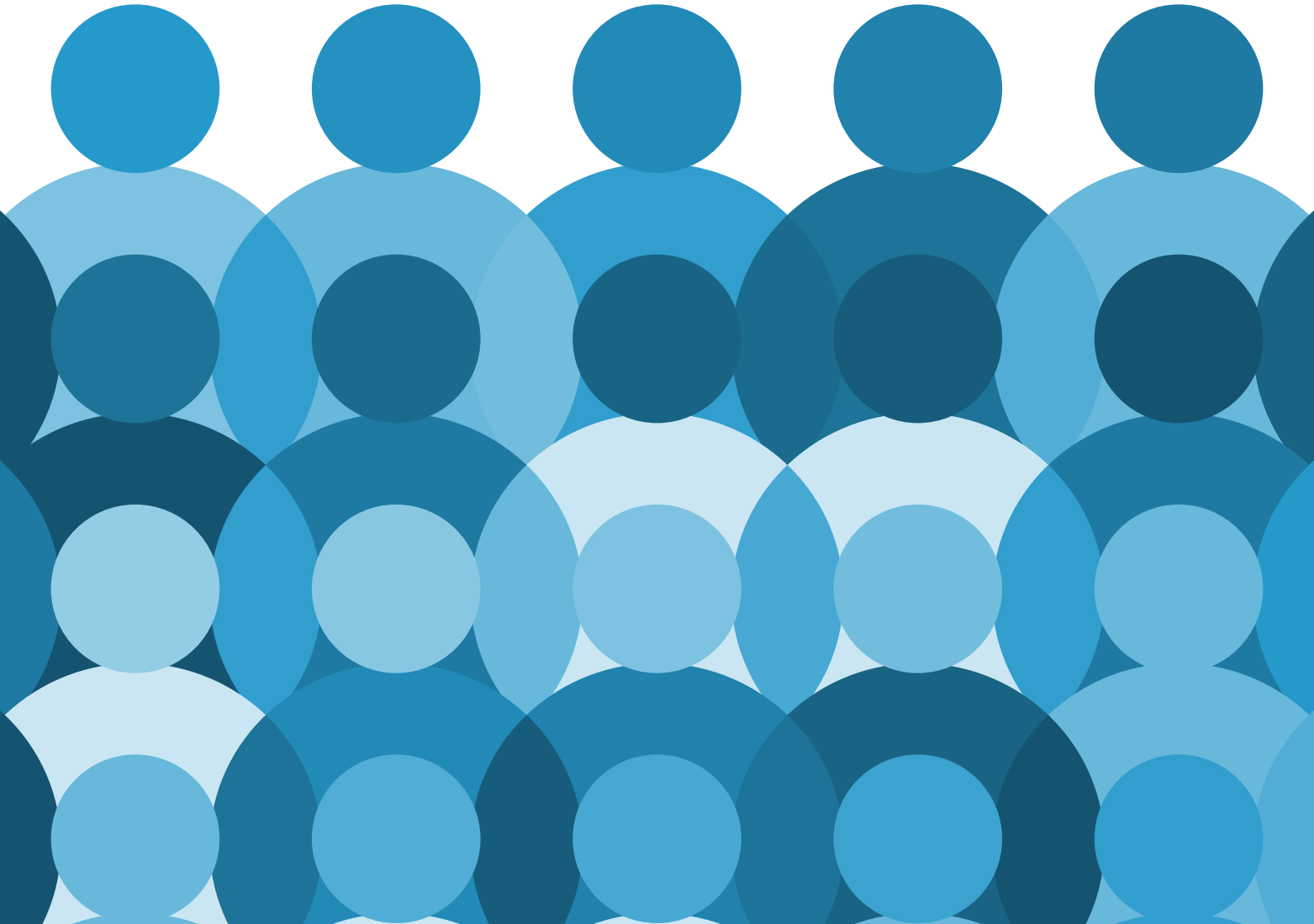
Implementation and early impacts of the Housing Support Grant in England

Kayleigh Sharp, Jennifer Bousfield, Avery Adams, Jessica Dawney, Alessandro Grosso, William Phillips, Lucy Strang, Katherine Morley, Jennifer Bostock, Andrew Jones, Nicola Kalk, Tom Ling, Tim Millar, Joanne Neale, John Strang, Jon Sussex & Jennifer Newbould on behalf of the D-SITAR team



Funded by
NIHR | National Institute for Health and Care Research

Funding for this study has been provided through a research grant from the National Institute for Health and Care Research (NIHR) Policy Research Programme (PRP). The number for this grant is NIHR205228.

