, stabilise their substance use, access physical healthcare and ensure they remain engaged in the service. However, in practice, they found that many required intensive support for considerably longer than 12 weeks due to the nature of their trauma and previous negative experiences.

> **"It might take 12 weeks for someone to just talk to one of our staff members, so those constant engagement attempts and trying to build that rapport with people and that trust, to then get them into treatment. It's very much about the team is not giving up, trying their very best to engage with individuals, who might have mistrust because of trauma and what they've experienced previously."** – Service manager

4.5 Trauma-informed working

One of the key features of RSDATG's national guidance was a focus on trauma informed working. Staff who took part in interviews understood "trauma-informed working" to be a multifaceted approach, prioritising relationships and building trust with service users. Participants emphasised the importance of consistent engagement, building rapport through patience, small gestures, and demonstration of genuine care and empathy. Trust-building was seen as essential, especially given that service users have often been let down by systems in the past. To understand individuals and their trauma, staff recognised that their own behaviour needed to demonstrate active listening, recognition of individual triggers and responses, an appreciation of the impact of past trauma on service users' current behaviour, and avoidance of re-traumatisation – for example, through insensitive language or actions.

Key to this was understanding that service users often presented behaviours and actions as responses to previous experiences of trauma, so RSDATG staff needed to work closely with them to address these underpinning issues rather than responding in ways that can reinforce stigma. Staff also identified the importance of understanding that individuals may not be able to engage with services at certain points, and that adaptable, tailored and responsive approaches were required to meet people's varying needs. This included measures such as flexibility in meeting times and locations, adapting communication styles to suit the individual, and sharing knowledge (with service users' consent when appropriate) between relevant support organisations.

One RSDATG team reported developing a 'client passport', setting out a person's 'story', what they are looking for, and what approaches they feel work well for them. This accompanied the service user when they were referred into new services to avoid them having to repeat themselves.

As such, RSDATG-funded staff showed an understanding of trauma-informed working that broadly aligns with the definition used by the UK government, that, *"Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development".*[20]

[20] Office for Health Improvement and Disparities (2022) "Working definition of trauma-informed practice" <https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice> [accessed 24 June 2025].

However, trauma-informed working appeared to be implemented variably across the case study areas, and some important limitations were identified:

- In some areas, trauma-informed practice was not well understood across all staff, or all staff types. Some staff suspected that others held misconceptions about what trauma-informed working is, such as thinking the practice is *"just saying nice things"*.
- In some cases, the application of trauma-informed work was uneven due to reluctance or lack of capacity amongst partner organisations or other services (such as housing or police) to receive training or consider updating their working practices. Some services may find it hard to implement trauma-informed practices, given their role – for example, police and probation may have a limit to how flexible they can be within their statutory responsibilities.
- Staff in some services associated with RSDATG projects were reticent to continue working with people who frequently missed appointments as they felt it required them to carry too much responsibility and risk – for example, worrying about the consequences of a service user dying while technically under their care, and criticism from, say, a Coroner's Court.
- Similarly, not all services felt able to cope with challenging behaviours that affected other service users. For example, few nursing homes were thought capable of accommodating people in the RSDATG cohort due to the risk they are perceived to present to other residents.

Areas that showed a good understanding and systematic implementation of trauma-informed working practices had gone further to promote this way of working more broadly, including providing training for partner staff. For example, some areas used RSDATG funding to deliver training on trauma-informed working or Psychologically Informed Environments (PIE) to staff working in housing, adult social care, or the local community safety team's street wardens. One team reported presenting at conferences about the PIE approach they practice.

The evaluation identified a broad set of requirements for the effective delivery of trauma-informed practice. These were:

- Working to bring all staff on board with the approach, including teams that work in conjunction with RSDATG, such as local authority housing staff, accommodation staff, police, street outreach, prison service, local authority teams that engage with RSDATG service users. This is important for enabling trauma-informed approaches to be most beneficial and effective, by avoiding retraumatising service users, as this can damage their trust in services more broadly.
- Providing effective training for staff on how best to work with service users in this way, and how to ensure they are taking care of their own emotional health to avoid burnout. This can include regular reflective practice, supervision, and a commitment to continuous learning and improvement.

- Providing opportunities for feedback from both service users and staff, to make it possible for processes to be constantly improved over time.
- Enabling a focus on harm reduction and meeting service users' immediate needs, to address physical and safety needs in tandem with longer-term recovery goals.
- Creating safe and welcoming environments for service users, to help them feel empowered to make choices and share their stories at their own pace.
- Shifting the narrative from blaming individuals ("What's wrong with you?") towards a more understanding and compassionate approach ("What's happened to you?"). This involves recognising that challenging behaviours are often trauma responses and require understanding and support, not judgement.

4.6 Harm reduction and stabilisation

Measures to reduce harm, and to help service users stabilise and reduce their substance consumption, were key elements of each RSDATG project, and for service users, could represent the first steps towards becoming substance free. They were commonly aligned with wider holistic approaches to help keep service users safe, which encompassed living safely on the streets (for example providing condoms and sexual health checks for sex workers) and steps to address pre-existing health conditions. As section 5.4 details, project staff commonly reported that harm reduction measures had helped reduce the number of local drug and alcohol-related deaths or decreased the rate of increase experienced previously (often compared to adjoining areas not receiving RSDATG funding). The following subsections discuss measures used to reduce harm and measures used to stabilise and reduce service users' consumption of drugs and alcohol.

4.6.1 Measures to reduce harm

RSDATG funding was used to support a similar menu of measures across the case study and wider areas consulted, which were commonly offered to service users on recruitment to their projects. These included:

- Prescribing and improving access to opiate substitutes (such as Methadone) or Buvidal – where rapid prescribing, delivery to users where they are, and helping ensure continuity of supply, were found to work well, helping bring stability to otherwise chaotic lives and reducing the risk of a return to street drugs. Many areas described funding a non-medical prescriber whose remit included supporting people with scripting, including on an outreach basis and on the street, as well as supporting service users restarting prescriptions, conducting titration reviews, and offering wider physical health checks and advice. Several areas also described the importance of ensuring continued access to opiate substitutes, including providing access to supplies over holiday periods (for example, using locked boxes to provide Opioid Substitution Treatment (OST) supplies to cover bank holiday weekends), and others reported how replacing lost scripts rapidly had also avoided potential relapses amongst service users.

Several projects discussed the effectiveness of traditional OSTs (such as Methadone) compared to Buvidal and considered that Buvidal offered several advantages, including needing to be administered less frequently and removing the need to withdraw from methadone. However, service users needed to be ready to abstain for Buvidal to be most effective, and in some areas, it was used primarily with people who had reduced their consumption sufficiently to be considered.

- Providing Naloxone, and training in its use, to service users and other services to counter opiate overdoses - while the use of Naloxone was widespread across the projects, several described distributing it to all service users, whether opiate users or otherwise, in case they encounter someone who had overdosed. Many support workers described carrying Naloxone with them to help ensure service users had supplies to hand, and in at least one case a support worker was able to save the life of a service user who was found to have overdosed. Areas also commonly provided training on Naloxone use to partner agencies, which raised awareness of its use (which in some cases had previously been variable across local partnerships) and helped develop local capacity amongst aligned services. In the case of one London project (Brent), this included equipping London Underground staff with Naloxone and providing training in its use.

- Providing clean needles or enabling access to local needle exchange programmes – for service users using substances intravenously, for example several projects described providing colour coded needles where they were likely to be shared.

- Providing drug testing kits to reduce the risk of contaminated supplies – the projects reported that local drug supplies were increasingly found to be contaminated with high strength synthetic opiates, which risked overdoses amongst service users. To help counter this risk, the RSDATG projects commonly provided drug testing kits which enabled service users to test their supplies prior to consumption.

In addition, projects commonly received intelligence from local drug alerts when contaminated supplies had been identified, which were shared with service users. However, project staff described how these communications needed to be carefully worded, to avoid attracting people to the area to acquire 'higher strength' substances. While this applied most often to synthetic opiates, one project also reported changing their approach to communicating drug alerts after a particularly strong formulation of 'spice', a synthetic cannabinoid, was found to have brought people into their area. Indeed, several areas reported increasing numbers of users of synthetic cannabinoids and illicit pregabalin, both of which posed harm reduction challenges as treatment options are less well understood. Several areas, including Stoke and Thanet and Canterbury, described having staff whose remit included identifying support options for users of new and emerging substances.

These measures were accompanied by support to improve the physical health of service users, detailed at section 4.9.2 and 5.8. In the harm reduction context these included offering BBV, HEP C

and liver function tests, and Pabrinex[21] injections, alongside arranging treatment for other health conditions resulting from time spent on the streets or due to substance use.

4.6.2 Stabilising and reducing consumption

Measures to help service users stabilise or reduce their drug and alcohol consumption were intrinsically aligned with steps to reduce harm. For example, the rapid prescribing of OSTs helped service users reduce their substance use, while also reducing their dependence on street drugs and the risk of receiving contaminated supplies.

The RSDATG projects also provided a range of education, advice and support to help service users stabilise and reduce consumption. These included encouraging service users continuing to use street drugs to change the mode of consumption (i.e. from injecting to smoking), consider moving from poly to mono-substance use and providing advice and support to regulate and decrease consumption over time. For those with alcohol dependencies, the projects provided advice and support on ways to reduce consumption, including reducing the strength of drinks and promoting the use of 'drinking diaries' to monitor consumption.

Some areas shared examples of pharmacies being reluctant or refusing to offer OST prescription services for this cohort, due to stigma or previous experiences of shoplifting and staff being abused. This can cause significant problems in rural areas, with some staff reporting that service users needed to make a three-hour round trip to the nearest city to collect prescriptions. In response to this, one area conducted a pilot at a local GP surgery to host a clinic to dispense medication, with an outreach van stationed outside the surgery to provide needle exchanges and harm reduction advice.

4.7 Access to detox and rehab

The RSDATG Programme allocated specific funding for inpatient detox and residential rehabilitation treatments. The RSDATG projects offered a combination of community-based and inpatient or residential detox and rehab treatment options, depending on the needs of their service users. Having dedicated detox and rehab budgets as part of the RSDATG funding helped ensure that the cohort was considered for treatment, with RSDATG services providing resources to help service users prepare and engage with detox and rehab options.

Although RSDATG funding was not intended to be used to invest in establishing additional inpatient or residential detox and rehab provision across all the funded areas, two examples of this were identified during the research. Firstly, one of the pan-London projects had focussed on increasing the supply of inpatient detox provision for people with complex needs, resulting in five additional beds. Secondly, one of the non-case study areas (Hertfordshire) reported funding a 'detox house' for service users experiencing rough sleeping or in temporary accommodation and who could not safely have a community detox. While not a clinical setting *per se*, the house

[21] Pabrinex provides a high dose of vitamin B1 (thiamine), which is used in alcohol treatment to help mitigate some of the more severe symptoms of alcohol withdrawal.

provides four beds dedicated to RSDATG service users, with support from the provider doctors and nurses who deliver the detox.

While community treatment options had led to some service users successfully achieving abstinence, the projects described how inpatient or residential options were often the most appropriate for their cohorts, given their levels of complexity and the nature and duration of their substance use. In a few cases, projects reported that service users with serious health conditions, including those with cognitive impairment due to alcohol use, were not suitable for detox and rehab, with long-term care or supported accommodation being more appropriate.

Across the projects the numbers of service users accessing inpatient detox and rehab represented a relatively low share of their overall cohorts. The majority of quarterly reports from funded areas show no service users in detox or rehab, and where numbers are recorded these are typically between 1 and 5. However, staff and commissioners commonly considered that these were broadly what was expected at the outset and an improvement on the numbers being sent for inpatient treatment by the local mainstream drug and alcohol services previously. The reasons for this relatively low share were explored in the case study fieldwork, where a series of enablers and challenges were identified in preparing for and accessing appropriate detox and rehab provision. A summary of these follows, including preparedness for inpatient treatment, accessing treatment, providing move-on accommodation and providing ongoing support.

4.7.1 Preparing service users for detox and rehab

Stakeholders, project staff and service users emphasised the importance of individuals being well prepared for detox and rehab for it to be effective. Steps taken to prepare service users included ensuring they were sufficiently physically and mentally well to attend, had sufficiently stabilised their drug or alcohol consumption, and had secured appropriate move-on accommodation to move to once discharged. This preparation period could be relatively short, but for others with multiple and particularly complex needs, staff reported that it could take two or three years.

As sections 4.4 and 4.6 described, preparation for treatment often started when service users first joined their projects, where they received health checks and support to stabilise or reduce consumption (through a combination of advice, support and rapid scripting). The psychosocial support provided by the projects was also key, in helping ensure that service users had a good understanding of the treatment process and what would be required of them.

However, not all service users are equally committed to becoming substance free on joining their projects, so project staff played a key role in encouraging them that achieving abstinence is possible with their support. This was particularly the case where service users had previous negative experiences of detox or rehab or felt they had been let down by other services in the past. Others described being referred to detox or rehab previously by their families, probation workers or the local authority when they did not want it or, on reflection, were themselves not ready to engage. Service users could also be concerned about the impact of becoming substance free, in

terms of triggering recollections of previous trauma that their substance use had protected them against.

Measures that had worked well in convincing service users that recovery is possible included:

- Clear and consistent messaging around their ability to recover, and that the project and its staff are there to give consistent support throughout the process – and emphasising that they will keep in touch and continue to support them during and after detox and rehab;
- Where possible, offering service users a choice of the detox and rehab provider - to engage them in the process, give a degree of agency, and foster further commitment. In some cases (e.g. Bristol) this included taking service users to visit several providers in advance to help them make informed decisions;
- Being clear on what will be required of them at the inpatient and residential providers - in terms of the structured environment and expected behaviours, which may be specific to different providers;
- Working closely with service users so they are aware of how their referral is progressing, sharing timetables and plans for move-on accommodation on discharge and giving confidence they will continue to be supported through aftercare plans; and
- Drawing on staff with lived experience and peer support workers as positive examples of what can be achieved. One project described how having previous service users return to the project to share their experiences of detox and rehab was also a useful motivator.

4.7.2 Accessing residential or inpatient detox and rehab

RSDATG projects commonly described a reduction in detox and rehab provision in their areas over recent years, particularly since 2020, and particularly in terms of specialist detox beds for people with complex needs. While some were able to draw on local detox and rehab services, others accessed out of area provision via existing contacts (or in the case of one provider, a national framework agreement), through either spot-purchasing or block booking arrangements. Some projects, however, found it challenging to secure suitable provision for their service users locally. Out of area provision was used by some projects. While presenting some logistical issues, it was found to offer benefits to service users whose preference was to relocate away from their home area to avoid previous negative influences.

In areas where detox and rehab provision was available locally, treatment was frequently delayed, often by 12 weeks or more due to long waiting lists. This meant that support workers had to endeavour to keep service users engaged and maintain their commitment for prolonged periods. Other challenges in securing access to inpatient or residential detox and rehab included:

- Certain service users not being considered suitable for treatment by the provider on referral, which included where service users:

  - were considered not to have sufficiently stabilised their consumption for detox purposes. Several RSDATG areas described how this could pose issues for some service users whose substance use was particularly high or entrenched, and who struggled to reach the threshold OST dosage to be accepted, which could lead to delays in finding centres who take people on higher OST doses (as well as additional costs and treatment time); and

  - were assessed as being too physically or mentally unwell to complete, placing their own and others' recoveries at risk. In one example, a service user was rejected for rehab based on an attempted suicide some years ago. Additionally, staff reported that difficulties obtaining mental health treatment for service users could hamper an application to rehab.

- Some sub-groups of the RSDATG cohort also faced specific challenges - for example non-English language speakers could struggle with English-only provision, people with specific offending histories may not be accepted, and people with certain health conditions, for example women with anorexia, could be hard to place.

- In some areas referral processes to detox and rehab were felt by project staff to be protracted and delayed service user access to treatment. Here the projects, while acknowledging the importance of ensuring individuals were adequately prepared, had worked with local authority colleagues to streamline referral processes.

Once a detox and rehab place has been secured, several projects described how taking service users to visit facilities in advance or having video calls between service users and detox and rehab providers, had helped preparations for entry. These allowed service users to meet provider staff, establish clear understandings, and allowed any outstanding concerns to be addressed. The detox and rehab providers interviewed reported that they also found these initial contacts with service users helpful, allowing them to better understand the needs of the individual prior to their arrival.

Project staff recognised that the structures and processes associated with inpatient or residential detox and rehab can be too strict for some service users, and too therapeutically challenging for others (for instance, for people who do not respond well to group therapy), which can lead to early exits. Consequently, having contingency arrangements in place for individual service users was key, with a view to re-establishing momentum towards recovery, attempting detox and rehab at a later point, or exploring different recovery options and treatment plans.

4.7.3 Securing move-on accommodation

Arranging suitable move-on accommodation for service users on discharge was a key part of preparing for detox and rehab, and a condition of acceptance for many of the detox and rehab providers used by the RSDATG projects. However, projects' experiences of securing suitable move-on provision for their service users varied.

While some areas described having sufficient move-on accommodation in place, the majority reported struggling to be able to offer suitable accommodation. While many of the RSDATG case

study areas had received the Housing Support Grant funding, the supply of appropriate move-on accommodation was a constraint to both accessing inpatient detox or rehab and service users' continuing recoveries post-rehab (for example, where a lack of abstinence-based accommodation meant service users were exposed to others continuing to consume). In many cases, it was common for service users to be placed in short-term accommodation, including bed and breakfasts, until more suitable accommodation became available.

Some rehab providers also offered move-on accommodation as part of their services, which provided an alternative option for service users wishing to relocate to a new area to escape previous negative influences or start-over. While examples were provided where this had worked well, in other cases difficulties accessing support in the new area was difficult and disconnected people from ongoing, post-rehab support.

4.7.4 Providing aftercare and continued support

Finally, providing continued support for service users on their return from inpatient or residential treatment was key. It ensured the momentum towards abstinence was sustained, demonstrated to service users the positives of accessing ongoing support, and facilitated rapid intervention if the individual experienced a relapse or was at risk of doing so. Key to this was a positive relationship of trust established between support workers and service user. Service users commonly reported feeling guilty that they had 'let their support worker down' if they relapsed. Therefore, good relationships established an open and non-judgemental dialogue that allowed problems to be identified.

4.8 Support for accessing accommodation

Reducing the numbers of people experiencing rough sleeping is one of the key outcomes RSDATG was intended to achieve. Guidance provided to commissioners on how to use the grant was primarily focused on drug and alcohol interventions, with the intention that addressing substance use would result in reductions in rough sleeping. However, this guidance also emphasised the importance of wrap-around support, and given the needs and priorities of people in the RSDATG target group, RSDATG-funded roles and services often played a more direct role in supporting service users to obtain housing and maintain their licence or tenancy.

The extent to which support for accommodation was viewed as within the remit of RSDATG-funded services, and therefore the activities undertaken to support positive accommodation outcomes, varied between areas. Some staff took the view that engaging well with drug and alcohol services would support service users to secure accommodation, whereas other staff held the inverse perspective that helping service users to become housed puts them in a better position to engage with drug and alcohol services. In some areas, staff believed that there was limited scope for RSDATG-funded services to address the accommodation needs of service users beyond referring them to housing services as this responsibility sat with the local authority rather than the drug and alcohol service.

> **"That's completely housing. We don't have any responsibility for commissioning accommodation. It's purely just the drug and alcohol treatment side of things. So, that would have to sit with the local authority housing teams."** - Commissioner

In other areas, commissioners commented that other services had already expected drug and alcohol services to have a role in making referrals to housing providers and helping to prevent evictions, but it was only since the RSDATG funding that this had become a realistic possibility.

The following subsections discuss support provided to access accommodation, to sustain accommodation, and the barriers encountered.

4.8.1 Support for people experiencing rough sleeping to secure accommodation

RSDATG workers in many areas supported people experiencing rough sleeping to obtain housing. The time workers had available to spend with service users (due to reduced caseloads) meant they were able to accompany individuals to housing assessments, assist them in completing housing applications, or provide advice on housing options, rather than simply directing them to the local authority housing team as they would have in the past.

> **"In the past, previous to [RSDATG], it would be like if a client came in and they wanted some housing advice, they would just get signposted to the local authority. Whereas what [service users consulted for RSDATG] said was, 'Actually, we just want a little bit of advice on what to do, do you know what I mean? We don't necessarily want to do a housing application, but we might just want a little bit of advice, like, what are our options?'."** - Service manager

Securing accommodation effectively required collaboration and a joint effort with housing services and other accommodation providers, often voluntary and community sector partners, especially where available options for this cohort were limited. Many RSDATG teams work closely with housing services to find their service users appropriate housing. In some cases, 'team around me' or MDT meetings were used to discuss individual cases and determine a referral pathway, linking individuals with housing officers, charities and churches for support.

Securing appropriate accommodation for a service user often meant not accepting the first place that became available, but rather identifying accommodation that would support sustained recovery. For example, this may involve avoiding hostels where residents were using substances for a service user who was leaving inpatient detox. Different accommodation types were needed to meet varying needs, including dry supported housing for those reducing or stopping substance use, and supported accommodation for those unable to live independently. Some areas have connected people with organisations that offer tenancy sustainment support, such as cooking, property care and other housing-related 'life skills'.

Service users generally felt that RSDATG-funded services had done their best to support them, particularly where RSDATG-funded workers had advocated for them to secure accommodation. This included finding accommodation that was appropriate for them, which took their

circumstances into account. They described instances where the worker had, in their view, gone above what was expected of them to ensure that they could access accommodation.

> **"[My drug worker] started fighting my corner for me, to get me where I am now. I'm bidding for a flat, but I'm in a little studio flat. It's not a permanent address, it's temporary supported housing, but it's a little studio flat, before you get a 1-bedroom. Because I refused to go in any of the hostels, because I wouldn't be able to stay clean being around all the other addicts."** – Service user

4.8.2 Support for people at risk of rough sleeping to sustain accommodation

In the later phases of RSDATG funding, the majority of those supported by the grant were 'at risk' of rough sleeping rather than currently experiencing it. Staff highlighted the importance of measures to bring stability to these service users' lives, to help them sustain their tenancies and avoid rough sleeping. A key factor in improving stability was supporting people to access drug and alcohol treatment or harm reduction advice, which helped people manage substance use and avoid antisocial behaviour that may lead to them being at risk of eviction. As well as this, RSDATG-funded roles also helped service users achieve greater stability in other aspects of their lives as part of a holistic approach.

Staff discussed helping to equip service users with skills to support the upkeep of their accommodation and live independently, such as cooking, cleaning and time management. Sometimes this extended to supporting them with these tasks directly, such as visiting a service user's flat once a week to clean for them. A different area used RSDATG funding to run classes in hostels around cooking and cleaning to help service users develop their skills. Recovery workers also applied for funding (or previously used personalised budgets) to purchase beds, white goods, carpets and TVs. They also delivered regular food bank parcels if needed.

In a few areas, there were some concerns about 'cuckooing', where vulnerable tenants and their accommodation are controlled and exploited by others. Interviews with staff highlighted that this is common among women who are survivors of sexual violence and whose drug addiction is exploited. However, it was noted that properties can also be 'cuckooed' by other substance users. Cuckooing was often hidden from authorities and support services, and intelligence was patchy. Two case study areas discussed working as part of a partnership to manage cuckooing.

> In one RSDATG project area, once an RSDATG service user is given a property, they inform a multi-disciplinary team consisting of the police, local authority adult safeguarding board and adult social care. These organisations will be made aware that there is a potentially vulnerable person living that property and will regularly monitor it to ensure the tenant remains safe.

Some RSDATG projects funded dedicated roles focused on tenancy sustainment and reported successes in preventing evictions. Staff in these roles identified individuals at risk of being evicted and liaised with local authorities, hostel landlords and other accommodation providers to help

manage issues around antisocial behaviour and defaulting on rent payments. These roles advocated with housing services to ensure the individual's situation was taken into account by using a trauma-informed perspective to explain their behaviours and triggers, and providing assurances that the service user would be receiving appropriate support to manage this behaviour going forward. Similarly, other RSDATG-funded workers worked with other teams who support those living in Houses with Multiple Occupancy (HMOs) and shared housing to promote understanding and flexibility regarding the challenges faced by people with substance use issues, ultimately to prevent eviction.

MDT meetings were used to put support in place to prevent evictions, and other joint working arrangements were used to provide quick access to emergency housing when needed.

> **"If somebody is going to be evicted from an accommodation, we have a supported housing panel, where you can work with the housing department, to say, 'Look, we've got somebody in supported accommodation who we can't condone this behaviour, but in order to prevent him from becoming a rough sleeper, is there an alternative temporary accommodation?"'** - Commissioner

4.8.3 Barriers to securing and sustaining accommodation

The most significant challenge in supporting people with their housing was widespread shortages of appropriate local accommodation, particularly options which were suitable for service users with complex needs. Several areas described how local accommodation providers had closed due to high costs associated with building maintenance, leasehold fees and other costs. One of these closures was a provider who had been receiving RSDATG funding to house and support RSDATG service users. One area described how they put out a tender for a provider of accommodation services as part of their RSDATG provision, but no suppliers wanted to take it on due to the short-term funding.

Some staff explained that it was out of their control whether housing was suitable for the service user's needs, and due to overall shortages of accommodation they had limited ability to consider this. In many areas, service users were placed in HMOs, often with no floating support attached. Staff and service users commonly described these accommodations as chaotic.

> **"It's a crack house. So, every single person in that house has, like, their own little rooms where they're actively drinking, doing drugs, or people come in and out the door constantly. So, yes, I've been living there for 4 years. I've been trying to get out of there."** – Service user

Being left alone or without support in independent accommodation can be detrimental to such individuals and those less able to manage their physical and emotional health needs. As discussed previously, RSDATG workers sometimes took on a role of directly supporting their service users with basic household tasks such as cleaning.

Housing requiring abstinence, which prohibits substance use on the premises, was seen as crucial for supporting the recovery and stability of some service users. As people moved towards detox and rehab, without abstinence-required housing, trying to maintain abstinence was acknowledged by staff and service users as being very difficult. Some housing options require abstinence; however, it was acknowledged that most hostels and HMOs may have rules prohibiting drug and alcohol use, but occupants are often using and not in treatment. This, staff reported, made it more challenging for people to reduce and stabilise their substance use, sometimes leading to relapse and disengagement from services. There was a feeling that ideally, both 'wet' and 'dry' housing should be available to support people at different stages of their recovery. It was also noted that there was a lack of women-only housing options, which are particularly needed for women who had experienced domestic violence from men.

In a handful of areas, there was mention of housing being unavailable to service users because they lacked a local connection. In such circumstances, staff had worked with service users to help them relocate to an area where they had a local connection. However, this was acknowledged to be difficult as some do not want to leave their current location and have good reasons not to return. There was also a recognition that some people may stay in areas without a local connection because they believe that drug and alcohol services are better there. In one coastal area, a support worker reported that if people did not have a local connection, they would sleep on the beach for six months. This would help them to gain a local connection and so be eligible to access housing support. A couple of other areas, which experienced high inflows of rough sleepers, described either operating on a 'local connection blind' basis or enabling those with family members in the area or those registered with a GP to access local housing services.

Out of area accommodation options were sometimes available for people leaving residential treatment, but not appropriate for all service users. One area reported that because they could only offer out-of-area move-on accommodation for people leaving residential treatment, this had put service users off engaging in detox or rehab. On the other hand, some staff thought it was helpful for some people to have a fresh start in a new area where they were away from influences that may have led to using substances.

