RSDATG Evaluation

Presentation of findings

May 2026

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Key messages

- RSDATG enabled provision of intensive, specialist support for **people with complex and high levels of need**.
- The outcome most consistently identified from the funding was that people experiencing rough sleeping or at risk were **engaging with drug and alcohol services when they were not previously able to** and that services were more effective **at keeping them engaged.**
- This was done by making services **more accessible**, developing good **relationships**, and providing **wrap-around support**. This was made possible by increased capacity / lower caseloads and the impetus RSDATG provided to focus on this group.
- RSDATG-funded services **supported more people annually** than anticipated.

Key messages

- The number of those **in recovery** having been supported by RSDATG was broadly as anticipated (c. 740 per year).
- The funding shifted the profile of those engaged with treatment services **towards those with higher levels of need**, and after the first few years, increased the overall numbers of people in housing need in treatment relative to non-funded areas.
- Impacts on housing outcomes and on access to mental health services were **limited by external capacity pressures,** but there are many examples of areas working effectively to tackle these issues.
- Interviewees stressed that many people in the RSDATG group would need **ongoing, long-term support.**

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About the evaluation

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The evaluation had 2 key aims and 9 themes

- To assess the **impact of the funding** on the grant's key objectives
- To gather **evidence on best practice** for supporting people experiencing rough sleeping, or at risk, with substance use problems -

Impact on service user treatment outcomes
Economic impact and cost effectiveness
The service user experience
Improved access to/effectiveness of inpatient detox and residential rehab provision
Accommodation and treatment outcomes
Impacts of trauma informed and psychologically informed working
RSDATG fit with local provision and alignment with other funding streams.
Experience of staff recruitment and retention issues
Lessons for the development and delivery of future policy

Evaluation delivery team

Ipsos conducting qualitative fieldwork with staff, data analysis, and overall synthesis and reporting

Groundswell conducting qualitative face-to-face fieldwork with service users

Dr Stephen Green (Sheffield Hallam University) providing advisory support to design, analysis and reporting

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The evaluation findings are based on qualitative and quantitative analysis

Qualitative data from 533 interviews, covering nearly all the funded local authorities:

- Service users (89)
- Commissioners and project managers (107)
- Delivery partners and frontline staff (202)
- Other local stakeholders, e.g. from organisations interacting with funded roles and services (102)
- OHID & MHCLG staff (33)

Analysis of monitoring data submitted by all funded areas

Analysis of NDTMS data from ten case-study areas

Analysis of cost data from ten case-study areas

Desk review of programme documents and documents from case-study areas

Strengths and limitations of the evaluation approach

Strengths

Engagement with service users brings crucial perspective

Case study approach provides depth

Reach of the evaluation to almost all funded areas

Triangulation of qual and quant findings

Contribution analysis allows systematic assessment

Limitations

Recruiting staff in some roles

Revisiting service users

Identifying suitable comparison group for impact analysis

Identifying precise impact of specific interventions

Gaps in monitoring data

Outcomes hard to value in monetary terms

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Findings

RSDATG funding had three key objectives

RSDATG comprised £262m of funding given to 83 LAs over 2021-25. Its aims were:

- Improving drug and alcohol treatment outcomes for people experiencing rough sleeping or at risk
    - Initial engagement
    - Sustained engagement
    - Treatment completion and recovery
- Reducing rough sleeping
- Reducing deaths from drugs or alcohol amongst people experiencing rough sleeping or at risk

RSDATG took place alongside several complementary initiatives

Ending rough sleeping

- Rough Sleeping Initiative
- Homelessness Prevention Grant
- Rough Sleeping Accommodation Programme
- Single Homelessness Accommodation Programme

Multiple needs

- Changing Futures

Drug Strategy

- Supplemental Substance Misuse Treatment and Recovery Grant
- Inpatient detox funding
- Project ADDER
- Drug Strategy Housing Support Grant

No standard model, but commissioners had common goals

- How funding was used depended on existing provision, and its strengths and weaknesses
- Multiple interventions and a variety of roles
- Some key themes:
  - Making services more accessible - outreach
  - Meaningful relationships – reduced caseloads
  - Wrap-around, holistic support – multi-agency approach
- RSDATG seen as **more flexible than other sources of funding**, allowing commissioners to complement and fill gaps

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Funding was used to work with people facing the most barriers to services

Funding was seen as an opportunity to work with the most vulnerable, entrenched and 'at risk' people, who faced multiple disadvantages as well as housing and substance use problems.