The views expressed in this research are those of the author(s) and not necessarily those of the NIHR or DHSC.

For more information on this publication, visit www.rand.org/t/RRA4735-2

About RAND Europe
RAND Europe is a not-for-profit research organisation that helps improve policy and decision making through research and analysis. To learn more about RAND Europe, visit www.randeurope.org.

Research Integrity
Our mission to help improve policy and decision making through research and analysis is enabled through our core values of quality and objectivity and our unwavering commitment to the highest level of integrity and ethical behaviour. To help ensure our research and analysis are rigorous, objective, and nonpartisan, we subject our research publications to a robust and exacting quality-assurance process; avoid both the appearance and reality of financial and other conflicts of interest through staff training, project screening, and a policy of mandatory disclosure; and pursue transparency in our research engagements through our commitment to the open publication of our research findings and recommendations, disclosure of the source of funding of published research, and policies to ensure intellectual independence. For more information, visit www.rand.org/about/research-integrity.

RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

Published by the RAND Corporation, Santa Monica, Calif., and Cambridge, UK

© 2026 RAND Corporation

RAND® is a registered trademark.

Cover: Adobe Stock

Limited Print and Electronic Distribution Rights
This publication and trademark(s) contained herein are protected by law. This representation of RAND intellectual property is provided for noncommercial use only. Unauthorised posting of this publication online is prohibited; linking directly to its webpage on rand.org is encouraged. Permission is required from RAND to reproduce, or reuse in another form, any of its research products for commercial purposes. For information on reprint and reuse permissions, please visit www.rand.org/pubs/permissions.

Conflict of interest statement

Prof John Strang is a clinician and academic who has worked with local, national and international government and non-government agencies to develop and test new approaches to tackling addiction and related problems. Through his employer (King's College London), he has received research and project grant support from a range of government and charitable research agencies and charitable organisations. Through the university, he has also worked with pharmaceutical and technology companies, from some of whom the university has received project grant support, honoraria and/or consultancy payments. In the past three years, these have included MundiPharma, Camurus AB, PneumoWave, Accord and Navamedic, alongside medication or device supply (PneumoWave, CMI and Catalent) to develop or study potentially improved formulations and devices. His employer (King's College London) has registered intellectual property for an innovative buccal naloxone formulation with which Prof Strang is involved, and he has been named as an inventor in a patent registration by a pharmaceutical company for a concentrated naloxone nasal spray. He is also named as a Patron of Addiction Family Support (formerly DrugFAM), a UK-based registered charity, and supported by the National Institute for Health and Care Research (NIHR) Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust and King's College London.

Since 2022, Prof Joanne Neale has received research funding from pharmaceutical companies Mundipharma and Camurus AB and honoraria from Indivior and Camurus AB for conference presentations and dissemination activities relating to drug treatment (including Buvidal) and recovery through her university (King's College London). She has also received honoraria from Addiction and the International Journal of Drug Policy for editorial work and from the Canadian Centre for Recovery Excellence for participating in an Expert Reference Group for a national survey of recovery from alcohol and other drug use.

Between 2019 and 2022, Prof Tim Millar was Chair of the Data Monitoring Committee for the investigator-led, industry-funded Extended-release Pharmacotherapy for Opioid Use Disorder (EXPO) Trial of depot buprenorphine preparation a (non-pecuniary) (EU Clinical Trials register 2018-004460-63).

As of December 2025, Dr Nicola Kalk is the Chief Investigator on the NIHR-funded, investigator-led research study BUILD2depot (NIHR206657), for which Camurus AB provides in-kind support to her employer.
The other authors of this report declare that they have no competing interests.

RAND Europe received sales data for quantitative analysis from Camurus AB in this project. This was non remunerated and Camurus AB did not receive early access to report methodology or findings.

Preface

This report is part of a wider RAND Europe evaluation of the former UK government's ten-year drug strategy investment in the Treatment and Recovery Portfolio in England (D-SITAR). As part of the Portfolio, the Department of Health and Social Care (DHSC) has provided additional funding to local authorities to improve treatment and recovery services for people who use alcohol and/or other drugs following Dame Carol Black's 2019–2021 independent review of drugs. In 2023, RAND Europe and partners (King's College London, South London and Maudsley NHS Foundation Trust, the University of Manchester and the University of Queensland) were awarded a grant by the National Institute for Health and Care Research (NIHR) to evaluate implementation of the first three years of the investment for adult services.