> **"There comes a time in a person's life when they're tired of that revolving door, going round in circles, and I feel taking them out of area, out of the current situation that they're in helps a lot. An example of this person, she was suffering domestic abuse, so she needed to leave, and the drinking was because of that, so for her to leave that area was a time for her to get detox."** – Frontline worker

4.9 RSDATG support for mental health and physical health

RSDATG service users commonly presented with a range of mental and physical health needs, including undiagnosed conditions, conditions exacerbated by living on the street, compounded by histories of drug and alcohol use, and underpinned by experiences of trauma. The importance of addressing service users' physical and mental health needs to support progress towards stability and abstinence was emphasised by RSDATG staff in all the case study areas. The following two

subsections discuss the support offered, and the barriers and enablers for both mental health and physical health.

4.9.1 RSDATG support for mental health needs

Mental health support is a key component of RSDATG-funded services. Guidance for commissioners on how to use the funding emphasised that it should include wraparound support for people with co-occurring mental ill health and substance dependence, and in applications, commissioners commonly recognised a gap in mental health support for the RSDATG target cohort and a significant need to improve this. Across ten case study areas studied, 75% of RSDATG service users who were in treatment were identified as having a mental health need, and this may be under-reported.

Mental health was addressed in different ways and with different degrees of success across RSDATG areas. Some areas recruited specific workers to help service users access mental health services, while others recruited specialist staff to provide support to service users directly. Some RSDATG projects reported that they were able to draw on psychologists from mainstream drug and alcohol services or partner agencies, while others recruited a psychologist directly. Despite these interventions, commissioners and staff commonly reported that it was still very challenging for RSDATG service users to access support from mental health services that met their needs effectively. The outcomes of the funding on mental health access are discussed in more detail in section 5.8.

Guidance to commissioners specified that the RSDATG grant was not designed to fund mainstream mental health services or replace specialist mental health services, but rather to fund posts to support access and engagement in these services. However, despite this, some areas funded regulated staff or small teams who worked directly with service users to address their mental health problems, for example using counselling or key-working techniques. This was in recognition that many RSDATG service users needed mental health support but were unable to access NHS mental health care (for example, by not meeting the thresholds for secondary care). Specialist roles included mental health nurses who could carry out health assessments and arrange medication, and psychiatrists and psychologists who could work directly with service users, such as those whose referrals to other services had been rejected.

One area described using a pre-engagement model they developed after research into how to work with people experiencing rough sleeping in a trauma-informed way. Their goal was to get people "through the door" of mental health services by providing a space to talk and consistent support, therefore building the therapeutic relationship. They had a dual diagnosis worker whose role was to advocate for people with mental health services and persuade services to build a relationship with an individual even if it was not possible to start formal treatment yet due to their intoxication. This meant that treatment could start more quickly once the individual's substance use had stabilised. The dual diagnosis worker also signposted service users to other teams and helped them with crisis planning.

Some projects recruited dual diagnosis workers to support service users with co-occurring mental health and substance use needs. Typically, these workers were primarily drug and alcohol workers and worked with a caseload of people who had co-occurring mental health problems. Dual diagnosis workers with this background had varied job descriptions, but their role often involved: advocating on service users' behalf with mental health services (for example by citing NICE and associated treatment guidance); identifying a first step into treatment; accompanying service users to appointments to increase the likelihood that they would attend; and/or working with people to reduce their substance use enough for mental health services to accept them. Typically, they were not trained to provide mental health support directly, but in some areas, those in dual diagnosis roles had a clinical background and could offer specialised assessment and treatment planning. The overall purpose of these roles was to improve access to mental health services and thereby facilitate more effective and sustainable recovery.

> **"Having that drug and alcohol worker being able to attend with the person to not only just to be there for support, but to also stress that just because somebody is drinking, doesn't mean they can't address their mental health. And just be that proponent for them to help stand up for themselves or not being sent away."**
> – Service manager

The use of dual diagnosis workers was felt to have had some impact on reducing barriers to mental health services. Other approaches to improve access included training staff on completing referrals to mental health services to maximise the likelihood of being accepted. Having referrals signed by the team psychologist could help secure appointments.

One area described receiving dual diagnosis training provided by a health and wellbeing charity, including toolkits on how to put together an SBAR [situation, background, assessment, recommendation] report. This enabled staff to make a more compelling case for service users to be accepted into mental health services by following the way that these services structure their assessments. The area reported successful referrals via this approach.

Where these services existed, they were seen as critical in meeting service users' mental health needs because they could provide more accessible, flexible and trauma-informed support than mainstream services. For example, some services had staff who could go out and meet service users flexibly in person instead of requiring them to attend an appointment at a set time, which helped with engagement and readiness for more structured mental health support. Some interviewees thought that adopting this approach more widely would contribute to increased uptake of mental health support and improved service users' mental health. Nevertheless, these workers or teams had limited capacity to meet all the needs of the RSDATG cohort.

As well as roles and interventions focused on mental health, it was noted that the impact of mental health interventions can be maximised if a wider group of frontline staff are provided with training around mental health. By fostering a skill mix where all frontline staff possess some level of

capability and expertise in relation to mental health, staff can understand the drivers of specific behaviours and propose effective responses, and services can ensure that individuals receive the appropriate level of care while also building the capacity of the workforce to address substance use effectively.

Another enabler to securing access to mental health services was having mental health and substance use treatment delivered by the same provider, which was reported to have facilitated coordinated care. Several areas described drawing upon staff within the local authority, NHS or partner agencies whose remit was to enable people with multiple disadvantage to better engage with mental and physical health services, in recognition of the particular challenges to access they face.

Despite the roles and interventions described above, commissioners and staff commonly reported that it was still very challenging for RSDATG service users to get support from mental health services. Ultimately, this was regarded as a capacity issue. Mental health services were perceived to be under significant pressure and reluctant to take on additional service users, particularly people in the RSDATG cohort because of their complex challenges: they were seen as more risky and more likely to struggle to attend appointments. Interviewees (who tended to be from outside mental health services) described unwillingness among mental health services to support people with substance use needs. There were widespread reports of the 'chicken and egg' nature of co-occurring conditions, whereby service users were turned away from mental health services if using substances but may be using substances to manage mental health issues.

> **"We refer them [service users] to the mental health service and they go, 'We can't work with you, you're using drugs and alcohol, please address that first.' And there never seems to be that willingness to accept that maybe the alcohol and drug use is in part due because of the mental health. It's not a one or the other, it's a combination of the two that need addressing."** – Service manager

Some interviewees acknowledged that addressing the needs of people with co-occurring conditions is a challenging issue even in the absence of capacity pressures. There are risks in both pharmacological and psychological therapies for people who are heavily using substances. In recognition of this, there is a NICE protocol on how to work with people with co-occurring conditions, and some areas had their own local protocol on this as well. However, there did not seem to be a high level of awareness about this guidance, and in some areas where protocols had been developed, the experiences of RSDATG staff suggested that they needed to be more firmly enforced.

Beyond these two key issues, staff commonly expressed frustrations at the 'systems' barriers that served to exclude service users from receiving support. For example, a lack of integration between the drug and alcohol service and wider mainstream mental health services, or a lack of engagement by mental health services in multi-disciplinary working, could prevent or delay service users receiving the support they require. In addition, while some areas found having specialist

staff such as psychologists in their RSDATG teams to be useful, many found it difficult to recruit to these posts due to salary competition and their ability to offer relatively short-term contracts.

4.9.2 RSDATG support for physical health needs

RSDATG programme guidance recommended that the funding should be used to provide wraparound support for service users, but did not specifically require support around physical health. Despite this, many RSDATG areas recognised the importance of support for service users' physical health needs, both in its own right and as a 'quick win' that could support initial and continued engagement with other services.

Commissioners had funded nurses for RSDATG projects who ran drop-in and outreach clinics and provided a variety of direct services or referrals including wound checks, alcohol assessments, sexual health screenings, access to long-lasting contraception, blood-borne virus (BBV) testing, dentistry, smoking cessation services, liver scanning and vaccinations. Some RSDATG projects had partnered with other established services to provide this. Staff were also able to register service users at GP surgeries, and it was noted that there is a common misconception amongst service users and some professionals that people with no fixed address cannot register with a GP.

Clinics that offered a drop-in service were considered more useful than fixed appointments for this cohort. Physical health activities were also dovetailed with activities such as breakfast and dinner clubs where several services, including nurses, could attend and engage with service users in an informal setting. The areas found the clubs to be especially helpful at engaging people who were sleeping rough, whereas those at risk of rough sleeping were less likely to require immediate physical health treatments. This emphasised the importance of bringing health services to service users, particularly those who are the most entrenched and sleeping rough and less likely to attend health services.

> **"They have a nurse, but people need to book appointments, so there is a barrier for people to actually access that support. [A service user] was complaining about her liver. I said, 'Oh, when did you do your checks last time?' 'Oh, it was last year.' I said, 'What was the result?' 'Oh, the doctor said there's some issue with my liver.' But there's no one who's going to pick up the case. We need to look not only to address the substance issue but also looking at how we can address physical health, how we can address the wellbeing as well."** – Service manager

In some areas, nurses accompanied recovery workers on outreach shifts to meet people sleeping rough or carried out home visits - particularly useful for service users with mobility issues. Several areas funded a health bus, or similar mobile facilities, which was used to conduct immediate health checks and healthcare interventions, such as vaccinations, prescribing and dental advice.

"I've done blood tests in a park, in a tent in a park. I've taken out stitches in parks and things like that. It's literally going to where people are." – Frontline worker

Some areas described how their treatment bus engaged service users, which helped to expose them to information about dental care, including advice on good oral healthcare. Service users often used drugs or alcohol to deal with chronic pain or were too ashamed of their appearance to seek such personal treatment.

"A lot of people that present to the bus don't really know what it means to have good oral healthcare. And what could happen if you've got an abscess or an infection, which is how it can get into your system. So, you've got dental nurses advising them and talking to them. It's information they didn't know." – Frontline worker

Such services were considered convenient for service users to access in comparison with mainstream services, and in rural areas they provided access to services where service users were unlikely to travel some distance by public transport to access treatment.

The accessibility of physical health services, therefore, has been enhanced through outreach efforts and supporting service users to access necessary medical care. In addition, such physical health services were reported to be beneficial to engaging with service users about drug and alcohol treatments. Physical health provision signified that RSDATG services could meet people's needs in convenient, friendly, non-judgemental and supportive ways and staff often discussed this as an encouragement for people to engage further with the project.

"Where they're not necessarily successfully completing treatment in the droves, but what they are doing is engaging with a service that's able to provide that intensive mental health, physical health wrap around support. It's getting them well physically and mentally getting them the support that they need and then beginning that treatment. The pre-engagement, building the relationships, the trust and then patching them up. Sometimes it might just be that the nurse will be like, 'Oh, can I just dress that cut on your leg? Can I just give you some antibiotics?' And then it's that that leads onto them then engaging in treatment." - Commissioner

Staff discussed diagnosing and supporting service users to manage long-term conditions such as diabetes and respiratory illnesses. It was noted that many service users rarely attended healthcare appointments and therefore had poorly or un-treated long-term conditions. Local GP practices were felt to be key in ensuring that service users' wider or long-term health needs were met. GPs with specific skills in working with people who are homeless were regarded as particularly beneficial. Staff discussed these GP practices being able to provide more holistic care than standard GP services, as they could conduct full health checks, provide both mental and physical health support, and prescribe OSTs appropriately. In some areas, training had been conducted with staff at mainstream GP practices to encourage them to initiate conversations about potential

substance use and equip them with the skills needed to handle such discussions sensitively and in a trauma-informed way.

> **"A lot of individuals may have underlying or untreated cirrhotic livers. Just to give some background, older drug users tend to age about 15 to 20 years quicker, from that physiological process, so a lot of people will have many acute or chronic conditions, that are either untreated or undiagnosed."** – Service manager

Staff acknowledged the difficulties that service users had accessing health support, which had often been a bad, stigmatising experience. As with mental health services, recovery workers accompanied service users to their appointments, to act as an advocate and ensure they received the appropriate treatment and care. Advocacy could involve citing legislation and guidelines on co-occurring conditions, challenging stigma, developing relationships with staff and being persistent about getting needs addressed. Such actions were reported to result in better care and better health outcomes for the service user, compared to engagement without a RSDATG worker present. Additionally, hospital liaison workers/services were reported to be a useful resource for supporting service users during hospital stays and encouraging them to sustain their full course of treatment.

> **"A lot of rough sleepers don't access medical care until it's dire straits, they tend to be in hospital for quite a while. They probably don't get visited by anybody, and also, they tend to just walk out a lot. So, the hospital liaison worker is the constant, to be like, 'Come on, you can do this, you've only got a couple of days left, and now I'm going to come and visit you again tomorrow. Can I bring you anything?' So, that's really good."** – Frontline worker

Case study fieldwork revealed that there remained some difficult barriers to overcome to open access to healthcare services for the RSDATG cohort. Interviews with support workers emphasised that stable housing provided a foundation for individuals to address their health needs and engage in treatment. As discussed in sections 4.8 and 5.6, difficulties in securing and sustaining appropriate housing for this population made physical and mental health interventions challenging.

Despite some positive outcomes related to physical health, service users described often experiencing discrimination related to their addiction or homelessness from healthcare professionals. This contributed to poor experiences of receiving care and perpetuated their mistrust of these services and their unwillingness to try and use them. Staff regularly reported that service users would refuse care that was offered by a service where they had previously had a negative experience. Such experiences suggest that direct health support and advocacy by RSDATG projects is critically important. It also suggests that mainstream services require different approaches if they are to be inclusive to people experiencing severe and multiple disadvantage.

"I hate ambulances. There are a couple [of paramedics] that I've met that have been alright but a lot of them, they treat you like a scumbag because you're an addict... there have been times I've refused to go to hospital because they were going to take me to [redacted], and [redacted] Hospital treats you like shit when you go there, if you're an addict." – Service user

5 Impact on service users

5.1 Introduction

This chapter of the report assesses the impact of RSDATG funding on outcomes relating to service users, including the key outcomes of the funding: improving drug and alcohol treatment outcomes for people experiencing rough sleeping or at risk; reducing rough sleeping; and reducing deaths from drugs and alcohol amongst people experiencing rough sleeping or at risk.

For each outcome, the chapter presents:

- Original expectations of impact (as set out in the RSDATG business cases and guidance to commissioners)
- The evidence of impact from:
  - programme monitoring information,
  - OHID's internal analysis,
  - quantitative comparative analysis drawing on NDTMS data, which compares RSDATG areas with non-funded areas
  - qualitative evidence from commissioners, staff and service users.

The factors which contributed to changes in each outcome are also discussed: these are largely based on qualitative evidence. The chapter uses the labels above when drawing on each evidence source.

The table below summarises the findings of the evaluation on service user outcomes.

Table 5.1: Summary of impacts on service users

Outcome	Overall trend	Effect of RSDATG funding
Access and initial engagement with treatment	Increasing (positively)	Positive in the long run
Retention	Not known	Moderately positive
Treatment completion	Not known	Uncertain given challenges in quantifying completion rates in the absence of funding
Numbers in detox and rehab	Increasing (positively)	Uncertain given context of rising demand for drug and alcohol treatment nationally
Drug-related deaths	Increasing (negatively)	Likely positive (though evidence not definitive)

Rough sleeping	Increasing (negatively)	Uncertain given challenges in quantifying effects on rough sleeping rates in the absence of the programme.
Access to mental health treatment	Not known	Below expectations given needs of the RSDATG group
Quality of life	Not known	Likely positive but uncertain given challenges in quantifying effects on quality of life in the absence of the funding.
Physical health	Not known	Likely positive

5.2 Note on comparative quantitative analysis of individual-level outcomes for matched groups

The evaluation conducted a comparative quantitative analysis in ten case study areas, comparing outcomes for people supported by RSDATG to a matched comparison group of people with similar needs and characteristics who were also engaged with drug and alcohol services but not supported by RSDATG. The outcomes in question included: retention in treatment after 12 weeks; change in housing status; whether individuals with mental health needs were receiving mental health treatment; and self-reported quality of life relative to self-reported quality of life at baseline.

As the evaluation progressed, it became clear that there is a key limitation to this analysis: within the same area, individuals supported by RSDATG are likely to have different needs and characteristics to those who are not supported by RSDATG. Case study data shows that before matching, people supported by RSDATG and in treatment have greater housing risks, are less likely to be employed or in contact with their children, and are more likely to be using opiates and to be injecting substances, compared to other users of drug and alcohol services. The analysis attempted to correct for this by matching the two groups on these and other personal characteristics, and after matching, the two groups appeared to have identical characteristics. However, due to small sample sizes, the categories used for matching were necessarily very broad (for example, it was necessary to collapse some variables that had multiple categories into binary) and this may have obscured differences between the groups. The nature of the matching process means it is not possible to gauge the extent to which this has happened. Furthermore, some potentially important differences between the groups, such as motivation, length of substance use history, amount of substance consumption, or distance to services could not be accounted for due to being unobservable or not recorded in the NDTMS data used for the analysis.

The nature of RSDATG-funded services indicates that there will be systematic differences between the two groups compared in the analysis. Broadly speaking (see section 3.1-3.4), RSDATG funding was used to improve services for people who were already known to drug and alcohol services but with high levels of need that existing services were not meeting well; and/or to engage new people who had previously found services inaccessible. In either case, people were supported by RSDATG based on their characteristics: RSDATG was intended to focus on those with the very highest levels of need. Because of this focus, it is unlikely that there would have been

substantial numbers of people with needs equally severe and complex as the RSDATG group who were engaging in drug and alcohol treatment yet not receiving support from RSDATG-funded services.

It is therefore likely that differences in outcomes between these two groups will be partly due to inherent differences between the two groups, rather than reflecting the impact of different services (RSDATG versus 'business as usual'). For this reason, the evaluation team have not presented detailed findings from this analysis in the main report since the analysis cannot be used to assess the effectiveness of RSDATG compared to mainstream services. Nevertheless, this comparison may be of interest for the following reasons:

- **Future service planning** to understand typical outcomes achieved by the RSDATG target cohort compared to others; and
- **Gauge impact** in a limited way, since if RSDATG service users would be expected to achieve worse outcomes in the absence of the funding (due to their higher levels of need), if they in fact achieve similar or better outcomes then this can be interpreted as some degree of success.

Alternative designs for the impact evaluation were explored to avoid this issue, but ultimately none were deemed to be feasible. For example, the evaluation team ruled out creating a comparison group from people with similar needs and characteristics in non-funded areas, because the nature of funding allocations meant it was not possible to identify non-funded areas that would have made a suitable comparator. The nature of the funding allocation process meant that it was not possible to identify areas that were 'only just' funded or 'just missed out'. Other designs were not feasible due to limitations of the dataset (for example changes in the way that housing status was recorded over time).

The results of the comparative quantitative analysis of matched groups in 10 areas are as follows.

- At the 12-week point after beginning treatment, people supported by RSDATG were more likely to still be engaged or have completed treatment, compared to people not supported by RSDATG, in six of ten areas. In 3 areas there was no difference[22] and in one area people supported by RSDATG were less likely to still be engaged or have completed treatment.
- Compared to people not supported by RSDATG but who had broadly similar housing needs at the start of their engagement with treatment, people supported by RSDATG were more likely to be experiencing rough sleeping or have no fixed abode on treatment exit, in 6 of the 10 areas studied. In a further 3 areas levels were similar and in one area, people supported by RSDATG were less likely to be rough sleeping or have no fixed abode. A further limitation for this outcome is that the combined category 'rough sleeping or no fixed abode' covers a

[22] Where differences existed but were so small as to not be statistically significant, this is described as no difference.

wide breadth of housing outcomes, and the analysis does not capture change within this range.

- People with mental health needs supported by RSDATG were less likely (in 7 areas) or equally likely (3 areas) to be receiving mental health treatment than people with mental health needs and a similar housing status who were not supported by RSDATG. Mental health outcomes, and barriers to achieving these outcomes, are discussed further in sections 4.9.1 and 5.8.

- The comparative analysis looked at the most recent quality of life score recorded and used a regression model which took into account baseline quality of life. For the same quality of life at baseline, people supported by RSDATG report worse quality of life compared to people with similar needs in treatment but not supported by RSDATG. In half the areas, people had worse self-reported quality of life than the comparison group, and 4 others there was no difference.

Further detail on the comparative quantitative analysis, including method, limitations and tables of results, can be found in Annexe 1.

The evaluation team also conducted a quantitative analysis at the area level comparing numbers of treatment starts in funded versus non-funded areas. Findings from this are presented in section 5.3.2 below.

5.3 Impact on engagement with services

RSDATG funding was anticipated to result in more people experiencing rough sleeping or at risk, in particular those with more entrenched or complex needs, engaging with drug and alcohol services. The business case for years 3-5 funding estimated that RSDATG funding would create 7,800 additional places in structured community treatment and 900 places in residential treatment (detox or rehab) each year.[23] This was anticipated to result from having teams of additional staff with more time to spend on each service user, more resource put into collaboration between services, and more flexible service delivery, so that services would be accessible to more people.

5.3.1 Engagement with RSDATG-funded services

Monitoring data submitted by all funded areas at the end of March 2025 reported that there had been 19,614 people engaged with RSDATG-funded services over the previous year. [24] In the final quarter of the year, 12,445 people were engaged: 31% of these people were experiencing rough sleeping and the remainder were at risk. The chart below shows numbers engaged by RSDATG-funded services in each quarter, based on monitoring data submitted by funded areas. Phase 2

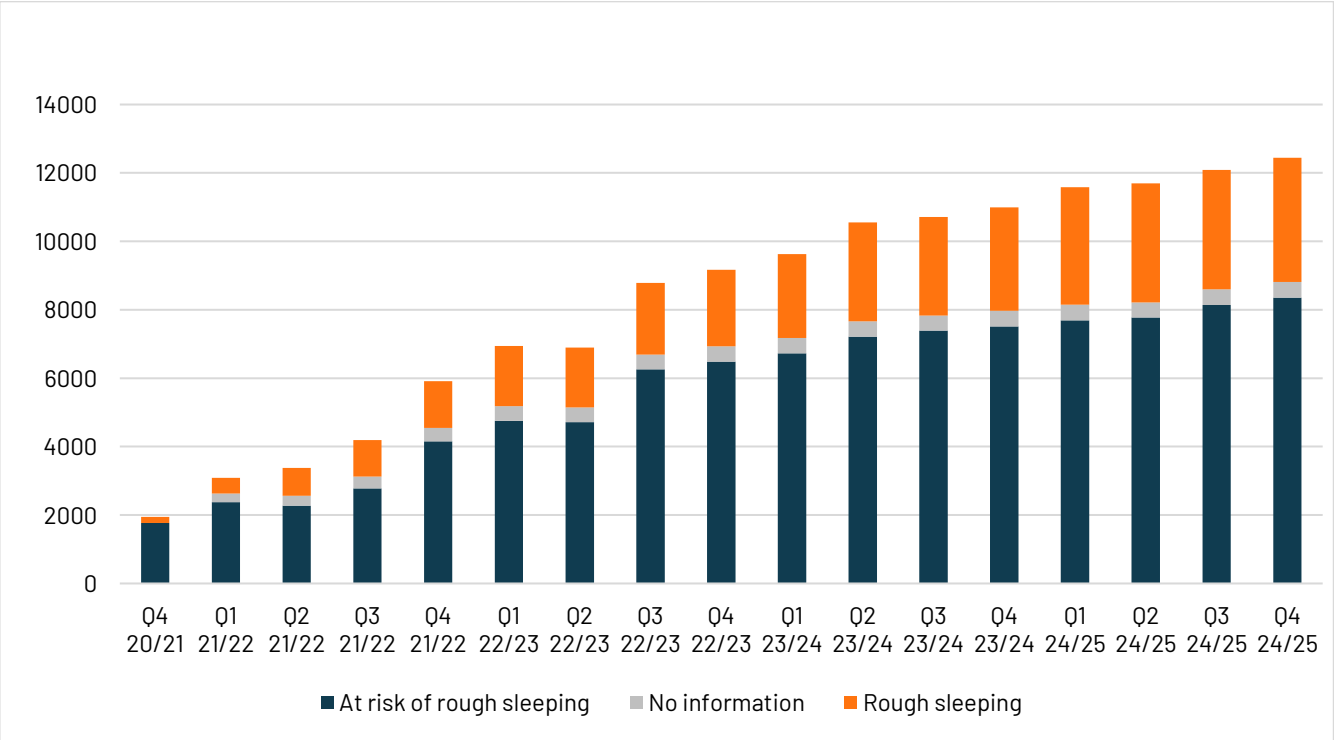
[23] RSDATG full business case, February 2022 (DHLUC at time of writing, now MHCLG). Numbers quoted are the numbers for "individuals that enter the treatment system" that were used as the basis for cost-benefit calculations.

[24] Calculated from monitoring information using 'The total number of unique individuals engaged with the RSDATG service since the start of the financial year' or highest quarterly number if this was higher, or number supported by RSDATG and in treatment if neither of these were available.

areas began delivery from Q2 21/22 (although some Phase 2 areas began in later quarters) and Phase 3 areas began delivery from Q1 22/23 (with the latest beginning in Q4 22/23).

It is not possible to calculate the total number of people supported by RSDATG over the lifetime of the funding as only annual figures are available, and adding them together would result in double counting.

Figure 5.1: Number of people engaged with RSDATG-funded services by quarter



Source: monitoring data submitted by funded areas

5.3.2 Access to drug and alcohol treatment

RSDATG-funded services and roles sought to support service users into treatment for their drug and alcohol use. **However, in the first 2.5 years of funding, RSDATG appears to have made no difference to the number of people with housing needs[25] starting treatment in funded areas when compared to non-funded areas. After this, numbers in treatment increase in funded areas over and above the national trend.**

Looking at monitoring data from the last year of the funding, RSDATG engaged 19,614 people. Of these, 85% were recorded as being in treatment.[26] The proportion of those engaged by RSDATG who were in treatment was the same across the rough sleeping and at-risk cohorts at a national

[25] Defined as people recorded in NDTMS as having an acute housing problem upon initial engagement.
[26] Calculated from monitoring information and based on numbers in Q4 24/25.

level. However, it varied considerably between areas depending on delivery models, from 100% of those supported by RSDATG being in treatment,[27] to fewer than1 in 5.

Around half (51%) of those in treatment had already been in treatment at the point of engaging with RSDATG.[28] This suggests that roughly 8,200 people in 2024/5 began engaging with treatment after or upon being supported by RSDATG. This is similar to the additional 7,800 additional treatment entries per year estimated in the business case. The exact number of additional treatment entries is uncertain due to two factors, which work in opposite directions:

- some of these individuals would have engaged without RSDATG support and so are not truly additional, meaning the number would be lower than that estimated.
- there is evidence that some areas may have recorded support from RSDATG in NDTMS incorrectly (specifically, as beginning later than it did) which may mean the number of people starting treatment after or upon being supported by RSDATG is higher than the 51% estimated; so the number would be higher than that estimated.