- Long history of substance use
- Co-occurring mental health conditions
- Past and/or current experience of trauma
- Contact with criminal justice system
- Experience of abuse
- Poor physical health
- Brain injury and/or cognitive difficulties

Many had a long history of engaging with services, including drug and alcohol services. Past experiences of being excluded, stigmatised or let down had made people feel mistrustful and wary of engaging.

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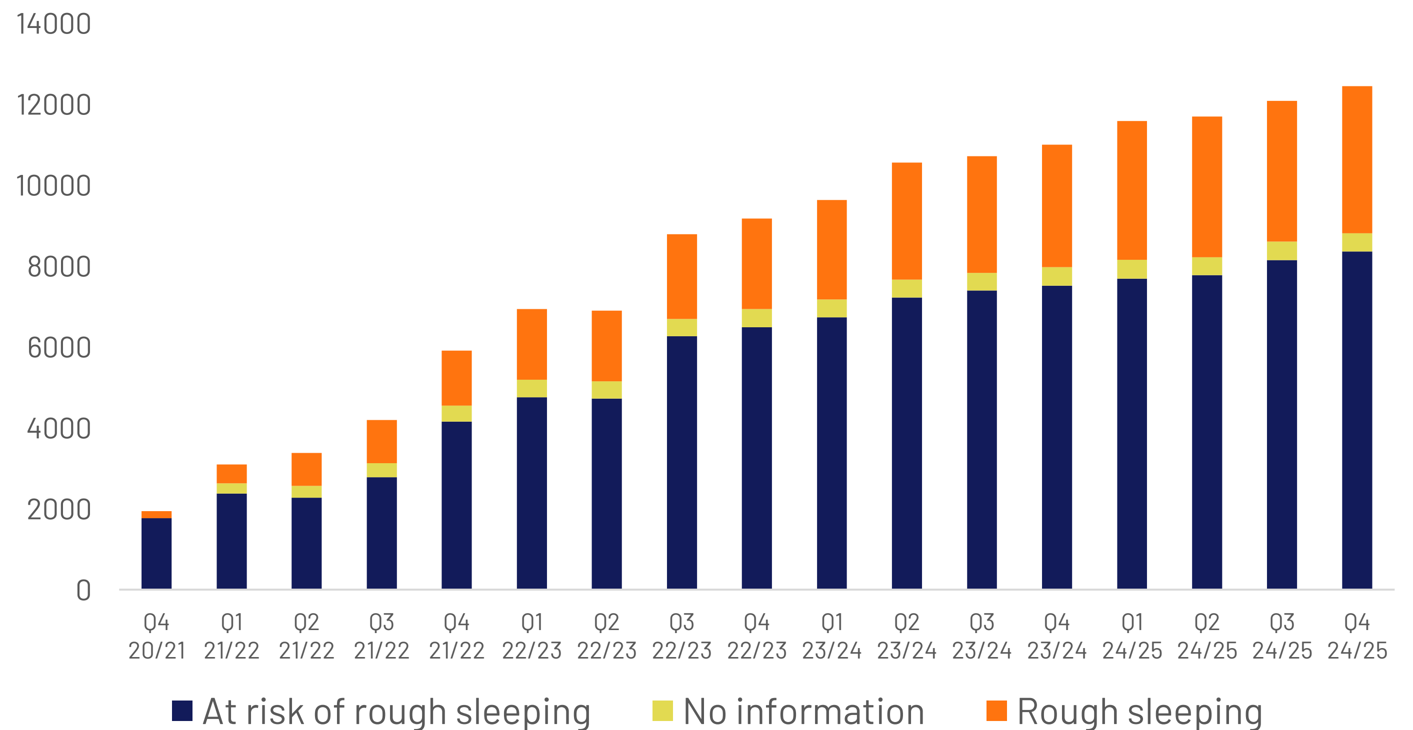
Funded roles and services engaged more people than anticipated

- 19,500+ people supported by RSDATG in final year of funding
- 30% of those supported were experiencing rough sleeping, 70% considered to be 'at risk'
- Around a quarter of service users were women



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The funding helped keep people engaged in treatment

RSDATG was seen as helping individuals engage and helping them achieve greater stability and progress. This resulted in:

- Reduction/stabilisation in drug or alcohol use
- Fewer drug and alcohol related harms
- Better physical health
- Building trust in services
- Reducing drug-related deaths compared to absence of grant

"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

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RSDATG's impact on numbers in treatment was limited at first