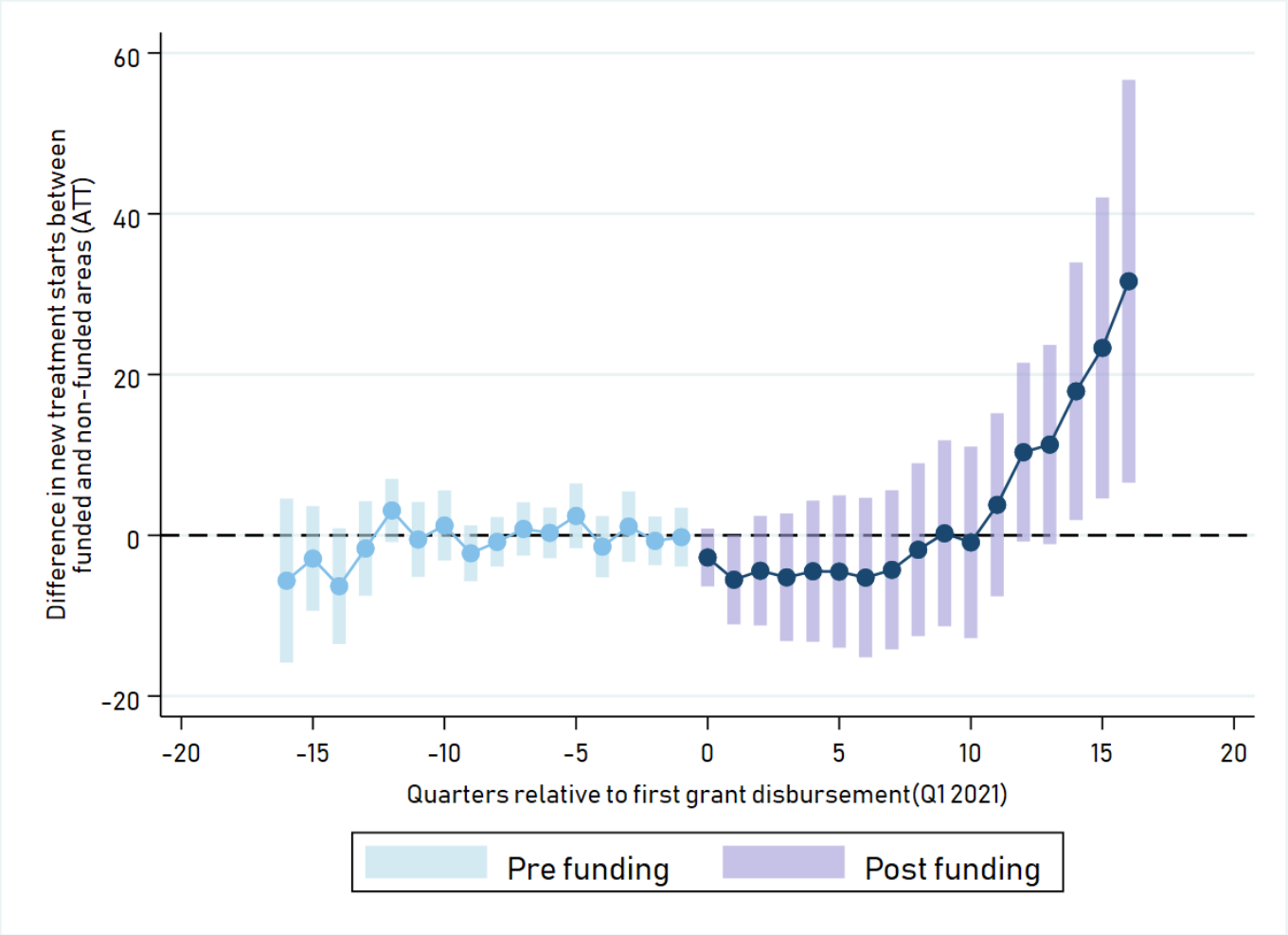
Looking at the numbers entering treatment over time, the numbers of people in housing need in treatment increased in the funded areas. However, a comparison to non-funded areas suggests that numbers would have also increased in the absence of RSDATG (likely influenced by national Drug Strategy funding such as the SSMTR grant). It is only after 2.5 years that RSDATG makes a difference over and above the general trend.

The chart below shows the difference in numbers of treatment starts (mainstream and RSDATG, people in housing need only) between funded and non-funded areas. Numbers of starts in RSDATG areas are shown relative to the national trend. Data from areas in different phases has been aligned around when they first received funding, shown as time 0.

[27] Areas that recorded 100% of service users being in treatment may have done so due to not being able to identify their service users before this point. All areas in fact had some element of pre-treatment engagement, so it is likely that overall numbers supported are higher, and the proportion in treatment lower, than the MI suggests.

[28] OHID calculations in autumn 2024

Figure 5.2: Numbers of people in housing need starting treatment in funded areas relative to national trends



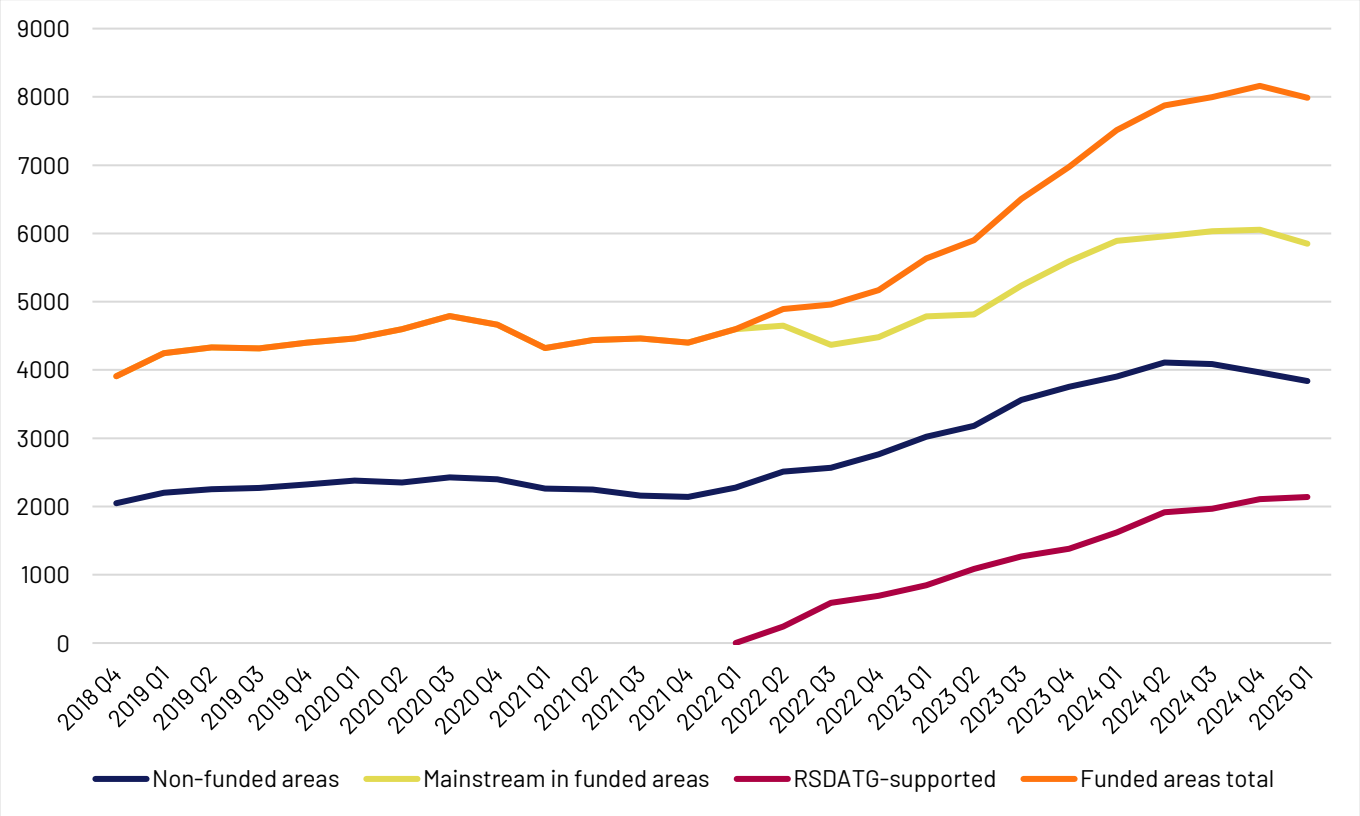
Source: Ipsos analysis of aggregate data on numbers of treatment starts supplied by OHID from NDTMS

The trend in number of people in housing need[29] accessing treatment was similar to trends in unfunded areas prior to RSDATG funding, and in the first two years of funding it did not increase any more than increases also seen in non-funded areas. In the third year of the grant, numbers begin to increase over and above increases in non-funded areas. In the most recent period (which shows the greatest difference) this increase is an additional 35 people per area per quarter on average.

The chart below shows trends in treatment starts among people with housing and mental health needs. This is shown for both non-funded areas and funded areas, with breakdowns of RSDATG-supported and non-RSDATG supported people within the funded areas.

[29] Defined as those recorded in NDTMS as having an 'acute housing problem'

Figure 5.3: Treatment starts in funded and non-funded areas among people with housing and mental health needs



Source: NDTMS data supplied by OHID. Note that the figures for RSDATG-supported (pink line) and mainstream in funded areas (yellow line) will be affected by an increase in RSDATG intervention flag usage in NDTMS over time. As this flag was not fully used at the start, the true number of RSDATG-supported starts is likely higher and mainstream starts in funded areas likely lower than the 2022 data suggests.

There are several possible explanations for RSDATG's lack of impact on overall numbers in treatment in the funded areas in the first 2.5 years of the grant.[30] One possible explanation is that numbers did not expand further in the funded areas because there were no further people in need of support, but OHID analysis on demand[31] indicates this is unlikely.

Another explanation is that some of the people RSDATG supported would have been working with drug and alcohol services anyway. Around half of RSDATG service users in treatment were in treatment already when they first engaged with RSDATG-funded services. Data from case study areas suggests that these people had been in treatment for an average of six months prior to engaging with RSDATG. These people have effectively just been transferred over to RSDATG support (which may be more effective for them – see section 5.2.3 below). As well as this, there will be some people who were supported by RSDATG who would have been able to enter treatment without the additional support.

However, the wider evidence based collated in other strands of the evaluation strongly suggests that RSDATG roles and services brought people into treatment who would *not have been able to*

[31] OHID slides from impact learning event, October 2024

engage without the additional support, because they faced greater barriers to doing so. In interviews, staff and commissioners reported that they had observed that people experiencing rough sleeping or at risk of this were engaging with drug and alcohol treatment services when they were not previously able to.

> **"Going to where those individuals are and… getting those people who have never been in treatment or who are really reluctant to access treatment or lack of trust with professionals and things and actually having that ability to start to support them. So, the rough sleeper team, they've got people in treatment that never ever would've accessed it before. They would never have just walked into that service."** – Commissioner

> **"I was really surprised how quickly we ended up with about 90-odd people on RSDATG's books, I was, like, 'Wow, I thought we knew all these people, I thought we had all these people,' and we've always had decent penetration."** – Frontline worker

Engagement was not only about reaching people who were completely new to drug and alcohol services, as RSDATG also offered the opportunity and time to re-establish relationships with people who had had previous interactions with services but not engaged for some time. NDTMS data shows that around 4 in 5 people supported by RSDATG were not 'treatment naïve', that is, they had engaged with drug and alcohol services in the area at some point in the past. However, many of these people were no longer engaging in treatment at the time of their first interaction with RSDATG-funded services. Staff believed that previous negative experiences of services (described by many service users) had prevented people returning to treatment without the additional support RSDATG provided to rebuild trust.

Increased initial engagement was attributed to an increased number of workers; increased collaboration between services helping to build relationships with specific groups; physically going out to locate potential service users or providing drop-in opportunities; persistence and consistency as a way of building trust; being able to respond more quickly; and offering basic healthcare or other practical assistance as a way to build relationships.

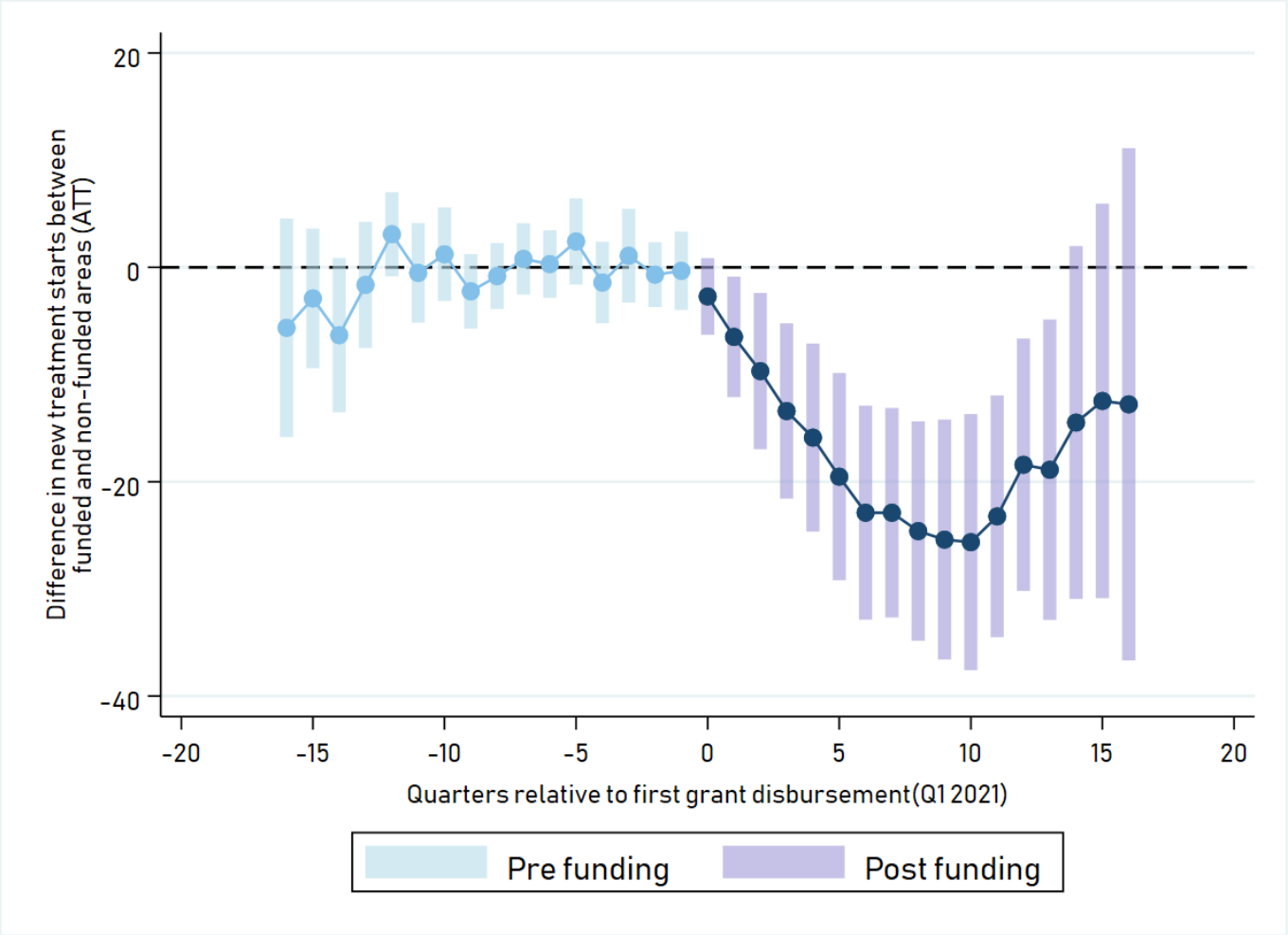
Other factors also helped services better identify and reach people in the RSDATG cohort. RSDATG staff often worked with outreach teams from the Rough Sleeping Initiative to pool knowledge about local people experiencing rough sleeping. In some areas, staff reported that the Everyone In campaign was the first time some people experiencing rough sleeping had been identified by services. This provided an opportunity to build relationships with individuals who had previously been hidden.

Given these findings, another explanation for the limited impact on overall numbers in treatment is that, to some extent, by bringing 'harder to reach' people into treatment and providing them with intensive support, RSDATG 'crowded out' another group of people in housing need (but with lower support needs than people supported by RSDATG) being able to start treatment during this period.

Although numbers starting treatment increased across England, because RSDATG-funded areas received RSDATG funding **as well as** other Drug Strategy funding such as SSMRTG, it would be expected that treatment starts would increase more in funded areas than in areas that did not receive RSDATG funding. To the extent that this has not happened, it suggests that there were some capacity constraints within services in RSDATG areas that prevented them expanding further, and that some people who might have been engaged by services were not because services could not expand as much as anticipated.

The results of time-series analysis of treatment starts in both RSDATG and mainstream treatment services provide support for this explanation. The chart below shows the same time period as figure 5.4, but compares treatment starts between funded and non-funded areas, excluding those supported by RSDATG. It shows that after the programme introduction, treatment starts in mainstream services sharply reduce over a period of 2.5 years, before increasing slightly, then stabilising. This supports the theory that, in the initial years of RSDATG, it may have displaced mainstream services because local authorities could not expand capacity in line with the additional demand. A smaller number of people were starting treatment under mainstream services, but the overall number stayed similar because more people were starting treatment under RSDATG.

Figure 5.4: Numbers of people in housing need but not supported by RSDATG starting treatment in funded areas, relative to national trends



This suggests that without RSDATG, numbers in treatment would have still increased at a similar rate to what is seen in the first few years (and possibly more so as services would have focused on a lower-needs group who require less support per person, so each worker's caseload could have been higher). **It appears that RSDATG funding shifted the profile of those engaged with treatment services towards those with higher levels of need, but overall numbers of those in treatment were little affected in the first few years.**

This limited impact on overall numbers may be because of skills shortages in the drug and alcohol sector[32] leading to staffing constraints (a common theme in interviews with professionals across the evaluation). At the outset of the grant, many areas experienced recruitment and retention challenges (see section 3.6). They reported that RSDATG and mainstream services were competing with each other for trained and experienced staff, which limited how much they could both expand at the same time. Several commissioners and managers noted that this meant delivery began later than planned or that the service could not be delivered at the intended capacity. Some

[32] See, for example: National Audit Office report on Drug Strategy progress, 2023 (https://www.nao.org.uk/wp-content/uploads/2023/10/reducing-the-harm-from-illegal-drugs.pdf)

interviewees described staff being 'poached', or several funding streams competing to recruit from the same limited pool; high turnover was a common issue.

> **"The districts are competing for outreach teams. The substance misuse services are wanting drug workers, the housing support services are wanting support workers, everybody is wanting staff, and you don't want to rob Peter to pay Paul."**
> - Commissioner

The evidence also points to staff being attracted into RSDATG-funded roles from mainstream services (for example because of the mission focus of the role).

> **"We pinched some particularly good staff from some of the existing treatment bits of the service." – Service manager**

To the extent that staff were recruited to RSDATG instead of mainstream services (or directly from those services), this would have 'crowded out' other people who also have housing needs but whose needs are less severe and complex: for example, there may have been less outreach to these groups or less effort to re-engage people who dropped out of treatment. It would also have limited the growth in numbers, since RSDATG staff tend to have caseloads that are half the size of mainstream service caseloads.

Another possible explanation is that additional Drug Strategy funding was targeted in different ways in different areas. It could be that, although they did not receive RSDATG funding, non-RSDATG areas used other additional Drug Strategy funding to expand the number of people with housing need in treatment. This would result in both groups of areas seeing similar increases in the numbers of people in housing need in treatment, but funded from different sources. Meanwhile, RSDATG areas may have instead used their Drug Strategy funding to expand numbers in treatment amongst other groups and overall seen a bigger increase in numbers, which would not be picked up by the above analysis as it is limited to people in housing need. This would mean that there was no 'crowding out' in RSDATG areas, although there might have been in the non-funded areas. It would also suggest that dedicated funding was not needed to achieve the goal of getting more people with housing needs into treatment. However, NDTMS figures on overall treatment numbers do not support this explanation, because since 2019/20 overall treatment numbers have risen more in non-funded areas than in funded ones.[33]

5.3.3 Sustained engagement and re-engagement

RSDATG set out to improve levels of sustained engagement with treatment services, and to facilitate service users re-engaging with services following an early exit or drop-out.

Qualitative evidence indicates that supporting people to remain in treatment was a major priority for the funding in many areas. Commissioners across a large number of funded areas reported achieving these goals around retention, in terms of seeing people maintain opioid substitute

[33] Data on new presentations by upper-tier local authority and year, accessed at https://www.ndtms.net/Viewlt/Adult

prescriptions and regularly attend appointments. Interviews strongly indicated that the funding allowed services to work more effectively with people with higher levels of need, and that people who had cycled in and out of treatment for decades were able to achieve greater stability and progress.

Supporting people to remain in treatment also helped some individuals maintain accommodation. It brought stability to people's lives and helped reduce antisocial behaviour that may lead to risk of eviction, as described in section 4.8.2.

Interviewees attributed improved treatment retention to: staff being able to 'handhold' individuals during the process and follow up if they had not seen them; being able to take time to understand individual needs and apply a more personalised approach; flexibility about where and when service users engaged; and a multi-agency approach that addressed multiple issues and practical barriers, and smoothed the way to help people to engage with treatment.

The features of RSDATG-funded services described above also facilitated service users' re-engagement following periods of disengagement: this will have contributed to the overall numbers engaged and in treatment. Service users said that their workers had made it clear to them that they would be welcomed back should they disengage. This meant they were more likely to feel safe and comfortable doing that – without the stigma or shame they might otherwise have felt.

> **"That's a good thing with the service, is that you can leave and bounce back. It's not, 'If you leave, you can't ever come back.' There's always an option to leave and come back whenever you feel like it."** – Service user

Communications between support workers and partner staff working with the cohort were also key in identifying service users at risk of disengagement or who had disengaged, so enabling rapid responses to re-engage them to be formulated. RSDATG staff were then able to follow up with service users who had dropped out, due to having more time and flexibility, and developed contingency plans for how to manage people dropping out of residential treatment.

> **"Do you know what, for me, is really important? The fact that I have peace of mind that I have, like, unconditional support. And I know I don't need to think about this but even if I were to relapse, I know they would help me get back into a detox centre."** – Service user

Interviewees noted that even if retention in treatment did not lead to completion, it would have other positive impacts for both individuals and the community.

> **"If we've got 40 people of rough sleepers that are on substitute medication and aren't using street opiates any more or very rarely using street opiates, shall we say, that's got to be an improvement because that's going to have a reduction on things like risk of overdose, reduction on crime potentially... So, it's going to have a community impact still even if we're not getting the successful completion."**
> - Commissioner

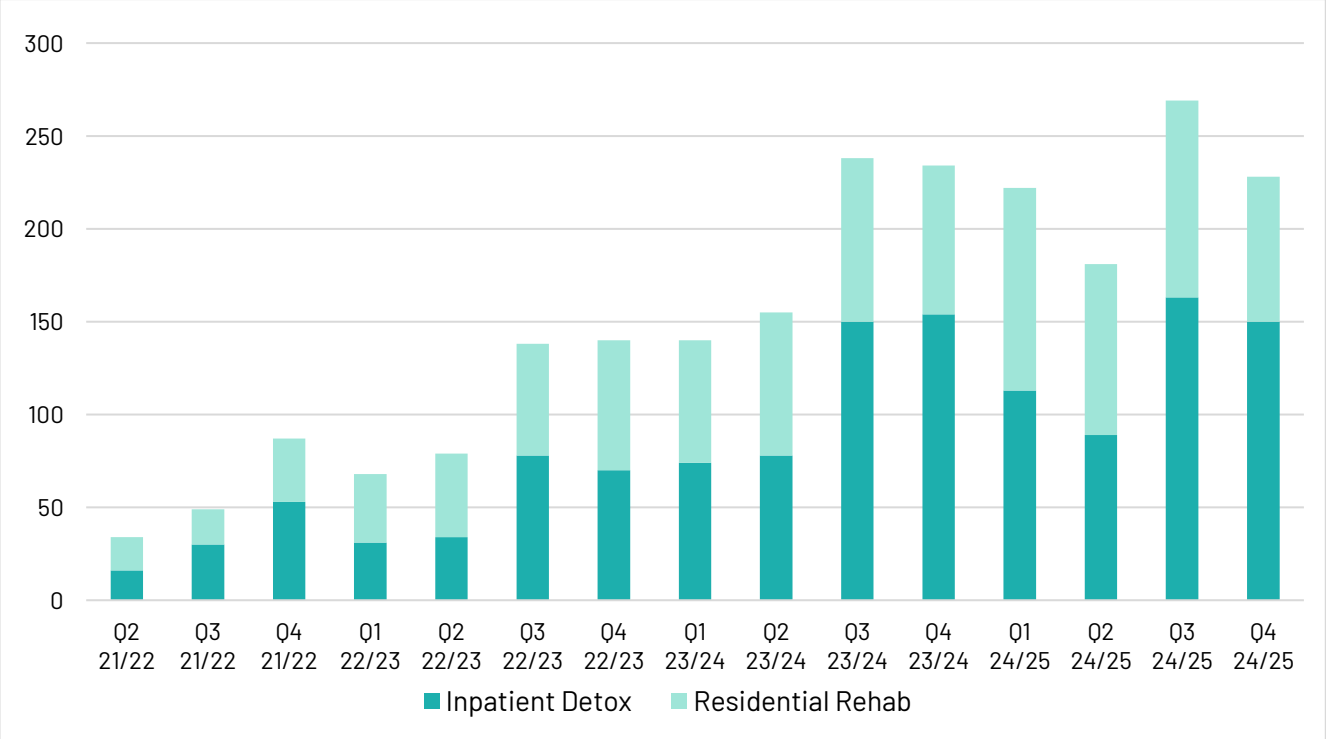
5.3.4 Entering detox or rehab

The year 3-5 business case for RSDATG anticipated 900 residential treatment places per year being taken up as a result of the grant, as a result of dedicated funding for people in the RSDATG cohort to enter detox and rehab, and more effective support to access and engage with these types of treatment.

Annual numbers of people in the RSDATG cohort entering detox and rehab grew over time to the level anticipated at the outset of the grant. While numbers in detox and rehab were low as a proportion of those supported overall, commissioners in many areas reported that they represented an increase compared to their previous experiences of obtaining residential treatment for people experiencing rough sleeping or at risk. Areas that had successfully addressed the challenge of finding move-on accommodation had been able to send people to residential treatment in relatively high numbers.

By 2024/5 the number of individuals engaging with detox and rehab via RSDATG-funded services was what was expected at the outset of the grant (900 places per year). The chart below shows that in the final year of the grant covered by the evaluation there were on average 129 service users in detox and 96 in rehab in each quarter, and actual numbers may be higher than this since data is missing from some areas.

Figure 5.5: Numbers in detox and rehab in each quarter



Source: monitoring data submitted by funded areas on the number of people that have received detox/rehab as a result of the staff posts funded by RSDATG

Across the projects the numbers of service users accessing inpatient detox and rehab represented a relatively low share of their overall cohorts. The majority of quarterly reports from

funded areas show no service users in detox or rehab, and where numbers are recorded these are typically between 1 and 5 (with numbers in rehab tending to be slightly lower on average than numbers in detox). 9 areas recorded no service users in inpatient detox, and 17 recorded no service users in rehab, across the lifetime of the funding. However, some areas were not able to identify the number of people supported by RSDATG who had entered detox or rehab since their IPD/RR contribution was pooled with other funding.

Staff and commissioners in several case study areas reported that they had seen more people from the RSDATG target cohort entering detox and rehab than they would have previously: for example, one area said that the number had increased from one or two per year to more than ten, and that they had spent more than the amount they had earmarked for detox and rehab from their RSDATG grant allocation and were partly funding it from the public health grant. In contrast to findings from earlier waves of the evaluation, wave 3 case study areas tended to say that they had achieved roughly what they had expected to in terms of the numbers of people in the RSDATG cohort entering detox or rehab.