- Numbers of people in housing need in treatment increased in areas receiving RSDATG funding, but at first by no more than increases that were **also seen in non-funded areas** (likely due to additional Drug Strategy funding).
- Two likely explanations for this:
  - Around half of RSDATG service users were already engaging with treatment services
  - Capacity (staffing) constraints within services in RSDATG areas that prevented them expanding further
- **RSDATG enabled local authorities to shift the profile of those engaged with treatment services towards those with higher levels of need.**
- **After 2.5 years, numbers in treatment increase in funded areas more than the national trend.**

Treatment completion rates were relatively low, although this was in line with local expectations

- Treatment completion not seen as realistic outcome for large proportion of cohort
- Completion rates lower than predicted (because predicted based on mainstream pop.)
- But number of people anticipated to be in recovery following RSDATG support was broadly achieved (c. 740 per year)
- Some evidence of developing effective pathways into detox and rehab

"In the past... 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... And there have been some really good outcomes from people that we wouldn't have funded detox and rehab before in the past." – Commissioner

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Shortages of housing made it challenging to affect housing outcomes on a wider scale

- Interviewees noted widespread shortages of housing, especially supported housing, move-on accommodation for people leaving residential treatment, women-only housing, and options for people with NRPF
- Some areas intended to fund accommodation directly, but this proved impractical
- This made it challenging for the funding to affect housing outcomes
- Overall rough sleeping has increased in the funded areas by 10% (compared to 9% in England as a whole)

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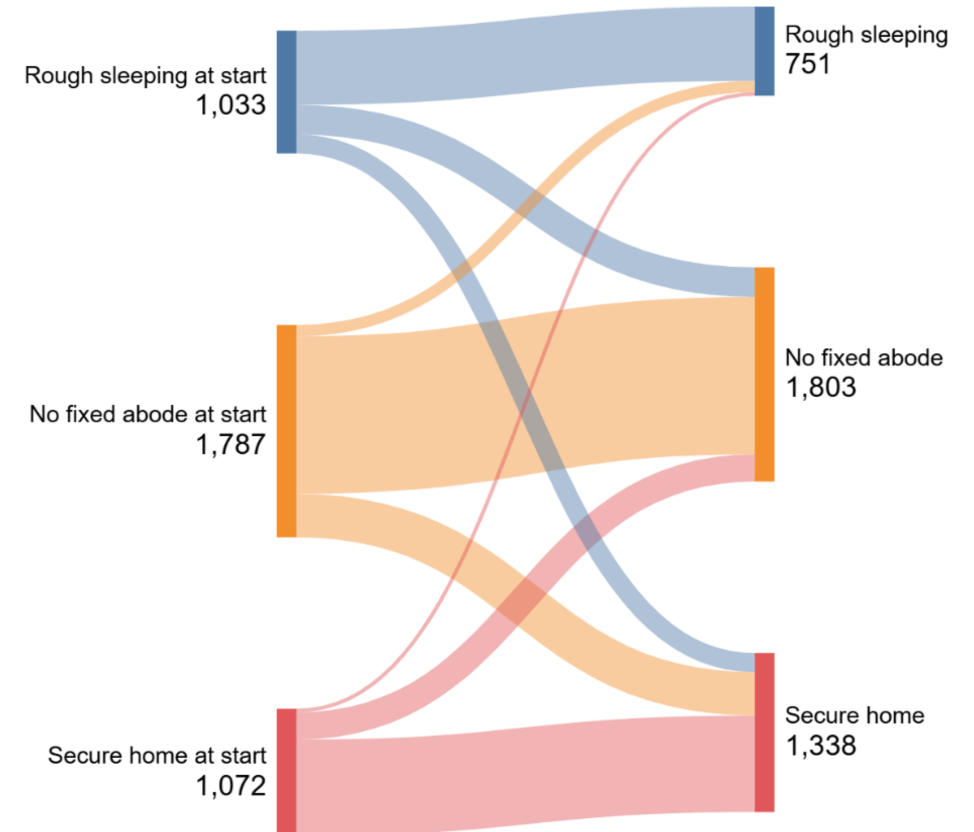
But some evidence of positive housing outcomes from case study areas

- In the ten case study areas studied, 40% of RSDATG service users who were rough sleeping at start were no longer rough sleeping at most recent data point
- Some qualitative evidence of lower eviction rates and of 'most entrenched' being housed successfully

"[My RSDATG worker] has been brilliant, absolutely, he's done everything. When you get in contact with [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.'" – Service user