> **"In the past we would have expected [service users] to get to a point where we felt it was – and this is going to sound wrong – worth investing that money in them... We were almost excluding them because they couldn't get to that point of showing that commitment... What I think [RSDATG] has allowed us to do is to just allow people to go to detox and rehab without all of that process... They [still] have to demonstrate motivation by attending groups. And there have been some really good outcomes from people that we wouldn't have funded detox and rehab before in the past."** – Commissioner

However, the overall impact of RSDATG on the numbers of people in housing need entering detox and rehab is uncertain in the context of rising numbers of people in drug and alcohol treatment more widely.

Factors which enabled more service users to enter detox and rehab included: flexibility about the preparatory work requirements (for example, having one-to-one instead of group sessions to suit the preference of the individual service user); identifying providers that were able to work with people with higher levels of need; improved multi-disciplinary working to inform decisions about offering a place; and support from staff or volunteers with lived experience. The case study areas which reported some of the greatest increases in the numbers of people entering detox and rehab attributed this to their ability to secure appropriate move-on accommodation for people leaving rehab, which was in turn attributed to RSDATG workers' persistence in negotiating with accommodation providers to allow this and their assurances that ongoing support would be provided by the RSDATG team.

In many areas an inability to secure suitable move-on accommodation and aftercare for people leaving treatment was seen as the biggest barrier to more people entering residential treatment. Commissioners and staff reflected that for this reason and others, expecting significant numbers of people from the RSDATG cohort to enter inpatient treatment was not realistic, although most

believed that it could and had worked for some people in their area. Other challenges included a lack of appropriate detox and rehab services, in particular of specialist services; and the experience of living on the street, which made it difficult for people to stabilise their lives sufficiently to be able to prepare, or adjust to the demands of residential treatment (see section 4.7).

5.4 Impact on treatment completion

RSDATG was anticipated to have an impact on reducing drug and alcohol use among people experiencing rough sleeping or at risk. At the outset of phase 2 of the funding, OHID analysis underpinning the cost-benefit analysis model for the funding estimated that 16% of people supported by RSDATG, projected to be 770 individuals per year, would successfully complete treatment and be in recovery from substance use. This estimate was based on data from NDTMS and reflected completion rates in the general population at the time[34], adjusted for the fact that RSDATG-funded services were expected to work with a higher proportion of opiate users, who have lower completion rates.

RSDATG has supported a large number of people to successfully complete treatment, in part due to the intensive support. Completion rates and thus overall numbers were lower than expected, which is likely to be because the RSDATG group's needs were more complex than originally envisaged. Service users drew a connection between the service improvement enabled by RSDATG and their ability to access and complete treatment.

NDTMS data from June 2025 shows that over the preceding year, 9% of those engaged by RSDATG-funded services (1,273 people) had completed treatment, and a further 19% (2,611) were still in treatment but had substantially reduced or stopped their use of substances (28% altogether had made substantial progress in treatment)[35]. This would mean that around 740 people in this year had completed treatment after being supported by RSDATG to enter treatment.

Overall, completion rates are slightly lower for people supported by RSDATG than in the mainstream population (9%, compared to 21% for mainstream[36], compared to the 16% expected in the business case), and so are rates of people showing substantial progress (28%, compared to 46% for mainstream).[37] These lower figures would be expected given the additional challenges faced by the RSDATG group. Similarly, just looking at those exiting treatment, the proportion of successful exits (27%)[38] is lower than for mainstream services (47%).[39] In this dataset 'successful completion' was defined as meaning that the service user no longer used opioids or crack cocaine and no longer required structured drug or alcohol interventions. In data from the 10 case study areas, 14% of people supported by RSDATG had successfully completed treatment.

[34] https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020
[35] Data supplied by OHID, September 2025.
[36] NDTMS data reported in RSDATG project board update, January 2025
[37] https://www.ndtms.net/Monthly/TreatmentProgress
[38] Monitoring data: total treatment exits for all reasons vs. successful treatment exits, over lifetime of funding
[39] https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024

When asked about RSDATG service users completing treatment, RSDATG staff and commissioners commonly said that successful treatment completion was not a realistic expectation for a large proportion of the RSDATG cohort. These interviewees were concerned that they might be perceived to have failed by not being able to support service users to achieve treatment completion, when in reality this was an inappropriate metric.

> **"I don't like the completion treatment measure… I don't even think you should ask me that question. This is about treatment progress… You know, these are individuals that have probably had trauma for 20, 30 years. You can't treatment-complete them in 12 months, six months. What you do make is progress with individuals. And so, if you're talking about treatment progress, absolutely, we've made treatment progress from a physical, psychological and a housing point of view. But they are always [going to] be baby steps, because these are complex patients."** – Commissioner

However, many interviewees could provide examples of people they had worked with who had successfully completed treatment and were now substance free. Whilst they acknowledged that this was not necessarily typical, interviewees were keen to stress that service users had made a range of positive changes to their substance use, up to and including recovery for some.

> **"The vast majority of our service users who are engaged, and are now finally having positive outcomes, being on methadone scripts, going to detox, and we have got in recovery, they've been in and out of core services for 20, 30 years and it's never worked."** – Service manager

This was corroborated by interviews with service users, who identified that a key benefit of engaging with RSDATG-funded services was the progress they had made towards recovery from substance use. This had taken different forms for different people: some had reduced their substance use or shifted from using multiple to just one substance; some had started on opiate substitute treatment such as methadone or buprenorphine; some were attending 12-step programmes; or engaging with the prerequisite activities for residential rehab. Regardless of where they found themselves on this continuum at the time of interview, service users tended to say that their position had improved as a result of RSDATG services. It is important to bear in mind that service users who have been able to reduce or cease their substance use were those most likely to be taking part in interviews and so it is likely that their experiences may tend to be more positive than that of the overall service user cohort.

For those who had completed treatment, key enablers for this were support from peer workers or other people with lived experience; and having suitable aftercare in place. In some cases, community treatment was sufficient for service users to become substance free: some staff and service user interviewees gave examples of people successfully coming off substances without going to inpatient detox or rehab. Particular successes included the high uptake of Buvidal, with one area reporting a 100% attendance rate among the eligible cohort for their regular injections.

Some service users also spoke of reaching the right mindset – being ready to stop using – being crucial to their progress.

> **"This time, everything's different because my mum and dad passed away and I've had a lot of life changing things happening to me, and I was just ready now. You know, I've got no one that I can fall back on that's going to help me or anything like that. I've got to do it all myself now and I can't do it on drugs; I've got to be clean. I've just come to time now where I'd had enough of this life, you know, yes, it's just time to change."** – Service user

A lack of suitable accommodation was a major barrier to achieving positive outcomes. Staff discussed the prevalence of 'wet' hostels (where use of alcohol and certain substances is permitted) and difficulties service users had in maintaining abstinence in an environment described as chaotic and with considerable substance use. Another barrier to improved outcomes was the emergence of new substances, for which treatment options were less well-developed or well-known – for example, synthetic cannabinoids and illicit pregabalin.

5.5 Impact on achieving fewer drug-related deaths

One of the three key goals for the RSDATG funding was that it would reduce the number of drug- and alcohol-related deaths amongst people experiencing rough sleeping.

There is qualitative evidence of the grant's impact on levels of drug-related deaths: it was believed to have either slowed a rise in drug-related deaths or to have reversed it in some areas.

Overall numbers of drug-related deaths have risen each year since 2019[40]; figures on drug- and alcohol-related deaths among homeless people have not been available since 2021, and were broadly constant in the five years preceding that[41]. However, commissioners and staff in funded areas reported that there had been a recent rise in drug-related deaths among the RSDATG cohort in their area, and this was echoed by OHID stakeholders. Interviewees in case study areas attributed this rise to an overall national trend and in particular an increase in the prevalence of synthetic opioids.

Nevertheless, staff and service user interviewees were consistent in their views that RSDATG-funded interventions have led to fewer drug-related deaths than there would have been without the funding. In areas where death rates had increased in recent years, staff and commissioners believed that RSDATG had helped to slow the rate of increase, or in some areas reverse it. These reports were based on local data collection about drug and alcohol deaths, with some interviewees citing comparisons to adjacent local authority areas that had not received funding.

[40]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2023registrations

[41]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsofhomelesspeopleinenglandandwales

> **“"I think we'd probably have had an awful lot more overdose death than we've had already, I mean, we've already had an unprecedented number this year, I've never known it this bad, to be honest, but I think there would have been an awful lot more.”** – Frontline worker

Interviewees believed the difference made by the funding had been ‘significant’, whilst acknowledging the influence of other funding streams on overall support available for the cohort. Project staff believed that given the exceptionally high-risk nature of the cohort, some of the people they worked with would be dead by now without their support, and this was echoed by service users themselves.

> **“They've stunted my drug addiction, like, dramatically… [I want to] say thank you to all the people. Just give them a thank you, as in, without your support, I probably would be dead.”**– Service user

Interviewees who believed that the RSDATG funding had saved lives attributed this to 3 key factors: harm reduction activities, assertive outreach, and wraparound support. A major element of the role of outreach staff funded by the grant was to deliver harm reduction activities such as providing naloxone and giving advice on signs of overdose, and providing drug test kits and alerts around contaminated substances. In some case study areas, service managers described “keeping people alive” as the main priority of RSDATG-funded staff.

Staff saw assertive outreach work as crucial in reaching people who would otherwise find it too difficult to access services. Without RSDATG funding, this assertive outreach would not have been as robust (or even possible) in many areas. Service users reported that they valued staff from RSDATG services regularly checking on their welfare.

> **“Over the last year or so, especially when deaths have been rising, drug-related deaths, especially locally … it's been really critical for us to be proactive and taking treatment out into the community and taking it to people's homes to try and re-engage people to help them… in days gone by, it might be a case of, 'Okay, well, they dropped out of treatment. Close them and then they can re-engage when they want.' But actually, now we try to do doorstep visits and drop letters through there. We might give naloxone through their letterbox or try and give that to them … I think those interventions are crucial in sometimes, actually, just saving lives.”** – Service manager

The wraparound support provided by RSDATG helped service users to get into some form of housing where they would be safer, and to address other health issues: for example, by supporting service users undergoing treatment in hospital for other health conditions to complete it rather than walking out. Staff said that seeing service users more often helped to identify other life-threatening health conditions that might otherwise have been missed, and so helped reduce the risk of premature death amongst the cohort.

5.6 Overall reflections on impact on substance use outcomes

Interviewees highlighted that people supported by RSDATG were often very unwell both physically and mentally, and experiencing the effects of trauma. They reported that many service users have brain injuries and cognitive issues which can affect capacity and impulse control, and their ability to engage with services. Interviewees also noted that service users were likely to be deeply mistrustful of services after repeated negative experiences. They stressed that for this group, making progress involves small steps over a long period of time, and some staff viewed their role as primarily keeping people safe and preventing problems from escalating rather than expecting to see significant changes.

> **"These are the most vulnerable people in our society. We've had nothing for them for a long, long time, we've got something for them now... Even if they're not ready for us yet, we can keep encouraging them, we can keep them safe, we can keep them alive and we can get them into treatment as soon as they're ready."** – Commissioner

Despite RSDATG's holistic approach, which aimed to resolve problems preventing engagement with treatment, people supported by RSDATG continued to face considerable challenges in addressing their substance use. For many people, a lack of appropriate or stable accommodation represented a major barrier to stability and progress: service users described the challenges of living in environments where everyone around them was using drugs or alcohol and encouraging them to do the same. There can be no 'completion' of the recovery process without the presence of safe, stable, appropriate housing.

> **"There are limitations, you know, it's just, you're kind of stuck there, really. Accommodation really would be key, my environment, my daily environment, is what's important really, and if that can be calm, that keeps me out of harm's way and encountering other people. Where I'm staying, people come and go, and I've got no control over that. People come into the house and do drugs in front of you, and it's not good."** – Service user

Limited access to mental health services prevented people from addressing the mental health problems or trauma which led them to continue using substances, and this was a factor leading people to relapse after completing detox or rehab.

In interviews, staff tended to be cautious about making claims about service users' treatment completion. Recovery from substance use is a complex journey that often involves relapse as a part of the process. As such, thinking of engaging with treatment as a step on the road to 'completion' can be misleading, especially for this cohort of service users. Staff said that more realistic and helpful measures for understanding service users' progress towards recovery include factors such as improvements in physical and mental health; increasing ability to manage various aspects of their lives, such as health conditions, independently; and improved understanding of what next steps they can take to continue expanding their recovery capital. Some service users reported having sought and received a mental health or neurological diagnosis, and that this had

been helpful in allowing them to understand why the world had always felt confusing or difficult for them to navigate. Having this new understanding of themselves helped service users to better communicate their needs to service providers.

Service users (and the staff who supported them) had different thresholds for when they considered themselves to have 'completed' treatment. For example, some service users who took part in interviews said they were preparing to go back to work; getting back in touch with family they had lost contact with; working to regain custody of their children; or (re)engaging with education. However, some service users stated that they did not expect to be able to cease using substances entirely, and that they expect (and prefer) to remain in supported accommodation indefinitely, because they have recognised that this was the best way for them to maintain their present level of health and substance use.

There was insufficient evidence to say definitively whether impact, or mechanisms for impact, may differ by groups within the RSDATG cohort.

5.7 Impact on accommodation outcomes

5.7.1 Overall findings

RSDATG set out to support service users into short-term accommodation, help them to maintain tenancies, and minimise evictions, with the overall aim of reducing rough sleeping. The logic underpinning this intended outcome was that tackling substance use issues would make positive accommodation outcomes more achievable for this cohort.

The original strategic case for RSDATG anticipated that it could reduce the overall numbers of people experiencing rough sleeping by around 600. This was thought to be achievable because RSDATG support was introduced alongside other funding streams intended to improve housing provision; however, in fact, rising need has outstripped increases in housing provision[42] and made it very challenging to achieve accommodation outcomes.

Based on annual single-night counts, **there are 288 more people experiencing rough sleeping in the RSDATG-funded areas than there were in 2019 (a 10% rise, part of a 9% rise nationally)[43]. The most commonly perceived reason for this was widespread shortages of housing, in particular shortages of housing suitable for people with more complex needs or vulnerabilities, a factor which was outside the influence of grant-funded roles and services and prevented the grant from having greater impact.**

However, in many areas, staff reported that RSDATG support had prevented the number of people experiencing sleeping rough from rising further, by securing housing for people experiencing rough sleeping and helping prevent rough sleeping among those at risk. Securing

[42] https://www.gov.uk/government/publications/systems-wide-evaluation-of-homelessness-and-rough-sleeping-preliminary-findings
[43] https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024

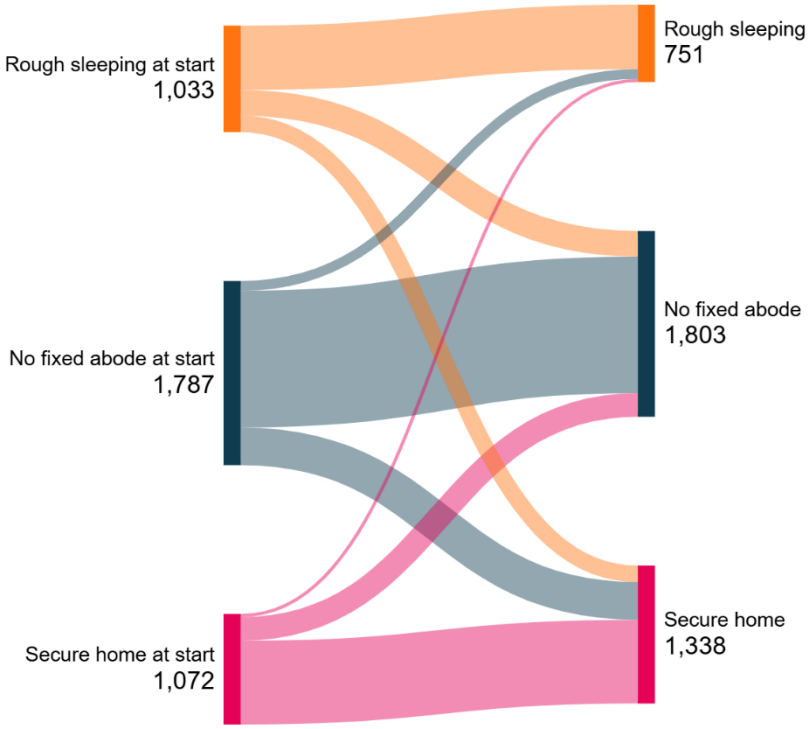
appropriate move-on accommodation was the most challenging outcome to achieve due to insufficient availability of suitable housing options. There was recognition of the interdependencies between housing and treatment outcomes; service users who had been supported into accommodation felt that, without it, other areas of their lives would have been negatively impacted.

Housing status has improved for some people in the RSDATG group. Some service users interviewed for the evaluation reported positive accommodation outcomes as a result of the RSDATG services they had experienced. They were generally highly positive about their experiences of using RSDATG services and grateful for the support they had received to be housed. They felt that it provided them with a stable base to sustain recovery or access support for other needs they had.

Data from ten case study areas indicated that of those experiencing rough sleeping at the start of their engagement with RSDATG, 40% had seen an improvement in their housing situation (becoming categorised as 'no fixed abode', likely to represent living in temporary accommodation; or to a more secure home). 60% were still sleeping rough at the most recent data collection point. Looking at the wider cohort in these areas, 27% of people supported by RSDATG were experiencing rough sleeping on entry to treatment and a further 46% had no fixed abode.[44] In the most recent data collected about these individuals' housing status, 19% were experiencing rough sleeping and 46% had no fixed abode. Overall, across these ten areas, 20% of RSDATG service users in treatment had seen an improvement in their housing situation since the start of their engagement (where improvement was defined as moving from rough sleeping to no fixed abode, or from no fixed abode into a more secure home) while 9% had experienced the reverse, and 71% had seen no change.

[44] The data set used for this analysis uses the following categories: rough sleeping, no fixed abode, rented home, other home, or homeowner. The latter three can be thought of as a more secure home. People in temporary accommodation would be classed as 'no fixed abode'.

Figure 5.6: Housing outcomes for RSDATG service users in ten case study areas



Source: NDTMS data on RSDATG service users in treatment in ten case study areas.

It is not possible to assess quantitatively the extent to which any changes were as a result of RSDATG, nor to measure any changes within these broad categories (for example, moving from sofa-surfing to a hostel) which may be positive or negative. Some interviewees suggested that increased numbers of people in treatment (both in RSDATG and overall) may put additional pressure on housing, as people in the RSDATG target group are likely to move to or remain in areas with effective drug and alcohol services.

5.7.2 Impact on reducing rough sleeping

Qualitative and quantitative data shows that RSDATG funding has helped RSDATG workers to get some service users experiencing rough sleeping into accommodation. There were examples given of getting individuals who had been sleeping rough for a long time and were the most entrenched into accommodation for the first time, as a result of the funding.

> **"We've seen that more intensive focus has got some of those people into accommodation for the first time, so that has been really, really positive."**
> – Service manager

RSDATG funding made these positive accommodation outcomes possible through:

- Bringing housing teams into multi-disciplinary teams, which facilitated partnership working to find accommodation from a wide range of sources;

- Enabling key workers to have smaller caseloads and more time to spend with service users addressing a wider range of issues, including advocating for their specific housing needs;
- Taking a person-centred and trauma-informed approach, which supported staff to build trust and relationships with individuals experiencing rough sleeping.

"The funding has enabled us to find alternative accommodation for individuals who have been found rough sleeping and there's more of a partnership approach to addressing the needs that have been identified." – Commissioner

5.7.3 Impact on preventing rough sleeping

Another way the RSDATG achieved some positive accommodation outcomes was by helping people at risk of rough sleeping remain housed. Frontline staff reported reduced eviction rates for members of the RSDATG cohort in comparison to what they would have expected previously.

This was achieved through mechanisms such as RSDATG-workers equipping service users with skills to support more independent living, supporting service users to manage substance use, and advocating for service users (see section 4.8.2), which reduced their risk of eviction. Service users who received support to upskill in practices to support them to look after themselves generally found it beneficial and that it helped them to maintain their accommodation.

"A lot of that temporary accommodation is able to be maintained by the service users by their engagement with the rough sleeper drug and alcohol team. So, by being a bit more stable on, for example, methadone scripts, bringing less drugs into the accommodations, which will lower their anti-social behaviour, things like that." – Service Manager

Several areas also described developing relationships with housing providers and local authority housing teams to get early notice of people with substance use problems who were at risk of eviction – for example when they received their first warning. This approach, where they were able to intervene earlier, proved effective at minimising the risk of returning to the streets.

These approaches to support people at risk of rough sleeping were possible because services had more capacity than prior to the funding to undertake these tasks, and in some areas had used RSDATG funding for specific posts for this purpose.

5.7.4 Supporting service users into move on accommodation

Supporting service users into move-on accommodation was the most challenging outcome to achieve. RSDATG workers in several areas felt they had reasonable success at getting people into accommodation initially, but that move-on was more of a challenge. This was because more factors needed to be taken into consideration, for example a need for 'dry' accommodation, which reduced the pool of available suitable housing options (see section 4.8.3).

Nevertheless, interviewees reported there had been some positive outcomes in terms of securing move-on accommodation, enabled by smaller caseloads, strong partnerships and communication. Staff had more time to build relationships and collaborate with housing providers and VCS partners and discuss the needs of individuals (e.g. not placing a service user leaving inpatient treatment into a hostel where other residents may be using) which they would not have been able to do if their resources were stretched across higher caseloads. This resulted in finding accommodation for service users that was more suitable for their needs, which they thought would not have been the case without dedicated RSDATG funding enabling more intensive, person-centred working by staff.

> **"[My RSDATG worker] has been brilliant, absolutely, he's done everything. When you get in contact with those guys [drug and alcohol services], they can't do anything about housing, right? But he's phoned up the council for me, he's spoken up on my behalf for me, he's said to them, 'It's imperative that he gets some accommodation, instead of waiting until Friday, for him to stay on the road to recovery.' He shouldn't be doing that, but he has done it."** – Service user

However, even with positive partnership working, it could still be challenging to synchronise discharge from detox/rehab with the availability of move-on properties, or keeping properties free until the service user was ready to return. This was due to housing shortages, which were beyond the control of RSDATG teams and posed a significant threat to getting people sleeping rough into suitable accommodation.

5.7.5 Barriers to achieving positive accommodation outcomes

Despite the above examples of positive impact, the impact of the grant on accommodation outcomes overall appears to have been relatively limited. Shortages of housing were widely reported and cited as a major barrier to achieving positive accommodation outcomes on a wider scale or over the longer-term (see section 4.8.3). The lack of availability of dry accommodation was a particular issue reported by RSDATG staff that limited their ability to support service users with other areas of their lives like managing substance use; shortages of supported accommodation and women-only accommodation were also cited as specific problems. Some of the service users interviewed for the evaluation were still sleeping rough or living in precarious or unsuitable housing and thought that they would not be able to make further substantial progress with their recovery until their housing situation had improved. Some said they had continued to sleep rough because of the unsuitability of the housing they had been offered; others reported that they did not qualify for assistance with housing or had lost contact with a support worker who had been helping them with this.

Challenges were exacerbated for people with no recourse to public funds (NRPF), [45] who were not able to access most kinds of accommodation and had to wait for night shelters to open. Interviewees pointed out that people with NRPF can fall into a vicious cycle where they are too

[45] Under the Immigration and Asylum Act 1999, people who do not have any immigration permission or whose visa comes with an individual NRPF condition are excluded from benefits and housing.

unwell to work, but without employment, they lack the right to claim benefits such as social housing.

Staff reported an increase in service users being supported into temporary, short-term accommodation. However, some described feeling powerless about the extent to which the housing was suitable for the service user's needs or whether it would be appropriate for more than just the short-term, which would jeopardise the goal of reducing rough sleeping.

Current housing options for this cohort, typically temporary accommodation such as hostels or HMOs, were reported to be more suitable for men with less complex needs, with a lack of appropriate options for women and people with more complex needs such as severe mental illness. The evidence does not show whether there are differences in accommodation outcomes for men with less complex needs compared to other groups like women. Irrespective, a lack of appropriate housing options poses a risk to achieving equitable outcomes for the whole RSDATG cohort.

> **"We find women often have to move around quite a lot for their safety or because of breakdown of hostels."** – Frontline worker

Interviewees highlighted some additional barriers they faced limiting positive accommodation outcomes, including wariness from housing officers to house 'vulnerable' people in more independent accommodation because of the risk of cuckooing.

5.7.6 The relationship between treatment and accommodation outcomes

A key argument underpinning the programme is that sustained accommodation improves treatment outcomes for service users[46]. In interviews, there was recognition of the interdependencies between housing and treatment outcomes, and many commissioners and workers felt that securing accommodation was important to working productively with service users. Securing accommodation for service users, in some cases after many years on the streets, was key to improving their life chances and health, and to provide the underpinnings for future abstinence. RSDATG staff felt that progress without housing was difficult for service users, therefore even short-term housing was useful. This relationship meant that variable availability of housing could limit the potential for positive treatment outcomes: there were examples of service users who were ready for inpatient treatment not being able to go because there was no move on accommodation available.

A small number of interviewees held the inverse view that people who are still using substances cannot sustain tenancies, and therefore there is a need for them to address their substance use before it is suitable to offer housing.

[46] For example, the strategic outline case for the funding quoted figures from Public Health England that people who present as of no fixed abode at the start of their treatment 'are 50% less likely to complete treatment successfully'.

Service users reflected that without the accommodation they had been supported into, other areas of their lives would have been negatively impacted, for example being back on the streets, using substances again, or even no longer being alive. On the other hand, some attributed the support they had received to manage their substance use as key to maintaining their accommodation. They noted the interplay between substance use and maintaining housing; the activities required to maintain housing like paying bills were manageable with support to manage their substance addiction.

> **"The upkeep of accommodation, like paying the bills, and things. Just motivate you. If it wasn't for my script, I'd have to find some way of feeding an addiction, and I wouldn't be able to pay my bills, and things like that... I'd still be homeless, and drug using."** – Service user

5.8 Impact on access to mental health support

RSDATG set out to improve access to mental health services for people experiencing rough sleeping, or at risk, with drug or alcohol treatment needs. Across ten case study areas studied, 75% of RSDATG service users who were in treatment were identified as having a mental health need, and this may be under-reported. Addressing the mental health needs of this cohort was recognised by interviewees as being more complex than physical health needs, as described at section 4.9.1, and was critical to service users' recovery.

There is limited evidence that RSDATG-funded services and roles supported improved access to mental health support for service users. Staff and commissioners commonly raised access to mental health treatment as one of the biggest challenges affecting the success of the grant. They reported challenges around co-occurring conditions and the capacity of mental health services which limited the extent to which improved mental health outcomes for service users could be realised. Reports that people using substances were being turned away by mental health services were heard in almost every area, suggesting a possible lack of awareness of NICE guidelines on co-occurring conditions, as well as capacity pressures on mental health services.

In the case study areas, 3 in 5 (61%) of those supported by RSDATG and in treatment who had a mental health need were receiving some kind of support for their mental health. In recognition that many RSDATG service users needed mental health support but were unable to access NHS mental health care, some areas used RSDATG funding to recruit workers to help service users access mental health services, while others recruited staff to provide support to service users directly (see section 4.9.1 for more detail). However, despite the work of RSDATG teams and people in mental health roles, obtaining mental health support for service users remained very challenging, ultimately because of limited capacity at mental health services and resultant gatekeeping. This particularly affected the RSDATG cohort because they were more likely to struggle to attend appointments, to be perceived as higher risk because of their substance use, and because they were more likely than other cohorts to be experiencing severe mental health problems requiring specialist support.

There is some evidence that RSDATG-funded activities and roles (such as dual diagnosis workers or small specialist teams), established specifically to address this challenge, improved service users' access to mental health services compared to before RSDATG funding. These roles linked to the community mental health team and helped get service users access to services that they otherwise would not be accepted into; and accompanied appointments to make sure that the service user attended and to advocate for their right to be seen and receive care. The advocacy they offered meant that service users were more likely to receive appropriate mental health support. Having dual diagnosis workers located within mental health services was considered to be more effective at improving access for service users as they were directly linked.

However, staff highlighted limitations on what a co-occurring conditions worker within drug and alcohol services could do to meet the mental health needs of those experiencing, or at risk of, rough sleeping. Many staff in these roles were not trained in a mental health specialism, which limited the extent to which they could support service users with complex mental health needs. Furthermore, these responsibilities were often only a small part of the staff member's overall role, affecting the amount of time they could spend focusing on service users' mental health needs. Most significantly, the scale of the challenges facing this cohort in accessing mental health services, including stigma, capacity pressures and 'systems' barriers such as a lack of integration between services (described in section 4.9.1) appears too great for these roles to have had a significant impact.

This was exacerbated by the fact that the RSDATG funding has brought more people into contact with services and thereby identified more people with (often severe) mental health needs; however, there is not sufficient capacity within the skilled workforce to work with this cohort. Moreover, the NDTMS dataset does not record levels of mental health need, but qualitative evidence suggests that many RSDATG service users had more severe and enduring mental health needs, which could have made it more difficult for them to access appropriate support.

The reported lack of availability of mental health support was perceived to lead to individuals self-medicating and using substances as a coping mechanism, and to reduce the effectiveness of substance use treatment. This is especially the case for those service users who have severe and enduring mental health needs that require intensive specialist support. Interviewees were resolute in their support for greater provision in this area for this cohort to strengthen positive mental health outcomes for service users, whilst recognising it as a complex issue to address.

> **"Even with dual diagnosis workers, they [mental health services] are still batting [service users] back… This has been going on as long as I've been working in this field. I think it's not the substance misuse or the mental health, it's the trauma. That's the underlying issue. So, the substance misuse is used as a medication, really, to block the trauma."** – Frontline worker

Going beyond the challenges of accessing support for mental health problems, there is some qualitative evidence of improved mental wellbeing for service users (mental wellbeing referring to

aspects broader than a clinical view of mental health, such as positive thinking and emotional resilience). RSDATG has resulted in services that are more trauma-informed, collaborative and person-centred, which has a positive impact on service users' mental health. Trauma informed approaches helped to build trust with service users and made some more open to seeking support from different services even when they had previous negative experiences.

The support offered through RSDATG also improved other areas of service users' lives, which contributed to some gains in mental wellbeing through secondary means. For example, supporting them into safe housing, offering them support with addiction, or helping address a physical health concern that had been ignored led to an improved quality of life for service users, which subsequently decreased stress and improved mental wellbeing.

> **"Well, I've still got my partner, I've still got my health, I'm not injecting, I don't wake up feeling **** every morning."** – Service user

NDTMS data includes a self-reported quality of life metric. This covers aspects such as an individual's ability to enjoy life and their relationships with their family and partner, and is scored from 0 to 20. 40% of RSDATG service users reported improved quality of life based on their score at the start of their engagement with treatment and their most recent score, while a similar number (39%) reported no change in their quality of life and 21% reported that it had decreased.

5.9 Impact on physical health

RSDATG intended to fund assessments of physical health needs for service users, registration with GPs and preventative healthcare, ultimately leading to better physical health. **There is strong qualitative evidence that RSDATG-funded services and roles have supported improved physical health among service users.**

As described in section 4.9.2, RSDATG enabled services to be brought to service users to address physical health needs that may not have been addressed without the funding. Interviewees gave examples of service users with long-standing and untreated health conditions, which had been exacerbated by years of rough sleeping, who were finally receiving treatment and improving their physical health. This was due to RSDATG workers either delivering treatment directly to individuals or working intensively to arrange for the relevant health services to treat the service user, which often involved a person-centred approach bringing the service to the service user.

> **"It's helping me get to appointments, it's booking the appointments for me on my behalf. I had a bad infection in my leg. [Worker name] from the rough sleeper team at the council... he actually went in his own time, out of work hours, and basically registered me with a doctor... And brought the nurse to me to get me on antibiotics and took the infection out of my leg."** – Service user

As a result of RSDATG funding, staff had smaller caseloads and more time to spend supporting service users to improve their individual physical health needs. For example, staff spent time registering service users with a GP practice to not only enable scripting but also to address wider

physical health issues; and accompanying service users to appointments. This was particularly effective given that this cohort can be hesitant to seek care for physical health issues because of prior poor experiences or difficulties attending set appointment times, which can make it challenging for improved physical health outcomes to be realised.

> **"We've got a woman who was really reluctant to be in treatment at all, because she's very unwell. So, one of my team members went to hospital, although she doesn't usually stay in hospital, because she doesn't like how she's spoken to. He stayed with her all day. She was seen, so she could be admitted and then she was treated for her serious chest infection."** – Frontline worker

Collaboration between services meant that service users' physical health needs were more likely to be met than they were prior to RSDATG. This is attributed to services working together and taking trauma informed and person-centred approaches.

> **"The fact that a GP will go to a community cafe to engage with people is more likely to be received well by the people who've experienced trauma as opposed to having to go to a GP practice because of the stigma and discrimination attached to it."** – Commissioner

There is evidence that improvements in service users' physical health occurred through exposure to health services and learning more about how to care for their physical health. Increased knowledge, as a result of interacting with health services that were convenient for service users to access, empowered service users with greater skills to care for themselves independently.

Despite positive outcomes related to physical health, service users' prior experiences of discrimination related to addiction or homelessness from some healthcare professionals presented a barrier to engaging individuals in treatment or preventative healthcare. To overcome this barrier to positive physical health outcomes, some areas worked with specialist or partner GP and dental surgeries who work with people experiencing rough sleeping, and with staff with increased awareness of addiction. These environments were more welcoming to service users, resulting in better experiences for them and making them more likely to access healthcare services again in the future. Furthermore, as physical treatment needed to be provided face to face, it offered a unique opportunity to build trust and rapport with service users and go some way towards minimising the impact of previous negative experiences interacting with healthcare services.

> **"The surgery is quite unique in that it is commissioned to support the homeless population specifically, so they don't have the same level of stigma and discrimination… it does work really well. They're highly skilled and compassionate practitioners."** – Commissioner

These mechanisms enabling positive outcomes highlight the critical role of workers who go above and beyond to bring care to service users. Interviewees emphasised the importance of care being delivered by outreach staff and ensuring that nurses were included amongst funded roles.

5.10 Negative outcomes

Staff and commissioners were asked about negative outcomes for service users who were supported by RSDATG services. Very few interviewees could think of any negative outcomes or unintended consequences.

Where negative outcomes were mentioned, these were often associated with service users transitioning from the RSDATG service. Sometimes service users were moved into the mainstream service too quickly without support, which did not work and resulted in them having to start again. In some cases, moving people on to in-patient detox and rehab too quickly, without adequate preparation, was also considered to be setting up the service user to 'fail'. However, in some areas, more effective referral processes to detox and rehab have unintendedly created a bottleneck, leading to longer waiting times.

In other instances, service users can form a dependence on the service and can feel unable to progress without it. Staff suggested this could be mitigated by careful monitoring and adopting a 'let's do this together' approach before progressing to a 'you can do this yourself now' position. Although this relies on the skills and expertise of the support workers in knowing when service users are ready and able to take more control. Other staff made similar, broader points around the balance to be drawn between making services accessible and providing intensive support, whilst still recognising service users' own agency and encouraging them to progress further.

Following from the above, positive accommodation outcomes, such as supporting an individual into housing, can lead to a 'cliff edge' of support, where support suddenly disappears. A lack of floating support can mean that once an individual is in accommodation, they are left without support, which can limit other positive outcomes.

Some staff described negative outcomes around outreach. Some people may want to be left alone, and their wishes are not respected when they are approached by outreach teams. In particular, some people may not want to engage if a service cannot meet their needs for accommodation. Additionally, poor coordination means that some people get visited by too many outreach teams and this can frustrate them and can be counterproductive.

Interactions with other people at the service sometimes had negative consequences for service users. Encountering familiar individuals at the service had negative consequences for some people, triggering difficult emotions that discouraged them attending, and in the worst cases lead them to use substances again. Group work sessions which involved discussing past traumatic experiences or hearing about other's experiences could be upsetting for service users. Staff also reported that holding some activities in central hubs could lead to anti-social behaviour and the involvement of the police, which has increased stigma around service users in their areas.

In some areas, service communications intended to warn the local population about the potency of a particular substance unintentionally drew service users to affected areas and increased their risk of harm.

As well as these unintended outcomes identified by interviewees, another unintended consequence of the funding identified by the evaluation was the 'crowding out' of other people from drug and alcohol treatment services due to limits on how quickly services could expand. Increased numbers of people in treatment may also have exacerbated capacity pressures on accommodation providers and on residential treatment providers, increasing barriers to entry.

6 Impact on services

Beyond having direct impacts on rough sleeping and substance use, one of the key aims of the RSDATG grant was to 'build resilience and capacity in local drug and alcohol treatment systems to continue to meet the needs of this population in future years'. This chapter assesses the impact of the grant on various aspects of this: collaboration between services, impact on understanding of the needs of the RSDATG cohort, impact on trauma-informed approaches, and impact on policies and procedures used by services. It draws on qualitative evidence from interviews with commissioners, staff and service users.

6.1 Collaboration between services

6.1.1 Evidence of impact

The RSDATG funding was expected to develop more integrated working across local systems of services that work with the target group. It was thought this would happen through increasing the capacity of teams, providing extra capacity to focus on multi-disciplinary working, and by establishing new ways of working.

There is strong evidence to suggest that the RSDATG grant has increased collaboration between services: this was commonly mentioned by commissioners as one of the key successes of the grant.

> **"We were really clear, with this funding, 'We want you to work hand in glove with [the housing team]. We want you co-located, we want you based out of the day centre, we want you in that building as much as possible.' We developed joint information sharing agreements, joint working protocols, and they just got it, and they worked beautifully together. They see each other as a team, I think, and we've seen referrals back and forth between the services, we can see that they're working really closely together, and it's really positive"** – Commissioner

Service users mentioned positive experiences with their key workers liaising with other services, such as housing, healthcare providers, and the police, to address their various needs and relay important messages. Some service users noted that coordination between services had improved compared to their previous experiences.

> **"They didn't use to [collaborate], because you'd tell-, and then they wouldn't know about it or vice versa. So, the people weren't communicating properly. Now they're communicating properly...Like, if I've got something with mental health then they can pass it to my worker."** – Service user

However, some service users also identified instances where the various staff supporting them did not appear to have been communicating, which meant that they had to make contact with services themselves: for example, one service user reported having to go to the council themselves to get support with accommodation and another person could not get hold of their housing worker. Some

service users wanted drug and alcohol services to join up better with LGBTQ+ organisations to provide them with appropriate and tailored support. In some cases, service users did not mind that their workers did not coordinate and felt the support they received was useful without a need to coordinate; some preferred to keep support for different problems separate since they perceived these as relating to distinct parts of their life.

The depth of collaboration appears to have been influenced by previous relationships and local system dynamics. In areas where there were pre-existing partnerships between services, the grant offered the opportunity to build upon and further embed this joint working. Some areas had a long history of collaborative working. In others, the Everyone In policy, and / or the Fulfilling Lives funding programme, had enabled services to work more collaboratively and develop close working relationships. The RSDATG funding strengthened these relationships, giving staff more time and capacity to attend and engage with MDT meetings and coordinate on activities such as outreach trips.

The RSDATG funding also had a significant impact in areas where there had previously been a lack of joined up working in relation to the target group, characterised by a lack of communication between services and a lack of understanding of each other's roles and processes. While this had been recognised as a long-standing challenge, staff had not had the time, impetus or capacity to work to improve these relationships. Staff reported that joint working takes time and infrastructure, not only willingness, and the RSDATG grant was seen as crucial in providing dedicated resources for this. This enabled service coordination to become systematic rather than relying on individuals to collaborate. The funding gave staff the capacity to set up and attend MDT meetings, the ability to share data and information and develop trust and knowledge of other services.

The process of applying for the RSDATG grant was also noted to have been a catalyst for services to come together and discuss how they could most effectively work with the cohort. It enabled commissioners to bring together local VCS and statutory providers to consider the specific needs of this group.

6.1.2 MDT arrangements

The funding strengthened collaboration through the establishment of new, or increased effectiveness of existing, MDT arrangements. Project staff reported attending regular MDT meetings to discuss individuals in the RSDATG target group and formulate collaborative, multi-service responses. In some areas, RSDATG funding was used to set up MDT sessions between the RSDATG team and other services who supported the cohort. In areas where MDT meetings were already in place, the RSDATG team joined them and, because of their smaller caseloads, had more capacity to engage with them and do more joint working around the meetings. The frequency of MDT sessions varied between areas, running weekly or happening on a case-by-case basis when needed. In some areas, joint working was also supported by weekly or monthly partnership meetings, where organisations came together to share information and ideas about their services

and how they can be improved by working more closely together: these were seen as particularly helpful where new partners and staff were involved.

> **"[At the first meeting, the service leads] each did a 10-minute presentation of who they were and what they did... On the second session, it was deeply moving... they stood up and did [their presentations] with more confidence. Some of them stood up with each other and said, 'We're now working as a team across our services.' [Others said], 'We've now extended our opening times and, between our teams, we [now] cover [some evenings and weekends].' You know when you get those moments when you feel really rewarded?"** – Commissioner

Generally, at MDT meetings, representatives from different services would review individual service users' progress, discuss next steps for getting them the support they needed and agree responsibility for this. They were considered most useful when they identified next steps for service users, set clear responsibilities for actions, and reviewed previous action points to ensure they had been completed. Interviewees consistently identified these meetings (whether instigated specifically for RSDATG or where RSDATG staff joined existing MDT meetings) as key to effective service delivery and the best example of joined-up working. They enabled staff to:

- Better understand the role and remit of other services, including the limitations of other services and the challenges they faced, leading to fewer disagreements over who was responsible for what. One interviewee thought that these meetings had increased recognition of the skills of drug and alcohol workers and their role in addressing other issues beyond drug and alcohol use.
- Reduce duplication and miscommunication by clarifying roles and responsibilities for different elements of the service user journey. This gave support workers confidence that people were receiving the support they need.
- Share intelligence between services. In cases where service users were only communicating with some services or staff, other services with an interest in that person could stay up to date with that person's situation, their whereabouts, and sometimes convey messages and make sure the messages were consistent.
- Get advice from other services on how to respond to a problem, and services could work together to come up with creative solutions.
- Highlight the links between different issues: not only rough sleeping and substance use but also mental health, crime, exploitation, domestic abuse and others. This was thought to have potential to inform more joined-up commissioning in future.
- Intervene in situations that they would not have been able to previously, by being able to speak to the right people and gaining an understanding of the issue.

Service users reported several instances of MDT meetings taking place, where for example, the GP, social services and drug and alcohol worker would meet regularly to discuss a service user's safeguarding concerns. One person felt surprised at the number of people involved, and had found that they did not need to repeat their histories to people as everyone working with them had the same information. In particular, the person responsible for allocating them council housing was aware of their needs and made sure they were not offered accommodation that was unsuitable.

There were some areas where the impact of these MDT arrangements on collaboration had been more limited: in particular where key organisations, such as mental health services or local authority housing teams, were not represented. There was a balance to be struck in terms of how much information to share: meetings were considered less effective when there were limits on sharing key pieces of information such as mental health diagnoses, but on the other hand, some interviewees felt that not enough consideration was given to service users' privacy and whether information being shared was truly relevant and necessary. Some service users and staff reported that they would find it useful to attend MDT meetings so that they are aware of the conversations happening around them. They saw this as something which could build trust and a more person-centred approach.

6.1.3 Information sharing

RSDATG prompted services to improve their information-sharing protocols so that key organisations, including treatment providers and local authority teams, could share information about service users with each other. Once a data sharing arrangement was in place, it allowed much more efficiency in providing support. Different partner agencies could report on individuals they see during outreach to keep other services informed. Referrals to other services could be made faster with these systems in place. Information-sharing also allowed services a better overview of the needs of this cohort and helped to identify previously overlooked areas of need such as neurodivergence, acquired brain injuries and foetal alcohol syndrome.

However, interviewees described that there is still some fragmentation, leading to duplication in assessments, overlapping functions, and difficulties around handovers of service users between agencies. In one area, a RSDATG-funded team that intended to make out-of-hours visits to 'at risk' service users, reported that they were not able to operate effectively because they did not receive details of who to visit. Some of the software used for recording information about service users was considered difficult to use and interviewees suggested that they needed systems that 'communicate' more efficiently.

Some service users also described inefficiencies in data sharing: for example, one individual's PIP form was submitted multiple times by different services. Another service user did not view information sharing positively and felt betrayed when his drug and alcohol worker told social services about his relapse.

6.1.4 Co-location of services

The RSDATG grant prompted several areas to co-locate their RSDATG teams with other teams, such as the homelessness service and in some cases with the council or GP. This was facilitated through the extra resource that the funding provided and informed by commissioners' existing aspirations to make services more joined up, as well as the grant's focus on integrated working as set out in guidance. The co-location of services and the ability to work face-to-face facilitated collaborative working and was a factor in its effectiveness. For example, having teams co-located in the same building helped them learn about each other's work and understand the challenges they faced, as well as making it easy to quickly discuss cases. Co-location also facilitated more collaborative delivery, as it was easier and faster for services to link service users up with other teams in the building: this advantage had informed the creation of drop-in, multi-service 'hubs' or events (see section 5.4.2). Where co-location was not possible, having services located near to each other (and also in places where service users tended to spend time) was important. Collaborating in this way was more difficult to put into practice in large rural areas, where services had to put more time and resource into travelling.

Some RSDATG-funded outreach workers were able to accompany other homelessness outreach services, for example teams funded by RSI, on outreach shifts. This approach brought a range of benefits, including drawing on each service's knowledge of people experiencing rough sleeping in their areas and bringing complementary skills (e.g. where RSDATG outreach nurses could offer treatment on the street), as well as minimising duplication of effort.

6.2 Impact on understanding the needs of the RSDATG cohort: among services

The RSDATG grant was expected to increase understanding of the needs of people experiencing rough sleeping and using substances. Prior to the RSDATG funding, awareness of this cohort's specific needs and characteristics varied across local authorities. In some areas, population needs assessments and qualitative and quantitative data collection was regularly undertaken, giving the local authority a clear idea of the needs of the cohort. Urban areas with high numbers of individuals in the RSDATG cohort typically had an awareness of their needs and the barriers to engagement and treatment they faced. However, other areas had not given as much consideration to the needs of the RSDATG cohort before the opportunity to apply for the funding.

6.2.1 Evidence of impact

There was evidence that RSDATG-funded teams have helped increase understanding among other services and commissioners.

Staff explained that working with other services collaboratively through the RSDATG funding has helped them better understand the needs of the RSDATG cohort. Examples interviewees gave of specific areas where understanding had improved included:

- Understanding the reasons why some individuals may not engage; for example, that women may be experiencing domestic abuse or wary of social services because they fear having their children removed.
- Understanding why individuals in the cohort require flexibility, the reasons they may find it difficult to turn up for appointments, and that a zero-tolerance policy may be "setting [service users] up to fail".
- Understanding how people's behaviour can be affected by learning disabilities or neurological conditions, so it was important not to attribute it only to substance use. Assessments for neurological conditions were carried out in some places by the RSDATG team, who then informed other services, such as accommodation providers that their behaviour should not be solely attributed to drug and alcohol use.
- Understanding communication needs. In one area, the RSDATG service worked with a speech and language therapist to create a language communication passport for a service user with a speech impediment and learning difficulties. This document outlined how services like the police can communicate with him so that he understands them.

6.2.2 Factors influencing understanding among services

RSDATG-funded teams have helped increase understanding among other services about the complex needs of people in the RSDATG cohort and what this means for working with them. This was achieved through a combination of increased exposure to the RSDATG cohort and experience of working directly to support them, and through awareness raising and training activities with partner services.

The grant was used to train staff in other services in topics around substance use. Interviewees gave examples of RSDATG teams running training for housing officers, health inclusion nurses, palliative nurses and the police, among others. This training covered information about substances, how they are used and what treatment options are available. They also trained staff in the wider system on harm reduction activities, such as administering Naloxone. RSDATG services commonly assessed local need to determine where harm reduction training would be most impactful: in some cases, extending this beyond key public services to organisations such as public transport providers. RSDATG teams also put out alerts of contaminated substances to the wider system and shared harm reduction messaging.

Training sessions and information sharing with accommodation services have contributed to a better understanding of the behaviour and needs of the cohort. For example, in one area, sessions were carried out to explain service users' barriers to accessing accommodation and why they may reject housing offers: a service user attended these sessions and spoke about why he did not want to be housed for a decade and how eventually he was accommodated. Services attending this training gained an understanding of why service users may reject housing offers to stay on the

streets, which enabled them to tailor their support to better suit the needs of the group. Several staff members in the area commented on the effectiveness of the training.

> **"It's been really instrumental in saying, 'Well, this is the voice of people that have slept rough and have substance misuse issue and this is why you might not get them into accommodation the first time you try. This is what they perceive as the barriers,' and it's just that way of getting an understanding from the whole network of professionals."** – Frontline worker

This training also covered why people who have gone to detox may end up relapsing if they do not have accommodation when they leave hospital. This prompted a discussion about whether local services could come together to offer accommodation for people in recovery phase, and interviewees reported that discussions about this were ongoing between an accommodation service and the Public Health team.

The Pan-London projects also contributed to wider knowledge about the group and why service users may not engage. One project, looking at individuals with No Recourse to Public Funds (NRPF) individuals, found that shame and stigmatisation amongst migrants are barriers to accessing support, and shared findings like this through training sessions, sharing documents and toolkits. The Pathways for Addressing Co-occurring Mental Health and Substance Misuse project, set up communities of practice in each ICS and an advisory group for London, brought different stakeholders together and shared knowledge. Despite this, the impact of these projects was not mentioned by commissioners or staff in London.

There were instances where staff felt the impact of increased understanding was limited, because RSDATG-funded roles and services were working within a wider system that was not person-centred or designed to meet the needs of this cohort. Despite the positive progress reported in chapter 4, it was widely considered that there could be a better understanding of the interplay between addiction, co-occurring conditions, and mental capacity amongst drug, alcohol and physical and mental health services and that this remained a barrier to service users accessing physical and mental health support.

Another barrier was that wider services did not always engage with offers of training and awareness-raising. In particular, other services commonly identified mental health services and local authority housing teams as less likely to engage. For example, in some areas housing teams were perceived as less engaged because they were focusing on other kinds of homelessness, which made it difficult to prioritise rough sleeping as an issue.

"We offered free psychologically informed environments and trauma-informed care training to all the staff, and they never had the capacity. I was disturbed of late, they are about to publish their homelessness and rough sleeping strategy, and a presentation basically said that they felt that the focus on SMD and the focus on rough sleeping in the city – what they see as an over focus – has contributed to their difficulties and kind of taken resources away. I think the reality is-, and again, they've got hundreds of families in bed and breakfast, they'll have people shouting at them and the cost on the bill, and that's where they want to focus." – Service manager

6.3 Impact on understanding the needs of the RSDATG cohort: among commissioners

RSDATG funding was intended to improve understanding of the needs of the RSDATG cohort among commissioners of drug and alcohol services, and thus enable them to commission services that were more integrated, trauma-informed and inclusive. There is some evidence to suggest that RSDATG had an impact on understanding of the group amongst commissioners.

6.3.1 Factors influencing understanding among commissioners

RSDATG created an opportunity to focus on the needs of this group and, in some areas, it had prompted commissioners to undertake research and exercises to gather evidence about them. For example, one area commissioned a research project which explored why people refuse accommodation. Many areas also reported producing case studies of service users which, while often focusing on success achieved, also highlighted any areas for improvement.

Medway used the grant to fund a "practice improvement co-occurring conditions co-ordinator", seconded for 18 months. Their role was to research barriers in different services faced by people in the RSDATG cohort and to produce a report and training for the public health team about this. This individual spent time in different services such as hospital teams, mental health teams, and the probation team, and produced recommendations on changes they advised. The commissioner also appointed an external research organisation to investigate the detox and rehab referral processes in Medway and produce recommendations for improvement. These included hiring a worker next year to help people prepare for rehab, under SSMTRG funding.

In Luton, outreach workers collected data about service users through hand-held devices. The real-time data capture provided a richer understanding of service users' needs. They track individual progress in terms of engagement with services but also understand patterns in people's readiness to engage, which seems to peak before and after the summer months, while the Christmas period was more challenging.

Some areas have conducted their own evaluative exercises to better understand the outcomes of RSDATG and its impact on service users, but these are not widespread. The team in Dorset developed a logic model to assess if they are meeting their intended outcomes for service users,

and in Manchester an impact report on pre-engagement services for trauma survivors (see box in 5.10.1) was produced.

6.4 Impact on trauma-informed approaches

A key part of the grant's purpose was to enable areas to expand and develop trauma informed approaches, since this was anticipated to result in more accessible services. Staff feedback was consistent that RSDATG funding had made it possible for services to offer trauma-informed approaches to a greater extent than previously. This is described in more detail in section 4.5.

6.4.1 Factors influencing trauma-informed approaches

Funded services have used RSDATG to hire more staff, meaning each staff member has a lower caseload than they would otherwise have; this in turn means that staff are able to spend more time with each client. This protected, focused time with specialist staff is needed in order for service users to build the trusting, therapeutic relationship that is necessary for trauma-informed approaches. Having a smaller caseload also enables staff to provide a more rounded and robust service for service users, because they have time to learn the client's needs and preferences. With sufficient time available to them, staff are also more likely to be able to communicate a service user's needs and preferences to other staff who are providing services to that person, thereby saving them from having to repeat their story to multiple additional people in a way that has potential to be retraumatising.

The flexibility inherent in RSDATG, such as the absence of KPIs, has meant that staff do not have target throughput numbers; there is, therefore, less pressure on staff to hurry service users through the system more quickly than is safe, comfortable or effective for them. Staff also feel more able to focus on service users who have higher or more complex needs, again because they are not being assessed on whether they have met their target numbers as may be the case in other circumstances.

RSDATG funding has enabled more cross-team working focused on trauma-informed practice. This has meant, for example, that some funded teams have been able to offer training on trauma-informed practice to their counterparts in other services. Similarly, RSDATG-funded teams have had capacity to build relationships with partner services, to help facilitate referrals when that is necessary for service users' care and treatment.

Funding has also been used to train staff to be more trauma-informed – for example, to recognise signs of conditions like brain injury. This upskilling has helped staff to recognise where service users may face particular challenges with processing language, remembering important information, or interacting with staff or fellow service users. In practice, this has manifested as actions such as advocating for service users who have showed difficult behaviour that puts them at risk of eviction; or accompanying clients to appointments and being on hand to take them outside or to a quiet room if they get overstimulated or anxious in a waiting area with other people around.