Housing outcomes for RSDATG service users in ten case study areas

RSDATG funding was used to support physical health

As part of a holistic approach to supporting people, and as a way to encourage initial engagement

Enabling people to engage with health services

- Health buses, drop-ins
- Accompanying people to appointments
- Advocacy
- Registering people with (sometimes specialist) GPs
- Training for GP practices
- Hospital liaison

Delivering health interventions

- Vaccinations
- Oral health
- BBV testing
- Wound care
- Sexual health screening and contraception
- Smoking cessation
- Liver scans

"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." – Service user

Funding provided resources and impetus to improve collaboration between services and understanding of the RSDATG cohort's needs

- Improvements in **collaboration** between services: due to new or more effective multi-disciplinary working, information-sharing arrangements, co-location of services, and dedicated resources and capacity to support these activities
- Improved **understanding of the RSDATG cohort** among services: through funded awareness-raising and training activities (particularly around **trauma-informed working**), through more collaborative working, and by providing impetus for commissioners to research the needs of this group
- Improved **job satisfaction** for staff through being able to work more flexibly and develop relationships

"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

What worked well: outreach and reducing barriers to engagement

- Outreach and in-reach, taking services to where people are
- Offering harm reduction and basic healthcare to encourage initial engagement
- Providing a quick response, in particular same-day prescribing
- Joint outreach using complementary skills and knowledge
- New pathways into residential treatment for people with complex needs
- Taking people to visit residential treatment providers in advance of treatment to establish understanding and address concerns

"I don't come into the office very much and to be honest, if it was a normal organisation, then they would probably discharge me, they'd have probably sent me on my way… Because I don't engage with them, I've made it difficult, where he's actually come out and found me, he's tracked me down and made sure that I'm okay and made sure that I'm still alive." – Service user

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What worked well: building relationships and trust

- Persistence in engaging people
- Staff having time to 'hand-hold' people during their engagement and follow up if they were appearing to disengage
- Offering social and creative activities, personalised budgets
- More flexibility around non-attendance policies
- Setting realistic goals
- Using trauma-informed working to understand how best to support people and respond to challenging behaviour
- Emphasising that aftercare will be available following residential treatment

"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

"Well, a lot of people, normally, like, order you around ... but [staff member] knows how to turn it around, he knows how to talk to me and he knows how to help me by giving me the right guidance ... He's actually learnt what I'm like, to approach me in the right way, so he can get the right stuff out of me." – Service user

What worked well: supporting people with other needs beyond substance use

- Organising drop-in hubs or events where service users can access multiple services and referrals can happen immediately
- Providing advice on housing options, accompanying people to assessments and helping them with housing applications
- Helping people maintain tenancies by supporting them to develop life skills, obtaining household goods and negotiating with providers/landlords
- Using MDT meetings to identify housing options or put support in place to prevent eviction
- Recruiting a social worker to assess and advocate for people in this cohort (though they can quickly reach capacity limits)

"If you need something done, they go out of their way to actually help you. Even if it was something not to do with drug use or whatever. So, like, I got problems with [mental health provider]. I've got a son, and he's under social services. My worker helps me with all that as well. So, not just drugs… they put extra work in what really they don't have to do." – Service user

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Summary of key challenges

- Shorter-term nature of funding affecting recruitment, longer-term support offer, and ability to innovate
- Some individuals required more support than RSDATG services had initially planned for
- Lack of housing, especially supported housing, housing pre- and post-residential treatment, and options for NRPF
- Unmet mental health needs a key barrier to achieving substance misuse outcomes
- Limitations to system change (e.g. fostering trauma-informed working) because of relative scale of RSDATG

Funding was used to help service users access mental health support and sometimes to provide this directly

- Commissioners identified a gap in mental health support for this cohort
- Limited capacity at mental health services created barriers to access
- Dual diagnosis workers had some impact in advocating for service users, accompanying them to appointments and helping them prepare
- Other approaches included training staff on writing more effective referrals
- However, challenges remained in accessing mental health support
- Some areas directly funded mental health support for service users, either a pre-engagement service or ongoing support for people who would struggle to access NHS mental health care

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Recruitment was a key challenge, particularly at the outset of funding

Recruitment challenges were attributed to:

- Skills shortages in sector e.g. mental health professionals
- Short-term funding allocations
- Lots of grants/initiatives recruiting over same period

This sometimes led to services being understaffed and not able to deliver as planned. Responses to this included:

- Recruiting for values and attitudes rather than qualifications, and providing training
- Developing staff through peer mentors and volunteers

THANK YOU

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