RSDATG funding also impacted on **services' understanding of trauma**: in some areas, RSDATG teams provided trauma-informed training or information about PIE approaches to colleagues working in related services, including police. There were also instances where dual diagnosis workers provided wider services with training and advice on the mental health of service users. While non-funded services were not always able to make time to receive this training, RSDATG-funded service staff reported that colleagues in services who did so found it helpful to better understand the RSDATG cohort of their service users.

In some cases, the funding seemed to be having an impact on perceptions and attitudes towards the RSDATG cohort amongst colleagues working in commissioning. An interviewee reported they noticed a change in understanding of trauma:

> **"I think there's been a change of attitude. I've noticed my colleagues working in mental health commissioning and in housing commissioning having a greater understanding of our clients, as it were. I think I've heard more conversations around trauma that isn't a generic trauma and that causes a mental health crisis that then goes away. But rather trauma that is life trauma, that is complex, that impacts people where substance misuse may or may not be a factor."**
> – Commissioner

Nevertheless, there were examples of organisational policies and practices not being aligned to trauma-informed practice, for example as described previously where service users could be discharged from mental health services for not attending appointments or refused entry to hospitals because of their behaviour.

6.5 Impact on policies and processes

In many areas, RSDATG has helped to make it possible for local authorities to reconsider policies and processes in place to support people at risk of rough sleeping, as well as the staff who run these services.

These changes included services working together to offer extended opening hours on evenings and at weekends: in one area this was reported to mean hospitals could discharge people more confidently at the weekend, although in another the impact of weekend working was seen as limited because no other services were open and onward referrals to other crucial services were not possible until the next working day.

The additional capacity created by RSDATG has allowed new ways of working (such as 'small steps' approaches) to be developed and tested against feedback from service users. This is discussed in more depth in sections 4.3 and 4.4. Another key difference in policies and processes was services' approach to discharging service users for non-attendance, with RSDATG-funded services being seen as much more flexible around this.

> **"So, I think with mainstream, it might be 2 contact attempts and then the person's discharged. With this service, it's 10 attempts, 20 attempts, it's trying to constantly actively engage."** – Service manager

6.5.1 Factors influencing changes to policies and processes

While some areas said that they had already begun to change their policies and processes as a result of other initiatives (such as Changing Lives and Project ADDER), RSDATG has contributed to areas being able to facilitate smaller caseloads for staff; a shift towards trauma-informed approaches; and other initiatives that have previously been considered aspirational or unrealistic.

Commissioners and staff reflected on the successes that this additional funding has made possible. They also pointed out that, should funding cease, many of those beneficial developments to policies and procedures may need to revert to the less successful (but less resource-intensive) business-as-usual approaches in place before RSDATG existed.

In some cases, barriers remain in place to prevent policies and processes being changed. Barriers mentioned by staff included issues with data governance between teams or organisations, coupled with incompatible IT systems, which make it difficult or impossible for partner teams (such as drug and alcohol services and housing services) to share information about service users (see 6.1.4). In addition, a small number of frontline worker interviewees mentioned having closed service users' cases after a period of non-engagement; likewise, there were many instances of interviewees reporting that mental health services had taken this approach as a matter of routine, going against some of the principles of their local RSDATG approach.

7 Economic evaluation

7.1 Aims and design of the economic evaluation

The economic analysis adopts a Cost-Consequence Analysis (CCA) approach, consistent with the pilot phase of the evaluation, to evaluate the RSDATG programme. Compared to other economic evaluation approaches, such as a Cost-Benefit Analysis (CBA) and Cost-Effectiveness Analysis (CEA), a CCA takes a broader perspective to consider all quantifiable and non-quantifiable costs and outcomes associated with the RSDATG programme.

A CCA can be advantageous as it allows the analyst to present details on diverse outcomes, which applies to RSDATG. It also offers a fully disaggregated summary of costs and benefits which allows for a richer interpretation by stakeholders and weightings to be applied to areas of interest or priority, subject to stakeholders' views or preferences. As such, the output of the analysis is a description and comparison of programme costs and outcomes, rather than a single metric (such as cost per QALY[47] or Benefit Cost Ratio) to determine value-for-money.

On its own, therefore, a CCA does not produce a single conclusive result, and this can render decision-making more challenging. It is also not straightforward to directly compare disaggregated outcomes and costs from the intervention group to a control group. This is because, in the absence of an RCT or pilot study, it is unlikely other interventions will hold all the same outcomes data in a like-for-like format. Instead, outcomes are shown in their natural units, and it is for decision makers to determine which elements of the programme they wish to focus on and draw their own conclusions on the programme's effectiveness.

The economic evaluation is focused on the same ten areas selected for impact evaluation.[48] This was designed so that the results of the impact evaluation could directly support the description of consequences (used interchangeably with "outcomes") in the CCA. This Chapter presents findings from the CCA at the collective level (i.e. for the set of ten areas) as opposed to individual areas. In addition, each area has been analysed separately, and these findings are documented in Annex 3.

7.2 Economic evaluation questions

The key economic evaluation questions are set out below.

1. What is the total cost of the programme to date?
2. What are the direct and indirect costs associated with RSDATG for the areas in scope between 2020 and 2025? Who bears the costs?

[47] QALY (quality-adjusted life year) is a measure used in healthcare economics to assess the value of medical interventions. It combines the quantity of life (life expectancy) with the quality of life into a single metric, allowing for a standardised way to compare the benefits of different treatments.
[48] The following areas have been analysed: Blackpool, Bolton, Bournemouth, Christchurch & Poole, Bristol, Camden, Doncaster, Great Yarmouth, Manchester, Nottingham, and Westminster

3. How do the programme costs break down to a cost per service user?

4. What are the measurable outcomes resulting from the programme in each area, and how are they categorised (e.g. access to treatment, sustained treatment engagement, improved housing status, self-reported quality of life)?

5. What are the specific outcomes (both intended and unintended) of the programme's implementation on stakeholders such as health services, local authorities, and individuals?

6. What is the uncertainty or variability in costs and outcomes?

7.3 Limitations

There are several limitations to consider when interpreting the findings of the CCA:

- **Cost proformas provide limited granularity**, restricting the ability to disaggregate expenditures, such as variations in specific costs for alcohol versus drug treatment. For years 2020-2022 local authorities reported high-level cost categories, such as community treatment costs. These were not broken down into staff and non-staff costs. OHID reported that this was due to streamlining data collection for local authorities. Furthermore, residential rehabilitation and inpatient detoxification services were initially reported in two categories in 2020-2022, but from 2022 onwards this cost is reported in a combined measure. Without consistent detailed cost breakdowns, it is challenging to assess the largest cost drivers, compare between delivery models, and identify potential areas for cost optimisation. This has informed our high-level cost aggregation approach (by broad type of service provision), which enables the most consistent reporting.

- **Differences in reporting amongst cost proformas.** Local authorities varied in how they allocated treatment costs, such as those for inpatient detoxification and residential rehabilitation. For some local authorities this was grouped under a specific cost category for inpatient detox and residential rehab, whereas for others some of these treatment costs fell under the non-staffing community treatment cost category. For some local areas, prescribing costs were reported separately in non-staffing cost categories, whereas in others these were absent. A possible explanation for this is that in some areas prescribing costs for RSDATG service users were funded through another source, such as the public health grant, and thus not captured in the main cost categories in the proformas. This local variation in funding decisions, along with inconsistency in reporting, led to difficulty in standardising costs across all local areas. The variation in cost characterisation was exacerbated by changes in OHID's reporting requirements during the RSDATG delivery period. As a result of the reporting format, pre-2022, community treatment, inpatient detox and residential rehab costs were reported together under a 'treatment expenditure' category. In later years, as the proforma adapted, only inpatient detox and residential rehab costs were reported, with community treatment costs absorbed under multiple separate categories. This has made it difficult to standardise treatment costs.

- **There is a lack of cost information available for mainstream services, as well as for comparable initiatives.** Desk research was unable to source datasets for mainstream services or comparable initiatives in the local areas during the delivery period. This prevents an assessment of cost-effectiveness relative to alternate provision of care. The PHE spending review estimates unit costs for opiate, non-opiate, and alcohol-only structured treatment, however a direct comparison to RSDATG cost data is not feasible given the lack of granular detail on specific drug and alcohol treatment costs for service users in the local areas.

- **People supported by RSDATG may also be receiving drug and alcohol support which is not funded by RSDATG.** For example, community treatment costs may be partially covered by the public health grant with wraparound support provided by RSDATG, and some people supported by RSDATG had a residential treatment place which was funded from elsewhere. This means that it is challenging to isolate RSDATG costs and mainstream service costs.

- **The comparative analysis between RSDATG beneficiaries and mainstream service users incurred its own limitations** (see section 5.2), which means that the analysis cannot be used to assess the effectiveness of RSDATG compared to mainstream services.

- **Several other outcomes are non-quantifiable.** It has not been possible to quantify broader consequences identified through stakeholder interviews, such as improved partnership working and enhanced physical health outcomes for service users. Without precise service user numbers benefitting from these outcomes, it is not possible to examine the effects, nor the associated costs absorbed by other services, such as housing teams facilitating accommodation. An estimate of indirect costs is therefore not possible, and this suggests an understatement of the true costs arising from the programme.

7.4 Description of consequences

For RSDATG, the consequences (or outcomes) presented in this analysis are derived from the impact evaluation results outlined in Chapters 5 and 6. Because of limitations with the comparative quantitative analysis of individual-level outcomes for matched groups, this cannot be used to assess the effectiveness of RSDATG compared to mainstream services. However, the evaluation team refers to findings from the area-level quantitative comparative analysis, descriptive analysis of NDTMS data and MI, and data from the qualitative programme of work. RSDATG outcomes considered for the CCA are categorised into outcomes for service users and outcomes for services and set out below.

7.4.1 Outcomes for service users

These are measured using both quantitative and qualitative sources and analysis. The table below lists outcomes considered by the evaluation and data sources for each.

Outcome	How measured
Increased numbers of people starting treatment (initial engagement)	Reported treatment starts in monitoring information submitted by funded areas; data on treatment starts in funded and non-funded areas from NDTMS; qualitative evidence
Better retention in treatment	Qualitative evidence; some limited evidence from quantitative comparative analysis
More people completing treatment	NDTMS data on treatment outcomes for people receiving RSDATG-funded interventions
Fewer drug-related deaths	Overall numbers of drug-related deaths; qualitative evidence including reports of local drug-related death figures
Reduced rough sleeping, through improved access to accommodation and/or support to sustain it	Overall numbers of people experiencing rough sleeping; descriptive analysis of NDTMS data on housing status for RSDATG-supported people in case study areas; qualitative evidence
Better access to mental health treatment	Qualitative evidence
Better access to physical health treatment	Qualitative evidence
Quality of life	Qualitative evidence

7.4.2 Outcomes for services

These outcomes are measured using qualitative data only, analysed using a structured contribution analysis approach.

- **Increased collaboration** between sector organisations, supporting greater co-ordination and provision of holistic care.
- **Increased understanding of service users** through supporting and providing care to a specific group of individuals with acute needs, particularly their trauma and co-occurring needs, in turn informing a better trauma-informed approach.
- **Changes to working practices** in moving away from reactive, office-based models to more flexible, trauma-informed working practices.

7.4.3 Second-order effects

Second order effects of RSDATG are also considered as part of the CCA. This considers implications on the workforce such as upward pressure on wages, crowding out of users of mainstream services because of displaced staff, and deadweight, whereby resources are allocated to outcomes that would have occurred in the absence of the programme.

7.5 Findings on the ten selected areas

7.5.1 Costs: funding and grant spend

All presented costs are reflective of the delivery period (2020-2025) of RSDATG to date, from Q4 2020/21 to Q4 2024/25, sourced directly from cost proformas provided to OHID by local authorities for ten local areas.

The ten areas in scope of the analysis had initially been allocated a total of £34.42m funding, spread across five years. Table 7.1 shows how the funding has been allocated by year, with a larger proportion allocated as the grant progressed, alongside the actual funding spent by year. Different areas began receiving RSDATG funding in different phases and years (see section 2.1).

Table 7.1: Funding Allocation[49] and actual spend of RSDATG by financial year

	2020/21	2021/22	2022/23	2023/24	2024/25
Areas spending RSDATG funding in this year (of 10 case study areas)	Bournemouth, Bristol, Camden, Manchester and Westminster	All except Great Yarmouth	All 10	All 10	All 10
Funding Allocation (£)	£3,534,113	£4,204,433	£8,357,310	£9,187,315	£9,136,096
Actual Spending	£365,008	£5,391,397	£7,052,334	£8,619,652	£8,799,663
Proportion of funding allocated spent	10%	128%	84%	94%	96%

Funding allocation source: *Extra help for rough sleepers with drug and alcohol dependency , GOV.uk, Government announces support for rough sleepers over winter, GOV.uk Rough Sleeping Drug and Alcohol Treatment Grant 2022 to 2025 funding allocations, GOV.uk*
Spending source: *OHID Cost Data, 2025*

As a result of the phased funding distribution most funding was allocated in the last 3 years when all ten areas received funding. Over half (53%) of funding was allocated during the last two years, which aligns with double the number of service users in the final year covered by the evaluation (4,105) compared with 2021/22 (2,056). Funding was allocated to areas based on funding applications they submitted. These included consideration of the number of people experiencing, or at risk of, rough sleeping in the area, and assessing the level of need against the adequacy of existing services (more details on how funding was allocated can be found in Annexe 3).

The total programme spend for RSDATG in the ten areas was lower than the allocated funding, totalling £30.23m, an underspend of £4.19m (12%). The largest underspends occurred during the first year and third year as shown in table 7.1. Qualitative research reported that underspend was largely attributed to difficulty in recruiting to the funded posts and to staff turnover meaning that posts were vacant for some periods. This in turn was attributed to the year-on-year funding allocation, which had made posts less attractive to recruit to (see section 3.6). Less commonly, some planned initiatives could not go ahead due to budgetary or timing constraints, which was sometimes also attributed to the annual nature of the funding application.

From 2020/21 to 2024/25 almost half the grant spend in the ten areas has been on wraparound and engagement costs (49%), compared with 43% on community treatment and 8% spent on inpatient

[49] RSDATG funding was first announced in 2020 and allocated in three phases: in total 43 areas were awarded funding in 2020 (Phase 1), 20 in 2021 (Phase 2) and 20 in 2022 (Phase 3). Funding was allocated to the local authorities with the highest levels of rough sleeping at the time. The Phase 1 areas were those with the highest numbers of people in Covid 19-related emergency accommodation and rough sleeping, known as the MHCLG 'taskforce' areas. Areas were selected for Phase 2 and Phase 3 funding on the basis of identifying the areas with the next greatest levels of need in terms of numbers of people experiencing rough sleeping or at risk; in phase 2 this was based on a review of multiple data sources, and discussion with MHCLG's expert rough sleeping advisers, and in phase 3 this was solely based on rough sleeping numbers.
Funding allocations were confirmed for year 1 (phase 1) in October 2020, year 2 (phases 1 and 2) in July 2021, and years 3-5 (all phases) in September 2022.

detox and residential rehabilitation. The relatively low share of costs allocated to inpatient and residential treatment reflects that only a small minority of those engaged with drug and alcohol services use these treatment types,[50] and it was the intention that the grant would fund far more places in community treatment than inpatient and residential treatment (7,800 vs. 900 in the year 3 business case). Moreover, qualitative evidence (set out in section 4.7) shows that the RSDATG target group faces greater barriers to engaging with detox and rehab than users of mainstream services. In the last quarter of funding, only 2% of RSDATG service users were accessing a detox and rehab place. However, the high costs of detox and rehab compared to community treatment mean the share of costs is higher than the proportion of people using these treatment options.

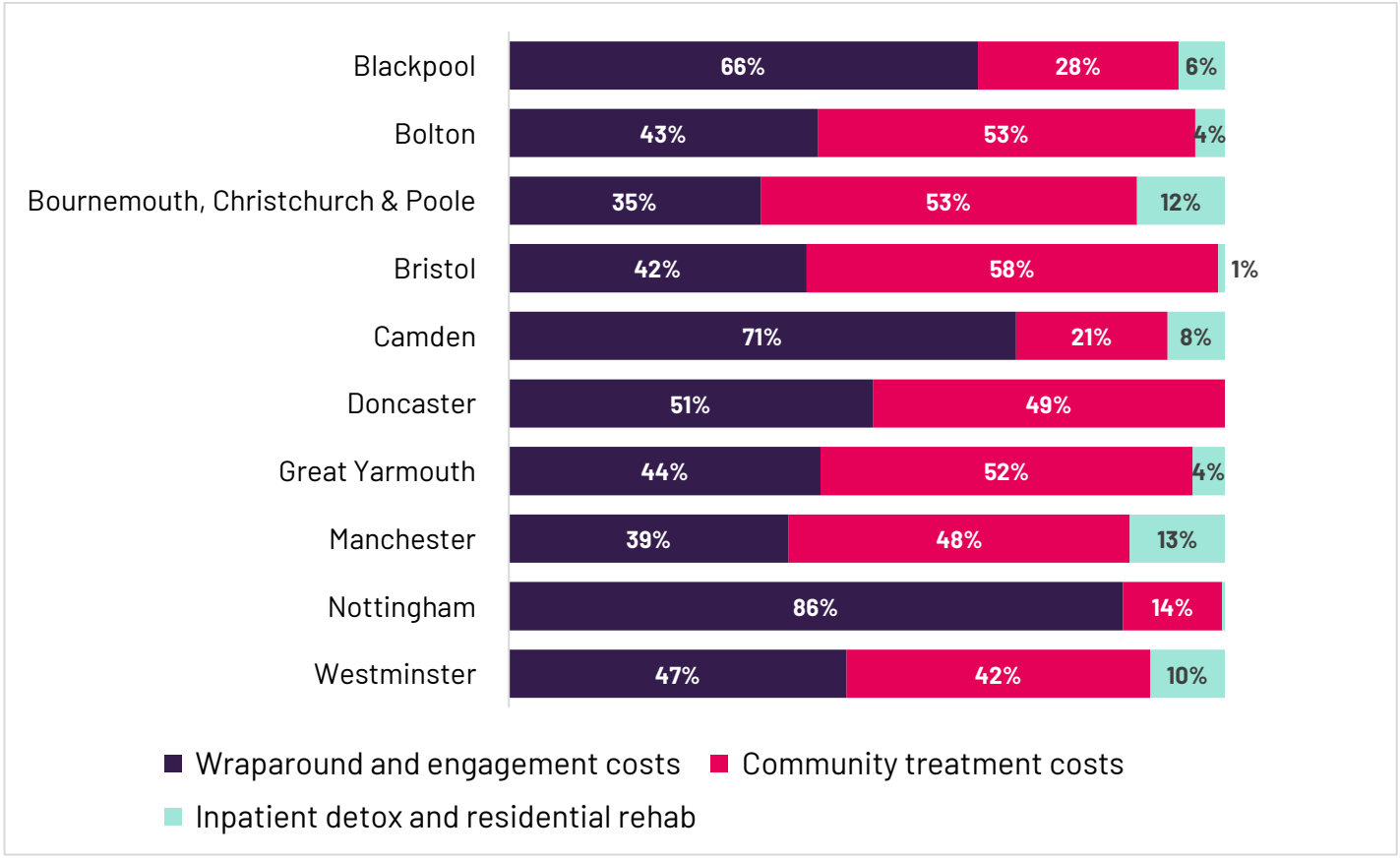
The largest cost driver from 2022-2025[51] across the ten areas is labour, accounting for 74% of the spend during this time (£18.0m out of £24.3m spent). Additionally, over 2024/25 71% of the programme costs were dedicated to labour. When assessing the type of labour that contributed to service delivery during this time, a marginally higher percentage of spending is on wraparound and engagement staff at £9.6m(40% of the ten areas' 2023-2025 spend) compared with community treatment staff which cost £8.4 (34%). A further 19% has been spent on costs to support the running of services, for which a higher proportion is given to support the community treatment at 11% of the ten areas' 2022-2025 spend, and 7% dedicated to supporting wraparound and engagement staff. Community treatment non-staff costs are largely comprised of medications and equipment, such as needle exchanges, Naloxone, Buvidal and prescription costs. On the other hand, the largest part of the engagement and wraparound non staff costs are made up of additional costs to support staff including training, management, travel, phones and hardware, and rental premise costs. The remaining 7% is dedicated to residential rehabilitation and inpatient detoxification over the course of 2022-2025.

There is a high degree of variation in costs across the areas. Figure 7.1 below demonstrates the local variations across the areas, largely driven by localised service design informed by the needs of local communities and the services that already existed in the area.

[50] In mainstream drug and alcohol services, only 4% of people in treatment receive inpatient treatment and only 2% receive treatment in a residential setting. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2023-to-2024/

[51] From 2022-2025 the data granularity provided allows an inference of cost drivers, prior to this granularity is not available

Figure 7.1: Total expenditure across ten local areas from Q4 2020-2021 to Q4 2024-2025



Westminster were given the highest funding allocation and spent the largest amount. The highest proportion of their total spending was spent on wraparound and engagement services (47%), and of this £3.5M, 59% were labour costs.

The inpatient detoxification and residential rehabilitation costs are the smallest across all ten areas. Doncaster has no spending on this, and only 0.4% of Nottingham's total spend is allocated to these services. Manchester spends the highest proportion on detoxification and rehabilitation services, at 13%.

Blackpool, Camden and Nottingham spent the majority of their RSDATG funding on wraparound and engagement services at 66%, 71% and 86% respectively. Camden used the funding for wraparound and engagement staff from 2021, with a focus on outreach workers, women's workers, dual diagnosis workers, specialised doctors and supporting office and IT costs. Camden began hiring staff (data analyst and a team leader) for community treatment services during 2024/2025. To support community treatment, they began paying for IT, communications and office space and supplies in the same year. Nottingham spent the highest proportion of their spending on wraparound and engagement. The remaining spend was allocated to community treatment spend, which funded consultant addiction psychiatrists, prescription costs, staff training, and administrative support.

The remaining seven areas spent the majority of the grant on community treatment. For example, Bristol and Bolton spent 58% and 53% of their total spending respectively on community treatment.

Bristol used the RSDATG to fund six specialist substance use support workers in 2020-2022 that continued to the end of the programme with the addition of four psychological workers, four outreach workers and a nurse prescriber from 2022 onwards. Non-staff costs include staff expenses and Buvidal medication costs.

Bolton's spending has been predominantly on labour with 17 additional staff including 5 FTE recovery coordinators in 2022-2024, and 3.5 FTE in 2024-2025 totalling £537.800 over the three years. Furthermore, there was spending on Buvidal and naloxone.

Dividing total spend by the number of service users allows for a cost per service user. However, the number of service users are reported annually, but individuals can receive services for multiple years. As a result, the number cannot be aggregated above annual totals as this would result in double counting. Table 7.2 below reports the cost per service user by year.

Table 7.2: Cost per service user from 2021/22 to 2024/25 based on ten case study areas*

	Total cost	Total service users	Cost per service user
2021/22	£5,391,396	1,843	£ 2,925
2022/23	£7,052335	2,725	£2,588
2023/24	£8,619.653	3,930	£2,193
2024/25	£8,799,663	4,404	£1,998

*2020/21 is not included due to low levels of funding as a result of the phased funding allocation that only began in Q4 2020/21. Consequently, the average cost per user was reported as very low and may distort interpretation.

The average cost per service user over five years from 2021/22 to 2024/25 is £2,315 in the ten case study areas, with the unit cost being highest in the first full year (2021/22). The number of service users has increased at a greater scale to the total spend over the years, meaning a lower cost per service user over time, excluding the first year.

7.5.2 Other costs

Other direct costs

As well as the funding given to local authorities, RSDATG had other costs:

- Centralised programme costs, which OHID's cost-benefit analysis spreadsheet estimated to be £450,000 per year
- The cost of the pan-London projects, estimated to be £3,841,236 per year
- The cost of the evaluation, which if spread equally between the last three years of the funding would be £373,333 per year.

Additional costs for commissioning or delivery teams

In interviews carried out as part of the qualitative case research, commissioners and delivery teams in some areas (those in the second and third waves of the research) were asked if they incurred costs as a result of RSDATG which were not covered by the funding they received; for example, recruitment or administrative tasks which could not be fully covered by the roles funded by the grant. Some areas said they did not have such additional costs, but in one area a delivery organisation said the funding did not cover the full costs of employing new staff (for example, it did not cover their equipment such as mobile phones) and in another area, the commissioner noted that there were "peripheral associated treatment costs within the treatment system" not covered by the funding. It has not been possible to estimate the size of these costs.

Indirect costs from increased use of public services

Indirect costs of the programme are not quantifiable, suggesting that the total cost of RSDATG is currently under-estimated. Drawing on insights from the qualitative programme of work, interviewees in the ten case study areas identified the following services accessed by individuals because of RSDATG support:

- Housing (largely temporary accommodation such as hostels)
- Welfare benefits
- Nursing and psychology support
- GP visits
- Calling ambulances for service users
- Hospital treatment for alcohol-related problems
- The local Find and Treat service providing early detection and treatment of tuberculosis, blood-borne viruses and other diseases
- Community mental health teams
- Domestic violence advisors/teams
- Dentists and oral healthcare
- Supporting users to engage with nutrition and cooking courses and other activities

The nature of data collection has not allowed the evaluation to gauge the proportion of service users accessing each of these services, the extent to which they would have done so without support and thus assess the likely scale of additional costs. However, the evaluation team knows that enabling people to access other services as part of a holistic, wraparound approach was a key part of the support delivered. For example, around one-third of the service users interviewed for the evaluation reported that RSDATG-funded roles and services had helped them to obtain support

for their health, most commonly by registering them with a GP and/or accompanying them to appointments. On the other hand, as described in section 5.7, the funding has had limited effect on increasing access to mental health care.

Desk analysis was conducted using the Unit Costs of Health and Social Care 2023 manual to collate unit costs that could be attributed to services targeting service users experiencing homelessness, or those at risk of rough sleeping. As previously mentioned, interviews did not probe for estimates on the proportion of service users accessing each of these services (except for the GP), the level of use of these services among service users, or the extent to which this was attributable to RSDATG support. This means that it has not been possible to calculate the costs of additional service use attributable to RSDATG, as the numbers of service users utilising these additional services is not able to be extrapolated.

Table 7.3: Unit costs of selected additional services[52]

Service	Cost
GP appointment (average 10-minute appointment)	£42 per appointment
Prescription costs	£28 per consultation
Appointment with nurse at GP practice	£11.75 for 15-minute appointment
Dentist appointment	£73 for half-hour appointment
Hospital outpatient appointment (average)	£217 per appointment
Hospital day case (average)	£1,111 per appointment
Non-elective inpatient stays (short stays)	£857 per stay
Ambulance attendance (average)	£254 per attendance
Community sexual health provision, face to face	£171
Contact with IAPT service (talking therapy for anxiety and depression)	£135 per contact
Contact with specialist mental health team	£296 per contact
Specialised supported housing: rent and service charge	£297 per week
Specialised supported housing: care package	£1,692 per week
Local authority care home	£237 per resident per day
Referral to social prescribing	£435 per person per year

7.5.3 Consequences

The consequences incorporate findings on outcomes from the qualitative research and MI data. The qualitative research is reflective of the delivery period up until the interviews were conducted (between February 2024 and May 2025).

Number of people engaged

Table 7.4: Annual service users by financial year across the ten local authorities[53]

	2020/21	2021/22	2022/23	2023/24	2024/25
Total service users	691	1,843	2,725	3,930	4,404

[52] https://kar.kent.ac.uk/105685/1/The%20unit%20costs%20of%20health%20and%20social%20care_Final3.pdf

[53] These figures are not cumulative and cannot be summed to make a total as an individual could engage with services for several years. 2020/2021 is only representative of 5 areas and 2021/2022 is only representative of eight areas, due to phased funding.

In the last year of separate RSDATG funding (2024/25), across the 10 case study areas, 4,404 people engaged with services or teams funded by RSDATG. The number of people engaging with RSDATG support increased substantially from 2020/21 to 2024/25, with the largest increase in users seen from 2020/21 to 2021/22, when the number of service users more than doubled.

These overall increases partly reflect the phased nature of the funding, in that more areas received funding and implemented services as time went on. However, there were also changes within individual areas, as shown in the table below. Blackpool and Manchester particularly saw an influx of service users in the final year covered by the evaluation. For all areas excluding Camden, Westminster and Bristol, the number of users increased consistently over the years.

Table 7.5: Number of service users by area and financial year

	2020/21	2021/22	2022/23	2023/24	2024/25
Blackpool	-	243	741	815	1055
Bolton	-	-	66	78	86
Bournemouth, Christchurch & Poole	189	322	699	1687	1762
Bristol	400	391	209	151	150
Camden	-	216	86	72	95
Doncaster		40	73	89	117
Great Yarmouth	-	-	6	61	59
Manchester	4	113	350	399	510
Nottingham		89	183	220	212
Westminster	98	429	312	358	358

As described in Chapter 5 above, the number of people in housing need in treatment increased in funded areas over the funding period. However, a comparison to trends in non-funded areas indicates that RSDATG funding only made a difference to the numbers of this group in treatment after 2.5 years of funding, when numbers begin to increase over and above the trends seen in non-funded areas.

Although overall numbers of those in treatment were little affected until 2.5 years in, it appears that RSDATG funding may have shifted the profile of those engaged with treatment services towards those with higher levels of need. Case study data shows that (before matching), people supported by RSDATG and in treatment have greater housing risks, are less likely to be employed or in contact with their children, and more likely to be using opiates and to be injecting substances, compared to other users of drug and alcohol services. The evaluation has not looked at the profile of treatment service users before the introduction of the grant, which would enable such a shift to be more clearly identified, but qualitative evidence suggests that the funding was effective at bringing people into services who would not have been able to engage previously.

Summary of consequences for service users

This table presents a summary of the evaluation findings about RSDATG's effects on service users.

Table 7.6: Summary of effects on service users

Outcome	Overall trend	Effect of RSDATG funding	Commentary
Access and initial engagement with treatment	Increasing (positively)	Positive in the long run	MI and NDTMS data show that the numbers of people engaging with treatment after or upon being supported by RSDATG are similar to that expected (around 8,200 per year). However, overall numbers of treatment starts do not increase more than increases also seen in non-funded areas, suggesting limited impact and potentially some crowding out, in the first 2.5 years of the funding.
Retention	Not known	Moderately positive	Broadly positive findings from the quantitative comparative analysis (which suggests an effect of the funding since the inherent differences between the two groups would tend to produce the opposite outcome), supported by strong qualitative evidence.
Treatment completion	Not known	Uncertain given challenges in quantifying completion rates in the absence of funding	Qualitative evidence and NDTMS data show that RSDATG has supported a large number of people to successfully complete treatment, in part due to the intensive support. Completion rates were lower than expected at business case stage, but this is likely to be because the RSDATG group's needs were more complex than originally envisaged.
Numbers in detox and rehab	Increasing (positively)	Uncertain given context of rising demand for drug and alcohol treatment nationally.	Annual numbers of people in the RSDATG cohort entering detox and rehab grew over time to the level anticipated at the outset of the grant.
Drug-related deaths	Increasing (negatively)	Likely positive though evidence not definitive.	Drug-related deaths are increasing overall, but qualitative evidence indicates that the grants were perceived to have either slowed a rise in drug-related deaths or reversed it in some areas.
Rough sleeping	Increasing (negatively)	Uncertain given challenges in quantifying effects on rough sleeping rates in the absence of the programme.	In many areas, staff reported that RSDATG support had prevented the number of people experiencing sleeping rough from rising further, by securing housing for people experiencing rough sleeping and helping prevent rough sleeping among those at risk. NDTMS data from case study areas shows that 40% of RSDATG service users experiencing rough sleeping at the outset of their engagement saw an improvement in their housing situation.

Access to mental health treatment	Not known	Below expectations given needs of the RSDATG group	Staff and commissioners commonly raised access to mental health treatment as one of the biggest challenges affecting the success of the grant.
Quality of life	Not known	Likely positive but uncertain given challenges in quantifying effects on quality of life in the absence of the programme.	40% of RSDATG service users reported improved quality of life based on data recorded in NDTMS at the start of their engagement with treatment and more recently. 39% reported the same quality of life. There is some qualitative evidence of improved mental wellbeing for service users. While self-reported quality life was lower on exit relative to similar individuals accessing drug and alcohol services via mainstream services, this would be expected given that RSDATG has supported a cohort with more complex needs.
Physical health	Not known	Likely positive	There were widespread views from both local staff and services users that RSDATG-funded services and roles have supported improved access to physical health treatment and outcomes among service users.

Other positive outcomes for service users were also observed by the qualitative research, including improved ability to live independently and manage aspects of their lives; getting back in touch with family; working to regain custody of their children; (re) engaging with education; volunteering or preparing to go back to work. Although such outcomes cannot be quantified or monetised, they can be considered theoretically in terms of indirect consequences of the grant. This includes reduced pressures on the NHS and social services and improved social and emotional well-being, which may indirectly contribute to societal stability and cohesion. Individuals regaining control over their lives and reconnecting with their families may result in the potential reduction in reliance on social services. Additionally, as beneficiaries engage with education and work, there could be long-term economic benefits realised through increased productivity and reduced unemployment-associated costs.

OHID's ex-ante cost-benefit analysis of the programme set out in the Phase 2 Business Case (March 2021) identified and quantified the benefits to society of individuals entering treatment, and of being in recovery and living substance-free, as a result of RSDATG. These benefits were anticipated to arise from cost savings to the public sector, including the NHS, social care services, other local authority services, and the criminal justice system, and through improved health and life expectancy, which was quantified using a Quality-Adjusted Life Year approach. These benefits were quantified using evidence from the following studies:

- Public Health England (2016-17) which matched NDTMS data with Ministry of Justice data on Police Reported Crimes, to estimate the number and type of crimes committed by individuals both pre- and post-treatment[54];
- Drug Treatment Outcomes Research Study (DTORS), a longitudinal study of a set of 1,796 participants considered to be representative of all adults in structured treatment[55]
- Social Return on Investment Analysis which used NDTMS data and other published studies to estimate likely outcomes (relating to health-related quality of life and mortality) for people receiving treatment compared to the outcomes expected had they received no treatment.[56]

The estimated monetary benefits are outlined in the table below. It is important to note that these estimates are not directly applicable to the RSDATG cohort as they are based on studies of the overall population of adults in treatment. However, they can provide an indication of the size and nature of savings to public services.

Table 7.7: Anticipated benefits of treatment and recovery as estimated for RSDATG business case (2021 prices)

Problem substance	Type of benefit	Treatment benefits per person per year	Recovery benefits per person per year
Opiates	Savings to public services	£9,780	£13,100
Opiates	Health and life expectancy	£4,311	£4,639
Opiates	**Total**	**£14,091**	**£17,739**
Non-opiate drugs	Savings to public services	£9,518	£12,269
Non-opiate drugs	Health and life expectancy	£3,318	£3,646
Non-opiate drugs	**Total**	**£12,836**	**£15,915**
Alcohol only	Savings to public services	£1,556	£3,289
Alcohol only	Health and life expectancy	£2,254	£2,229
Alcohol only	**Total**	**£3,810**	**£5,518**

Given the complexities of the target group, it might be possible that positive outcomes are observed over the longer-term, and beyond the timescales of this study. The dynamics of drug and alcohol recovery and homelessness involve multifaceted challenges that often necessitate prolonged periods of support to witness substantial, enduring change, and therefore analysis may not yet fully capture the gradual improvements in housing stability, well-being, and societal reintegration.

[54] https://ukhsa.blog.gov.uk/2017/11/02/how-alcohol-and-drug-treatment-helps-to-reduce-crime/
[55] https://www.gov.uk/government/publications/summary-of-key-findings-from-the-drug-treatment-outcomes-research-study-dtors
[56] https://www.ndtms.net/VFM

Summary of effects on services

Qualitative evidence from the case study areas identified a number of positive effects for services:

- Increased collaboration between different services working with the RSDATG client group
- Increased understanding of the needs of this group, among both funded services and the wider set of services working with this group, and among commissioners
- The wider adoption of trauma-informed approaches

There was less evidence for the grant having led to changes in policies and practices.

In many areas it was hard to isolate the specific effect of RSDATG on these outcomes from that of other recent initiatives relevant to the RSDATG client group.

System wide effects

The area-level impact analysis shows that RSDATG funding did not lead to an increase in the number of individuals with acute housing needs starting treatment over the first 2.5 years of funding. After this point, the data suggests that the number of people starting treatment in funded areas increases over and above the trends seen in non-funded areas.

It is not possible to definitively determine the root cause of this time-lag of effect, but two hypotheses are presented (see section 5.3.2 above) which are not exclusive:

a. The people supported by RSDATG would have been in drug and alcohol treatment in the absence of the funding, and therefore any benefits occurring would have naturally happened without the programme. This would reflect a deadweight loss, where resources might be expended without generating additional public benefit.

b. RSDATG funding has widened access to treatment by bringing 'harder to reach' people into treatment and providing them with intensive support. However, by injecting additional demand in the context of supply constraints (e.g. because of skills shortages) this has 'crowded out' another group of people with lower support needs being able to start treatment. The results of time-series analysis of treatment starts in both RSDATG and mainstream treatment services provide support for this explanation. This crowding out effect can challenge the balance and sustainability of service provision, requiring careful management and resource allocation to ensure that both new and existing service users receive appropriate care. This has negative implications for the cost-effectiveness of the programme, suggesting that value-for-money is not achieved in the short term.

7.6 Conclusions

Assessing the overall value for money of the RSDATG programme is complicated given the complexities of the programme, breadth of quantifiable and non-quantifiable outcomes, and the availability of BAU data to form a judgement on cost-effectiveness. This means that the net effect on public spending is uncertain. The CCA has presented a disaggregated "balance sheet" of costs and outcomes, leaving the final judgement to decision-makers to weigh these elements according to their own priorities.

- On the "cost" side, the programme spent a total of £30.23 million across the ten areas, with spending focused primarily on wraparound and engagement services (49%) and community treatment (43%). However, this figure must be considered an underestimate of the true total cost, given unquantified indirect costs, such as the increased use of other public services (GPs, hospitals, housing, benefits) stimulated by RSDATG, and additional administrative burdens on local teams not covered by the grant. Furthermore, significant limitations in the financial data, such as a lack of granularity, inconsistencies in reporting between areas, and changes in reporting requirements over time, make it challenging to pinpoint precise cost drivers or identify opportunities for optimisation.

- On the "consequences" side, the programme demonstrates clear successes in process and engagement, engaging over 4,000 individuals (in the ten areas studied) in the final year covered by the evaluation who, according to qualitative evidence, are harder to reach than mainstream service users. Positive outcomes include increased entry into detox and rehabilitation, and strong qualitative evidence of improved physical health and enhanced collaboration between services. The evaluation has noted that several consequences are likely to have been omitted from the analysis due to lack of measurability and data. Specifically, it is possible that positive outcomes evidenced by the qualitative research, such as improved ability to live independently, getting back in touch with family, (re) engaging with education, volunteering or preparing to go back to work will have longer-term positive knock-on effects such as cost savings to the NHS and social services and improved local productivity. Moreover, the relatively short-term nature of the analysis will not capture any longer-term benefits such as reduced duration of rough sleeping and avoided costs to health and criminal justice services. OHID's ex-ante cost-benefit analysis of the programme set out in the Phase 2 Business Case (March 2021) identified and quantified RSDATG's expected benefits to society through cost savings to the public sector, including the NHS, social care services, other local authority services, and the criminal justice system, and through improved health and life expectancy.

Key messages to derive from the CCA analysis:

The cost of delivering RSDATG interventions has been substantial, though key nuances must be considered. The programme has spent £30.23 million in the ten areas to date, with the majority of this investment (68% in later years) funding labour costs for specialist staff. This demonstrates the

higher costs involved for projects which are intensive and person-centred. Additionally, the annual cost per service user decreased over time to £1,998 in the final year, suggesting increased efficiency as the programme scaled. It is important to note, however, that this cost estimate excludes indirect and opportunity costs, such as unquantified costs passed on to other public services (e.g. GPs, hospitals, and housing bodies). The cost of the programme in these ten areas is therefore likely to be greater.

The programme has successfully engaged a high-need, hard-to-reach cohort. Qualitative research supports the claim that the RSDATG programme enabled services to reach a vulnerable group of individuals with more complex and acute needs who would otherwise not be well-supported by mainstream services. Over the funding period, the programme successfully engaged an increasing number of people, reaching over 4,000 individuals in the final year across the ten areas. A key success factor of the programme was its ability to contact and provide intensive wraparound and community treatment to this specific cohort.

Outcomes are mixed, highlighting both successes and challenges. The evaluation presents a nuanced picture of the programme's outcomes. It achieved significant success in engaging and retaining a high-need and hard-to-reach population, reducing their entry barriers to treatment. Qualitative evidence also points to improved physical health and better collaboration between local services. However, this did not translate into statistically significant improvements in reducing rough sleeping or improving mental health access. The area-level analysis, however, indicates that local services initially struggled to expand capacity in response to the additional demand for drug and alcohol services induced by RSDATG within an overall context of rising demand. Relative to non-funded areas, there was no net increase in the number of individuals with acute housing needs receiving drug and alcohol treatment for 2.5 years after grants were awarded to local authorities, with the numbers receiving treatment through RSDATG being offset by relative reductions in the numbers receiving treatment through mainstream services. As individuals reaching drug and alcohol treatment via services funded through RSDATG had more acute needs and a lower likelihood of achieving a positive outcome, it is likely that this will have reduced the overall efficiency of drug and alcohol treatment services over the adjustment period. There were signs that these pressures began to ease 10 months into the programme with statistically significant increases in the number of new starts from 2.5 years.

The economic case for intervention is not straightforward, and weighted considerations need to be applied to the results. The value for money of the RSDATG programme cannot be clearly determined based on the impact and CCA results. The evidence suggests a "crowding out" effect may have occurred in the first 2.5 years, where the programme shifted resources to the RSDATG group at the expense of individuals who would have otherwise accessed mainstream services. This displacement, combined with the fact that mainstream services deliver an estimated positive BCR (£1.23), implies that the overall value for money of the drug and alcohol treatment system may have been reduced in the short term. After the implementation phase, however, the data shows a positive turning point, suggesting that once the services were fully embedded and staffed, they

generated additional value. This demonstrates the programme's potential in helping a vulnerable population that is otherwise left behind, proposing a strong moral case for intervention as well as suggesting that the value for money trajectory may be positive in the longer-term.

8 Looking forward

8.1 Areas' plans for the future/post-RSDATG

At the time of the final wave of case study fieldwork, the RSDATG areas had been awarded funding for 2025/2026 through the DATRIG grant which was slightly less than their 2024/2025 allocations. Interviewees suggested that services were working well, and plans for the immediate future were around maintaining the current service and building on learning to fill any gaps, for example recruiting staff to support mental health, working with service users from ethnic minority backgrounds or improving routes into detox. However, some areas were not planning on expanding the service and felt under strain due to the funding decrease. A few areas were planning to pare back elements of their funded services; however, it was difficult to decide which activities to deprioritise as the service was felt to be working effectively. Some RSDATG projects described having to reduce staff numbers (or redeploy staff to the mainstream drug and alcohol service), while others expressed concerns about whether the RSDATG element of DATRIG could be used as flexibly as the RSDATG funding.

Areas were less certain about their future plans beyond 2026 and were anxious about the funding ending. Many people reported that without the RSDATG funding, the service would not be able to be maintained. Interviewees expressed their concern about losing elements of a whole system which was working well, as this would reduce the holistic nature of the services supported under RSDATG and have a major impact on service users. Because of this uncertainty, one interviewee said that they were warning service users that the service may look quite different in the future and was encouraging them to get a space in detox.

> **"It probably will not be possible [to sustain the team without RSDATG funding]. I mean if I get an increase in my Public Health grant which is probably not going to happen, then I might be able to change one of the workers with the Public Health grant to be a homeless worker, but it will be one worker and that's it, so we go back to what we were previously, which is a real shame, because, you know, we've made huge inroads over the last three-and-a-half years."** – Commissioner

In some cases, areas had plans to maintain various aspects of the service that were seen as particularly effective. One area said that they had made plans to keep their trauma informed navigation roles, by incorporating them into the main treatment grant. The new service will be based within treatment and will carry out outreach on the streets and in hostels, as well as linking up with the hospital as the area know that this cohort often present at A&E. In an area where the MDT working had been very successful, the borough-based NHS partnership wanted to fund someone to run these meetings and manage the progress being made outside of them. Places for inpatient detox and rehab were being maintained in one area, by restructuring the service delivery model into two primary lots, ensuring a protected budget within the clinical lot to safeguard these services. These services were viewed as essential, and the commissioner aspired to get at least four individuals through these programmes annually. Before the 2025/2026 funding was

announced, a drug and alcohol charity in one area had committed to use its reserves to fund the service for three months while longer-term solutions were sought. A few areas had hired staff on permanent contracts as part of the core service stating that if funding were to end, that they would move to another role within the service.

Interviewees were asked on a hypothetical basis about which elements of the service they would prioritise sustaining if funding were to end. The most commonly cited element of the service to keep was outreach, as this was said to add the most value and was critical in engaging and building trust with service users. Interviewees said that they would try to maintain a small team of outreach workers and were thinking about how they could do this by using other funding streams, such as using the supplemental grant or public health funding. However, there was some concern that reducing the outreach team to one or a couple of individuals would increase caseloads and reduce their ability to work flexibly around service users' needs. A few areas said that they would keep other activities to try to engage service users, such as physical health provision or breakfast and dinner clubs because they were considered important in attracting people to the service. Having a co-occurring conditions component to the service and a psychologist was considered a priority in areas where these posts had been effective, and others mentioned wanting to keep their prescriber. One area said it would prioritise funding its detox house as there were no other similar services in the area.

A few areas also spoke about things they would cut from the service if the funding ended. One would reduce the budget for residential rehab, while another said that they could reduce training activities as other services had already embedded trauma-informed delivery into their practice as a consequence of their training.

Interviewees described the potential impacts of stopping the RSDATG funding on service users. Several staff members and commissioners said that without the RSDATG funding, the service would not be able to be maintained, and service users would have to be transferred to the mainstream service. There was worry that with caseloads already being high, mainstream services would not be able to provide the intensity of support that individuals in this group need. They expected to see a high drop-out rate if service users lost their key workers and were not given the same intensive and personalised support. A staff member said that it felt unsafe and unethical to increase numbers of people into treatment through RSDATG and then not be able to subsequently provide the same intensity of aftercare and follow-on support that they need. Several staff said that transferring service users to mainstream services could result in more drug related deaths in their areas:

> **"He would die, 100%, he would die if nobody was supporting him with this trauma informed flexible route into services, he would not be able to access it through mainstream."** – Frontline worker

They also predicted a rise in anti-social behaviour in their areas and increased strain on other services such as A&E and the criminal justice system, as well as potential knock-on effects on families and carers.

Finally, several areas commented that to be able to support service users from the RSDATG cohort, the mainstream service would need additional investment,

> **"[It's like,] 'Here, have some grant money, address some of the primary issues, and then, take the learning from this and bolster your service but without the money.' The financial climate we're in... I genuinely don't think that the significant impact that RSDATG has had could be sustained without continued investment."**
> – Service manager

9 Conclusions and implications

9.1 Introduction

This chapter provides the conclusions of the evaluation, drawing on the evidence presented in the previous chapters. The highlighted boxes provide comment on the themes explored in the evaluation where these are not expressly reported in the text.

9.2 Aims, objectives and rationale for RSDATG

RSDATG provided £262 million across three phases to 83 local authorities experiencing the highest levels of rough sleeping in England. The grant aimed to improve drug and alcohol treatment and recovery services for people experiencing rough sleeping (and from 2021, those at risk of doing so). RSDATG was one of a series of programmes which collectively aimed to achieve the then Government's goal to end rough sleeping by 2024, as well as supporting the implementation of the National Drug Strategy.

The grant had three specific objectives, namely to:

- Improve drug and alcohol treatment outcomes for people experiencing rough sleeping or at risk of doing so;
- Reduce rough sleeping; and
- Reduce deaths from drug and alcohol poisoning amongst people experiencing rough sleeping or at risk.

The grant also intended to improve capability and increase the resilience of local drug and alcohol services, so they are better able to meet the need of the cohort in future.

The rationale for the grant was that people experiencing rough sleeping with multiple and complex needs were less well served by mainstream drug and alcohol services, as they faced additional challenges to achieving positive treatment outcomes. Given the relationship between substance use and homelessness, addressing substance use issues was expected to contribute towards reducing rough sleeping and enable those in accommodation to better sustain their tenancies.

The evaluation found that **RSDATG-funded roles and services were working with cohorts with particularly complex and often inter-linked needs**. These commonly included lengthy histories of substance use, rough sleeping and unstable accommodation, commonly combined with accompanying histories of trauma, mental health issues and physical health needs. Service users also often held a mistrust of treatment and wider services, based on previous negative experiences and feelings of stigmatisation. This meant that to engage service users and sustain their engagement, RSDATG staff had to counter these pre-existing perceptions, establish relationships of trust and show how RSDATG services were different to those experienced previously. The additional resources provided by the grant allowed service users to receive more

intense support, over a longer duration, than would have been possible under mainstream services.

9.3 How the funding was used

The grant enabled RSDATG-funded services and their local partners to identify, engage and support a cohort facing a range of complex and often interlinked barriers to recovery, by developing integrated, multi-agency responses that provided holistic responses to service user needs.

In preparing their applications for RSDATG funding, local authorities worked with their partners to identify gaps in existing mainstream services and propose new or enhanced approaches to improve outcomes for service users. One of the strengths of the grant reported by commissioners was the flexibility to develop services which addressed specific local needs and enhance existing provision, rather than being given a prescriptive list of interventions to deliver. This enabled multi-agency responses to be developed, recognising that addressing the multiple needs of the cohort commonly required contributions from partners across treatment, health, housing and associated services.

Theme 7: Fit with local provision and alignment with other funding streams

In preparing their applications and establishing their RSDATG services, commissioners and partners worked closely to ensure RSDATG resources enhanced rather than duplicated existing provision. This posed both opportunities and challenges, as several initiatives and funding streams with similar objectives and targeting similar cohorts were launched around the same time as RSDATG, most notably the RSI.

To maximise these opportunities, commissioners worked to ensure that the roles of RSDATG and other funded teams were sufficiently distinct to avoid duplication, establish good working relationships and develop clear and effective support pathways.

However, there were challenges in ensuring alignment with other provision and funding streams. Some areas found establishing multi-faceted responses given the range of activities supported under different funding schemes posed issues and had discouraged collaboration. In others coordination between services was less effective and led to duplication and friction. Over time these issues were resolved through discussion, problem-solving sessions and MDT meetings; establishing partner networks; and clearly defining specific roles and responsibilities.

However, while RSDATG funding was welcomed as it provided dedicated funding for the cohort, commissioners and RSDATG services, some aspects of the funding arrangements challenging. The annual funding cycle made forward planning difficult, and while some areas were able to utilise underspend to enhance their services, the ability to 'carry funding over' would have been helpful.

This also meant many areas' delivery organisations could only offer annual (or shorter) contracts, which hindered their ability to recruit and retain staff.

The introduction of RSDATG alongside additional funding streams and initiatives with similar aims and targeting populations with similar characteristics, provided considerable additional funding for a previously highly resource constrained sector. After many years of underinvestment, the specialist skills and outreach teams/staff required were not in plentiful supply. The arrival of new funded roles, with a specific focus on and the freedom to work flexibly with a particularly complex and challenging cohort, exerted additional pressures on overall labour supply and so the ability to support both RSDATG and mainstream service users. As described below, this led to recruitment challenges, particularly in the early stages of the grant.

9.3.1 Establishing RSDATG teams

The roles and responsibilities of RSDATG teams reflected existing local service structures and partnership arrangements, which enabled recognised service gaps to be addressed and avoided duplication. In many areas, the lead RSDATG providers commissioned were also delivering the mainstream drug and alcohol service, so were able to build upon understandings of the local area, existing relationships with partners, and in some cases share or second staff.

RSDATG teams commonly comprised teams of support workers, whose remits included conducting outreach/in-reach to engage service users; providing continued support and help to address health needs, reduce harm; and support preparation and entry to treatment. They also included regulated staff, including psychologists, dual diagnosis workers, nurses and non-medical prescribers (NMPs), who provided clinical support and helped address health needs. Services also drew upon staff or others with lived experience (including previous service users) and benefited from these individuals' ability to emphasise with and be credible to service users.

The specific composition of RSDATG teams, in terms of the types of roles that were funded and the organisations they sat within, depended on the existing services in each area. RSDATG-funded services also worked with partners best suited to deliver their respective roles, including local authority housing or RSI-funded teams who led on securing housing, and in some areas included conducting joint outreach work to recruit service users. RSDATG teams also worked with partners to address wider, more complex health needs and with psychologists and dual diagnosis workers where these were not included in their core teams (including staff from mainstream services).

Theme 8: Staff recruitment and retention

Many areas faced challenges in recruiting staff, particularly in the early stages, due to a limited pool of suitable staff, competition from similar services, and roles being less attractive due to the short-term nature of the funding. This was particularly the case for regulated staff, which led to some positions remaining unfilled. While a few providers offered permanent contracts from the outset, others were able to mitigate these issues by

amending staffing configurations, secondments, or recruiting staff with the necessary attributes but who had not worked with the cohort previously.

Retention was also a challenge, in part due to continued competition with other services, annual contracts being less attractive, and the pressures inherent in working with the RSDATG cohort. Providing support for staff, through reflective practice, supervision and structured team meetings, helped to reduce attrition.

9.3.2 Services provided

The grant effectively enabled the delivery of multi-agency approaches to addressing the needs of the RSDATG cohort and helped them progress towards positive treatment outcomes. Key enablers of effective delivery included:

- Working more intensively with service users to provide the additional support they require – with RSDATG support worker caseloads commonly being around half those of their mainstream service equivalents;
- More closely tailoring support to service users' needs and preferences – providing person-centred support, delivered at a pace service users were comfortable with;
- Taking services to people through outreach and in-reach provision rather than expecting them to attend set appointments;
- Working with partners best able to meet different service user needs – to enable the coordinated, multi-agency responses required to address the complex and inter-linked challenges they face; and
- The application of trauma-informed approaches – which were recognised as essential to working effectively with the cohort, as described below.

Theme 6: Trauma informed approaches

RSDATG guidance emphasised the importance of following trauma-informed approaches when working with service users, and overall RSDATG staff demonstrated a good understanding of its underpinning principles and their application in practice. These included understanding that service user behaviours were often responses to previous experiences of trauma, and that tailored responses were required to address their underpinning issues rather than re-triggering trauma or reinforcing stigma.

However, trauma-informed approaches were followed more variably across associated partner services, where understandings were less well developed, capacity to adapt services was limited, or their statutory roles restricted their ability to work with the necessary flexibility. RSDATG services often facilitated training in trauma-informed working to both their own staff and those in other services, which helped proliferate understandings and practices more widely. This was one of the successes of the grant, influencing and changing

practice to better understand service users' needs and the factors which underpin them, and are key to effective work with the RSDATG cohort.

While the specific roles and interventions delivered varied between RSDATG-funded areas, a similar range of services were provided across areas.

RSDATG teams placed a strong emphasis on **assertive outreach and inreach**, to engage new service users, maintain their engagement and provide continued support throughout the recovery journey. This could include conducting outreach work with partners, to avoid duplication and reach those most entrenched. Key enablers in securing and maintaining service user engagement included establishing trust, building positive recovery-focused relationships and following trauma-informed approaches. The increased capacity, and reduced caseloads, enabled by the grant allowed RSDATG support workers to provide more intensive support than their mainstream colleagues, and was a key point of difference between the services.

When new service users were recruited to RSDATG, attentions commonly focused on addressing immediate **physical health needs** which were either undiagnosed or left untreated previously. RSDATG nurses and NMPs provided initial health assessments, BBV tests, vaccinations and facilitated early scripting, and worked with GPs and other health partners to address more complex and enduring health conditions. These measures also marked the first steps in **preparing to receive treatment**, through early scripting and providing advice and support to stabilise and reduce consumption, in some cases convincing service users that recovery was possible with their support and to counter concerns (such as the risk of abstinence re-triggering previous trauma or potential relapses). In parallel with additional measures, such as distributing Naloxone, clean needles, sharing alerts of contaminated drug supplies and support to moderate alcohol consumption, these also served to reduce **substance-related harms**. Harm reduction was widely reported as being a key success of the grant, helping keep service users safe and contributing to limiting the number of substance-related deaths amongst the cohort.

Addressing **mental health** needs was, however, more challenging across the RSDATG areas, and hindered recovery for service users with co-occurring conditions. Where RSDATG-funded psychologists and dual diagnosis workers were in place they were able to improve access to mainstream mental health services to some degree, but service users commonly face barriers to access if they were continuing to use substances or were discharged if appointments were missed. While RSDATG staff recognised that mental health services were stretched, they felt that national guidance (such as NICE guidelines on co-occurring conditions) was not being followed and should be more robustly enforced. Challenges accessing mental health support represented a barrier to service user recovery given the relationship between substance use and trauma, could also lead to them not being accepted into IPD/R, and so influenced the ability to achieve both improved treatment and mental health outcomes.

For service users experiencing rough sleeping on entry, **securing accommodation** was also an initial priority. Responsibilities for this varied between local authority housing and RSI teams,

RSDATG support workers and local accommodation providers, although in many areas this was a collective effort given the challenges of securing suitable accommodation. All the RSDATG areas described how the supply of temporary accommodation was limited and had reduced in their areas, and the quality and appropriateness of what was available was highly variable. In some cases, housing providers were reluctant to accept the RSDATG cohort due to their accompanying behaviours, which could be mitigated by the offer of continued support which included intervening if tenancies were at risk. Supplies of appropriate 'dry' move-on accommodation were also limited in many areas, which led to some service users being re-located outside of their areas (although this could bring benefits such as escaping previous negative influences). Accommodation supply challenges hindered the achievement of treatment and addressing rough sleeping outcomes, although the scale of investment required was beyond the remit of the grant and the ability of local authorities to address individually.

RSDATG service users were commonly offered a combination of **community-based treatment and IPD/RR**, depending on the complexity of their individual needs and the nature and duration of their substance use. Across the areas the most common route to recovery was via community-based treatment, with a smaller share accessing IPD/R, although many commissioners commented that this was around the number expected and represented an improvement on entries to IPD/R in mainstream services. Shortages of 'dry' move-on accommodation also presented challenges and risked exposing service users to others continuing to use substances. Enablers and challenges in terms of accessing IPD/R are summarised below.

Theme 4: Inpatient detox and residential rehab provision

The supply of supply of IPD/RR provision was widely reported to have reduced in recent years, across the RSDATG areas, notably for people with more complex needs. This led to the variable availability of places and delays in entries as waiting lists could be lengthy. While some services were able to draw upon provision within or adjoining their areas, others used out of area facilities which presented logistical issues in providing continued support during treatment episodes. Other challenges to accessing IPD/R included service users not having sufficiently reduced or stabilised consumption, not being sufficiently physically or mentally well to participate, or not having move-on accommodation in place. Some service users also faced specific issues, such as non-English speakers, people with certain health conditions and having offending histories.

In addition to adequately preparing service users for IPD/R, enablers included offering service users choice (as far as practicable) and taking them to visit IPD/R facilities or having discussions with staff in advance to help improve understandings of the process and address any outstanding concerns. This also helped facilities better understand service user needs prior to their arrival. Recognising that IPD/R regimes may be too strict or therapeutically challenging for some service users, and can lead to early exits, having contingency plans in place was key in enabling re-engagement.

RSDATG support did not end with the completion of treatment, reflecting that recovery journeys and re-integration into wider society could be lengthy and the risk of relapse was high. Providing

consistent, post-treatment support which built on relationships of trust established with service users helped make them more comfortable in disclosing relapses, which enabled support workers to intervene and restore positive momentum.

Over time, the intensity of support provided could reduce as service users became better able to take control of their recovery, helping to improve resilience with their support workers being available to offer help if needed. This also enabled service users to make positive changes in other aspects of their lives, such as establishing new and more positive friendship groups, participating in positive activities (such as recreational activities, education and training and reuniting with family). For others more reluctant to engage in treatment on entry or facing particularly complex challenges, support needs could remain high, and the ability of RSDATG services to continue to provide intense support over a prolonged period was a further differentiating factor compared to mainstream services.

Theme 3: The service user experience

Service users were broadly positive when reflecting on their experiences of RSDATG services, particularly for those able to draw comparisons with previous use of mainstream services. Key factors which convinced service users to engage with RSDATG and work towards abstinence included:

Services and staff presenting as welcoming, emphasising the positives and forming relationships of trust from the outset;

The ability to engage on a flexible and tailored basis, with services being brought to them rather than attending fixed appointments, and providing consistent support;

The skills, characteristics and experience of RSDATG staff were valued by service users, who were seen as reliable, trustworthy, credible, able to empathise and had a better understanding of their needs and preferences;

The fact that RSDATG offered a greater degree of choice over the support received and how they engaged with it, and that support workers worked with them at the service user's pace, and were persistent with exerting undue pressure; and

The ability to access a range of services through a single route and having a wider choice of treatment and support options than they had experienced from previous services.

Many described having strong and positive relationships with their support workers, who they felt often worked beyond their strict remit to help ensure service user needs were met. However, this could lead to issues when support workers changed, where well planned handover process were key.

9.4 Impacts for service users

RSDATG service users achieved a range of positive treatment, accommodation and health outcomes, as shown in the grant management information (MI) and reported in the qualitative work

with project staff, partners and commissioners. However, for some outcomes (particularly around housing and mental health) external capacity pressures appear to have prevented the funding from having as much impact as intended.

9.4.1 Treatment impacts

Overall, entries to treatment, sustained engagement and completions achieved by RSDATG service users were close to or below those expected at the outset of the grant, and on several measures below those achieved by others receiving mainstream services. The principal explanation for the mixed results is that outcomes were more difficult to achieve for RSDATG service users compared to those receiving mainstream services, particularly as the qualitative evidence suggests that the cohort overall may have faced even greater challenges than anticipated at the outset.

- **Entries to treatment** – findings here were mixed, with the RSDATG MI showing that the number of treatment entries in the final year of the grant covered by the evaluation was close to the business case estimate after discounting for service users already in treatment when first engaging with RSDATG. However, quantitative analysis of treatment starts showed little difference in the overall numbers of people with housing needs starting treatment compared to numbers in non-funded areas, until 2.5 years into the funding period. This suggests that to some extent RSDATG was supporting people who would have been in treatment anyway, albeit likely supporting them more effectively; or displacement of other people from starting treatment in mainstream services, as services struggled to expand overall capacity as much as anticipated from the various additional Drug Strategy funding streams (due to workforce constraints).

- **Sustained engagement and re-engagement** – here the findings were more positive, with RSDATG service users being equally or more likely to remain engaged with treatment than the mainstream comparison group. This represents a considerable achievement given the additional challenges and barriers faced by the RSDATG cohort. However, greater engagement of people in the RSDATG cohort implies working with a group of people whose support may incur greater costs and (as discussed below) who have a lower likelihood of achieving positive outcomes on exit.

- **Completing treatment and successful exit** – again findings here were mixed. In the year to June 2025 NDTMS data shows 9% of RSDATG service users (1,273 individuals) had **completed treatment** in that year, below the 16% estimated at the outset. The data also shows that a further 19% of RSDATG service users were still in treatment but had substantially reduced or stopped their substance use: overall, 28% of service users in treatment had made substantial progress. Completion rates were also lower for RSDATG service users compared those receiving mainstream services (9% vs 21%), although the RSDATG cohort faced more significant barriers to treatment. The share of those **completing treatment successfully** and no longer using substances on treatment exit was 27% for the RSDATG cohort compared to 47% in mainstream services.

9.4.2 Impacts on accommodation and reducing rough sleeping

Securing accommodation was key to service user recovery, with RSDATG support also enabling them to better sustain tenancies and reduce the risk of a return to rough sleeping. However, despite RSDATG's goal to reduce rough sleeping, levels of rough sleeping have risen in the funded areas.

NDTMS data from case study areas shows that 3 in 5 of those sleeping rough at the start of their engagement with RSDATG were still sleeping rough at the most recent point recorded, while 40% were no longer sleeping rough. In these areas, overall 4 in 5 of those supported by RSDATG had experienced no major improvement in their housing situation. Limited local housing supply (notably shortages of move-on accommodation) was seen as the key factor limiting greater impacts on accommodation. However, overall RSDATG support was widely thought to have helped prevent the numbers sleeping rough from rising further, for example through reducing eviction rates compared to the pre-RSDATG period. The qualitative evidence showed that accommodation outcomes were achieved for numerous service users with lengthy histories of rough sleeping or who had cycled between rough sleeping and temporary accommodation.

9.4.3 Impact on reduced deaths

Qualitative evidence suggested that the grant had a positive impact on levels of substance-related deaths, slowing or reversing the overall trend of increased deaths amongst the RSDATG cohort in recent years.

Although data on drug and alcohol deaths amongst the homeless population has not been collected nationally since 2021, RSDATG staff and service users were convinced that RSDATG support had led to fewer substance-related deaths in their areas or reduced the rate of increase. This was seen in the context of the nature of the cohort, the risks they faced while consuming substances, and the increased availability of synthetic opioids.

Efforts by RSDATG services to reduce substance-related harms were felt to have contributed to this achievement, although wider partners also played a role. Measures such as distributing Naloxone (including providing training and Naloxone supplies to partner agencies and others) and encouraging safer consumption, aligned with assertive outreach approaches, helped support workers check in on those at risk and provide harm reduction support. Helping secure accommodation, improve physical health also contributed to reducing deaths amongst RSDATG service users.

By further proliferating approaches to help reduce harms, RSDATG services helped keep service users alive, while also improving local capability to respond to overdoses.

9.4.4 Impact on physical and mental health

There is strong qualitative evidence that RSDATG services had improved the physical health of service users, although the findings were less positive in terms of impacts on their mental health.

The qualitative evidence showed that RSDATG support had led to the **physical health** needs of service users being addressed that would not have been addressed otherwise, by conducting health assessments on entry, registering service users with GPs, and working collaboratively to facilitate access to restorative and preventative healthcare. There was also evidence that access to health services helped improve service users' ability to better engage with wider services and maintain their health independently.

However, access to **mental health** services was a common area of challenge, despite RSDATG often funding dual-diagnosis and associated roles intended to improve access to mainstream mental health support. This may be because RSDATG service users had more severe and enduring mental health issues which made accessing support more challenging, alongside limited capacity in mental health services and accompanying policies and practices which did not reflect trauma-informed approaches.

9.5 Impacts on wider services

As well as working to improve treatment and associated outcomes for service users, RSDATG funding helped improve the capability of partner and aligned services to better meet the needs of the cohort in future.

The evaluation identified strong evidence that this was achieved in three main areas:

- Improved collaboration between services – leading to increased joint working (particularly in areas where collaboration was less well developed previously) and improved understandings of partner roles and remits. This was achieved through MDT arrangements, service co-location and improved information sharing.
- Improved service and commissioner understandings of the needs of the cohort and how best to address them – based on increased exposure to people with more complex needs, joint working, and awareness raising and training for partners on substance use, treatment options and harm reduction measures.
- Raising awareness and proliferating trauma-informed approaches – while services working directly with the cohort were often already familiar with the principles and practices involved, others had benefited from training facilitated by RSDATG-funded teams and from experiencing trauma-informed practice in action. Several areas reported this had also helped to change attitudes to their cohorts, although in some cases policies such as discharging service users for missing appointments or for displaying challenging behaviours were still in place.

9.6 Economic evaluation

The economic evaluation sought to address key questions on the cost of the programme (direct and indirect costs), and the unit costs per service user, in 10 of the RSDATG areas, following a Cost-Consequences Analysis (CCA) approach. As the economic evaluation chapter describes,

challenges were faced in conducting the analysis (and those reported for the impact evaluation also hindered the detailed outcome analysis), which led to a series of limitations which should be considered in interpreting the results.

The grant was used primarily to fund wraparound and engagement (48% of spend across the 10 areas) and community treatment (43%). IPD/R accounted for 9% of spend, which was proportionally higher than the share of RSDATG service users accessing inpatient treatment, due to the higher costs in comparison to community-based treatment. There was a high degree of variation across the 10 areas on the distribution of spend by activity, which reflects the specific configurations of local RSDATG services and responses to specific local needs and circumstances.

Unit costs per service user were calculated on the basis of RSDATG spend against the numbers of service users engaged in each year of the grant. The analysis showed that unit costs across the 10 areas ranged between £2,645 in 2021/2 to £2,192 in 2024/5, with an average of £2,448. As service user numbers increased over time this resulted in a reduction in unit costs. However, RSDATG also incurred additional costs, including for programme management and evaluation, and the costs of the pan-London projects. It was also not possible to quantify the indirect costs of the programme (for example those incurred for partner services such as housing and health services), suggesting the overall cost of RSDATG is underestimated.

The value for money of the RSDATG programme cannot be clearly determined based on the impact and CCA results: weighted considerations need to be applied to the results. The evidence suggests a "crowding out" effect may have occurred in the first 2.5 years, where the programme shifted resources to the RSDATG group at the expense of individuals who would have otherwise accessed mainstream services. This displacement, combined with the fact that mainstream services deliver an estimated positive BCR (£1.23), implies that the overall value for money of the drug and alcohol treatment system may have been reduced in the short term. After the implementation phase, however, the data shows a positive turning point, suggesting that once the services were fully embedded and staffed, they generated additional value. Overall, the CCA demonstrates the programme's potential in helping a vulnerable population that is otherwise left behind, proposing a strong moral case for intervention as well as suggesting that the value for money trajectory may be positive in the longer-term.

9.7 Concluding comments

The RSDATG grant provided additional resources which enabled the introduction of new and enhanced services for a previously underserved and particularly challenging cohort, against a background context of increased numbers of people experiencing rough sleeping and increased substance-related deaths amongst the general population. The funding was highly valued by commissioners and enabled a greater intensity of support to be provided, better tailored to individual needs and delivered following trauma-informed principles. The grant also acted as a catalyst to bring services together, building on existing structures and partnerships, to provide the multi-agency responses necessary to meet service users' inter-linked needs, achieve positive

outcomes and move towards substance-free lives. This had also resulted in positive impacts for services working with the cohort.

There was strong qualitative evidence that RSDATG-funded teams had successfully engaged a particularly complex cohort who faced additional challenges achieving outcomes, perhaps more so than envisaged in the initial policy intent or in forecasting its effects. In the views of commissioners, RSDATG-funded staff and other services working with the cohort, and service users, the grant had successfully supported the cohort to prepare for, enter and complete treatment; find and sustain accommodation; improve their health; and reduce substance harms and related deaths to a greater extent that would have been possible in its absence. These views were supported by the RSDATG MI, which showed that in terms of numbers entering and completing treatment, and numbers entering IPD/RR, performance was close to or slightly below that expected at the outset. Commissioners and RSDATG staff also expressed the view that some outcomes, notably about treatment completion and recovery, were unrealistic for many RSDATG service users in the short to medium-term.

However, findings on other outcomes were less positive: evidence from across a number of sources suggests that the funding has had more limited impact on overall housing outcomes, and on obtaining mental health support for service users, than anticipated.

Considering treatment outcomes, it is likely that some of the RSDATG cohort would have engaged with treatment services anyway, given the share receiving treatment prior to engaging with RSDATG. It is also possible that by increasing the number of particularly complex service users in treatment RSDATG crowded out others with housing needs but with lower levels of accompanying needs. The time series analysis supports the hypothesis that in the early years RSDATG displaced mainstream services, so while RSDATG enabled more people with greater needs to enter treatment the overall numbers in treatment were little affected until later in the funding period.

This displacement is likely due to skill shortages in the drug and alcohol treatment and recovery sector, leading to staff constraints as both RSDATG and mainstream services drew on a common, but limited, recruitment pool. This was reflected in delivery organisations' experiences of recruiting staff to RSDATG-funded roles, particularly in the early stages of the grant, and reflected wider capacity constraints across the treatment system.

The injection of additional resources from multiple funding streams to a system experiencing capacity constraints may have created other pressures on services beyond the displacement effects described above. As both RSDATG and mainstream services worked with increased numbers of service users across the funding period, this exerted additional system pressures on other local services, such as accommodation, particularly for move-on purposes; local health and mental health services; and the availability of IPD/R. While these pressures would have influenced the ability to achieve impacts for RSDATG and mainstream service users, they are likely to have been felt most acutely by the RSDATG cohort, despite the best efforts of the projects and their partners, given the additional challenges they faced.

In conclusion, the findings of the evaluation are mixed, with examples of improved performance for the RSDATG cohort compared to mainstream service users whilst in other cases the effects were more neutral or in some cases negative.

However, the qualitative findings demonstrate that there is a continued need for an intensive, outreach-led approach to addressing substance use for those experiencing rough sleeping or at risk. In this case the initial rationale for the programme is proven, at least in part, and there is strong evidence of continued need for the intensive support which the additional capacity provided by RSDATG funding allowed. Given the mission focus of the current government on addressing rough sleeping, and the wider moral imperative for improving the lives of some of the most disadvantaged members of society, there is a strong argument for dedicated support for those with the most complex needs. How this continued support for the cohort can best be structured is considered in the recommendations that follow.

10 Recommendations

10.1 Introduction

Across the RSDATG funding period the numbers of people experiencing rough sleeping, and substance-related deaths amongst the general population, have increased. This illustrates the need for continued, intense support to address the needs of those facing the greatest challenges to recovery and to sustain the improvements reported both across the RSDATG areas and in wider mainstream services – particularly as some of the other funding streams, such as project ADDER, which also supported improved provision draw to a close.

There are also opportunities to share and adopt lessons from local areas' experiences of RSDATG service delivery, which apply equally to mainstream services. Similarly, the approaches and partnerships developed to deliver the grant represented positive improvements for the cohort, and commissioners, staff and partners expressed concerns that without continued support these benefits risked being lost.

Our recommendations for RSDATG areas, and for OHID and for central government more widely, are provided below.

10.2 Recommendations for commissioners and providers in RSDATG areas

RSDATG funded areas should:

1. Seek to explore, in collaboration with their local partners and OHID, **how the improved services for the RSDATG cohort can be sustained going forward**. Aspects that made RSDATG different, such as the increased capacity to deliver outreach, provide intense support and offer increased flexibility in provision were all aspects that commissioners were keen to continue. These will be dependent on the final configuration of DATRIG funding, and inevitably the level of funding available in future years.

2. Take steps to share experiences and learning from RSDATG delivery with partners, mainstream drug and alcohol services, and associated services in their areas. This should focus on the practical to enable effective practice to be embedded in local service provision.

3. Continue to **proliferate and embed trauma-informed principles with local services**, to ensure common levels of understanding and promote their application in practice. There remains work to be done to ensure services working with the cohort are following trauma-informed practices, and to ensure their policies align with the underpinning principles, so they avoid stigmatising service users and enabling equality of access.

4. Where existing in-patient detox and rehab facilities are in place, areas should **continue to work closely with them to improve understandings of treatment readiness and referral processes**. Areas should also consider whether their referral and approval processes could be streamlined to limit any delays to entry.

5 Local areas should consider whether there are **options for improving the availability of appropriate accommodation for service users**, particularly for those with more complex needs and including 'dry' move-on accommodation. This would include working with housing associations and representatives of the private-rented sector to include innovative options to improve accommodation supply.

6 Local areas should decide on the most appropriate local arrangements for the management and coordination of efforts to secure accommodation for service users, which most effectively draw upon local knowledge, experience and local partner networks. These could include having a dedicated housing lead within the project itself, or follow more of a partnership model, depending on existing local arrangements and structures.

However, to sustain the positive progress made by RSDATG, continued funding for the cohort will need to be provided, and addressing common challenges such as limited local housing supply or to improve wider capacity within drug, alcohol and aligned services, are beyond the influence of individual local authorities. Below, the evaluation team provides recommendations for OHID and central government.

10.3 Recommendations for OHID and central government

Our recommendations for OHID and central government are provided below.

1 OHID, and other central government partners, should consider **how best to enable the positive developments resulting from RSDATG to be sustained**. Given increases in rough sleeping and substance-related deaths over the funding period, demand for more intensive, flexible and multi-agency responses will continue to be required if the need of those with most complex characteristics can continue to be met. OHID should consider:

- Providing **longer-term funding to meet the needs of the RSDATG cohort**, rather than on annual basis as under RSDATG. This would enable improved long-term planning, improve the attractiveness of RSDATG roles, and provide the necessary resources to ensure improvements are embedded and sustained.

- **How best this continued provision should be positioned** – either as discrete services or integrated within local mainstream drug and alcohol services. Both options offer potential strengths and weaknesses, and decisions should also consider existing local provision and specific local needs. This may be best negotiated between OHID and local areas, although it will be critical that any future arrangements maintain a close focus on those with the most complex needs. This would include ring-fencing allocations where services for the cohort are integrated within mainstream services, to ensure continued focus.

- Consider introducing **more structured targets for local service outputs and outcomes** – with appropriate and clearly defined output and outcomes measures and data collection and reporting requirements for funded areas. Care should be taken in establishing suitable

measures to ensure they capture relevant data while remaining practicable to implement by local areas, and that their application has the desired intent of driving service performance without introducing perverse behaviours such as cherry picking (which would risk those with the most complex needs missing out). Measures should capture treatment entries, completions and outcomes, but also seek to include engagement, harm reduction and associated progress measures.

2 OHID and central government partners should also consider how the **capacity constraints identified in the evaluation can be addressed**, particularly in terms of the supply of move-on accommodation, improved access to mental health services, and the availability of IPD/R. This will require action across government, as in the recommendations below.

3 OHID and central government partners should consider **how best to improve the availability of suitable 'move-on' accommodation, and wider temporary accommodation**, to better meets the needs of those with complex needs. While it may be possible to re-purpose some existing temporary accommodation to better meet the needs, this would exert additional pressures on existing temporary provision. Instead, the evaluation team suggests consideration be given to a more radical solution, which while requiring significant and long-term funding could make a material difference to the availability of move-on accommodation. This would involve:

- OHID and MHCLG jointly funding a programme of investment in 'dry' move-on accommodation delivered in partnership with local authorities, housing authorities and third sector providers working with people experiencing rough sleeping. This could be by funding the re-purposing of existing accommodation or purchasing and modifying suitable properties.
- Each site would be staffed to provide the support for people leaving treatment, with the capacity to deliver positive activity programmes and linked to local education, training and employment provision to help service users reintegrate and become self-supporting. This would also help build resilience so service users can move to their own permanent accommodation.
- This would create a national network of move-on accommodation to be used both by the local authorities where the facilities were set and others sending service users out of area following treatment.

4 OHID should consider how best to **increase the supply and improve access to in-patient detox and rehab provision** for people with complex needs, given the decline in availability in recent years. This will require:

- Research to establish and map the current availability of inpatient detox and rehab facilities nationally, including their characteristics and ability to cater for people with varying needs.

- Consider the feasibility of a programme of investment in new or expanded facilities to arrest the decline in supply, which will require capital and long-term revenue funding to ensure sustainability.

5 Consider, with DHSC at a national level, **how mental health support for people with** co-occurring conditions **could be improved**. This will require investment to increase capacity and exerting influencing changes to local policies and practice.

- First, OHID and DHSC should consider a programme of investment to increase capacity of mental health services, with a particular focus on co-occurring conditions provision, to enable the needs of those facing mental health and drug and alcohol can be met concurrently.

- Second, OHID and DHSC should more forcefully communicate existing NICE guidance on co-occurring conditions, and more strictly reinforce compliance with it. This should also be paralleled with efforts to influence change in mental health service policy and procedures, for example discharging those missing appointments or not engaging with those using substances, to make services more trauma-informed and more easily accessible to people with complex needs.

- OHID and government partners should continue to emphasise the importance of trauma-informed working across drug and alcohol, homelessness services and aligned services, with clear guidance on how trauma informed principles can best be put into practice.

6 Consider improving the availability of data to better evidence effectiveness, including:

- Re-introducing national data collection on the numbers of substance-related deaths amongst people experiencing rough sleeping/at risk, to enable trends to be established and the effectiveness of harm reduction approaches more robustly explored; and

- Exploring whether the data variables in NDTMS can be improved to more precisely characterise and differentiate those with more complex needs from the others with housing and drug and alcohol issues. As above, this would enable a richer picture of tends to be established, and allow the improved assessment of comparative outcomes and achievements.

7 The final recommendation relates to areas uncovered by the evaluation where further research would be beneficial, as listed below.

- Research to **further understand the extent to which the drug and alcohol treatment journey is different for specific populations**, the extent to which approaches designed for these specific populations are needed, and the effectiveness of these where they exist.

- Research to **develop approaches to treatment for 'new and novel' substances**, which could include Spice and other synthetic cannabinoids, diverted prescription medications such as

pregabalin, and chemsex drugs such as GHB. This suggestion is not for a clinical study – though such a study may indeed be of benefit – but rather research into what solutions are available. Research could look to organisations such as Terrence Higgins Trust's work on chemsex.

- A comparative study to **understand the efficacy of community-based treatment, in contrast with inpatient/residential detox and rehab**. The evaluation found that some service users were able to treat their substance use without needing to engage with inpatient/residential services, so improved knowledge of the reasons behind this could help services to implement person-centred pathways for service users in the future.
- Current understanding is limited in terms of the **provision of 'dry' move-on accommodation** for people experiencing rough sleeping with drug and alcohol issues, who are leaving detox and rehab. Research could seek to understanding the current position and explore practical solutions where this is currently lacking, including an element of market testing.
- There also appears to be a **knowledge gap around the link between homelessness and gender**. In particular, it would be helpful to have more data on the experiences of women experiencing homelessness, who are categorised as 'unaccompanied' (by their children). In addition, greater understanding of the role of homelessness in family separation could help to improve future service pathways for this particularly vulnerable group.
- A **longitudinal study with the cohort, to explore recovery trajectories over time**. A study of this nature could extend beyond the 'typical' evaluation period to better understand service users' relapses and responses, helping to design pathways and services to better meet service users' needs in future as a result. However, this would be a very complex and challenging study to deliver.