This report presents the results of an evaluation of the Housing Support Grant (HSG). This evaluation is accompanied by four further evaluations of priority areas of the Portfolio, focusing on the workforce transformation programme, Lived Experience Recovery Organisations, mental and physical health service integration and the provision of depot buprenorphine, as well as a process evaluation of the first three years of implementation of the Treatment and Recovery Portfolio. The results of these evaluations are described in separate reports.

This study is funded by the NIHR Policy Research Programme (NIHR205228). The views expressed are those of the authors and not necessarily those of the NIHR or the DHSC. This work was produced by the Health and Care and Defence, Security and Justice teams at RAND Europe under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care.

Keywords: Housing Support Grant, drug and alcohol treatment and recovery services, Supplementary Substance, Misuse, Treatment and Recovery grant

Executive summary

Background

Dame Carol Black's 2019–2021 independent review of drugs highlighted the importance of safe, suitable and stable housing in the treatment and recovery journey (Department of Health & Social Care 2021). In 2022, through the Housing Support Grant (HSG), the former UK government provided up to £53m across three years to help local authorities (LAs) address the housing needs of people who use alcohol and/or other drugs. During this period 28 LAs received the HSG as a pilot to gather learning from the programme for future policy development. This funding aligns with the ongoing implementation of the former UK government's 10-year drug strategy 'From Harm to Hope' (HM Government 2021), which included ambitions to improve access to safe and suitable housing for people who use alcohol and/or other drugs. The HSG was designed to support people who use alcohol and/or other drugs, irrespective of whether they were receiving structured drug or alcohol treatment.

The HSG aimed to enable more people to maintain or access appropriate housing and improve housing stability, reduce barriers to accessing treatment for alcohol and/or other drugs, and to improve treatment outcomes. LAs and other local stakeholders were encouraged to integrate key service design principles into their intervention plans, including tailoring support to align with local population needs, increasing the flexibility of service delivery and promoting partnership working. They could choose from several interventions, including recruiting specialist housing support workers, providing specialist staff training and offering personalised budgets enabling staff to pay for services or items that support housing needs.

Study aims

This evaluation aimed to understand how the HSG has been implemented by reviewing 28 plans and examining three case study sites in England. The research focused on whether the HSG was implemented as intended, the barriers and facilitators encountered in its implementation, and the influence of wider and local context on delivery. It also aimed to explore what intervention types within the HSG worked well, for whom and why, as well as the impact on health outcomes for individuals in treatment and recovery services and any unexpected outcomes.

Methods

Data was collected across three phases (2024–2025) through:

- Review of HSG plans submitted by commissioners in LAs across all 28 sites that received the HSG
- Interviews with HSG leads in eight LAs that were not included in our case studies
- Case study data collection in three sites, involving interviews and focus groups with people who received HSG interventions and local HSG leads and staff
- Analysis of the National Drug Treatment Monitoring System (NDTMS) and HSG monitoring datasets submitted by LAs.

For the qualitative data, framework analysis was applied both deductively and inductively to identify and develop themes. Analysis of the NDTMS dataset was limited to descriptive statistics. The integration of quantitative and qualitative data was supported by regular team discussions.

Key findings

Implementation and approach

We found that the HSG pilot was generally implemented as planned as an intensive, person-centred approach to address the challenges of housing insecurity for people who use alcohol and/or other drugs. Support was often delivered through a combination of interventions, taking a holistic approach to meet individual needs. While the specific components of the HSG, such as financial interventions and housing support workers, are not new, they appear to be filling important gaps in service provision, building upon existing services and in some instances replacing what had been removed through previous funding cuts. Sites varied regarding whether the HSG was provided to those only in structured treatment, or included those who use alcohol and/or other drugs and are not in treatment.

Many staff and people who use alcohol and/or other drugs praised the adaptability of the HSG and its flexibility to meet local and individual needs. This had enabled treatment and recovery services to align with wider local priorities, such as support for vulnerable women or people who use particular substances. Accordingly, the HSG was described as particularly beneficial for people with additional challenging circumstances not specifically relating to housing (e.g. people who experience cuckooing, people with children, and people with pets).



Service provision and workforce

The HSG funding provided targeted support for people who use alcohol and/or other drugs whose housing was unstable or where tenancies were at greatest risk. This included improved wrap-around support through increasing the number of venues, such as community centres, for outreach, offering more home visits and enabling longer-term support through reducing caseloads in the new housing support worker roles (floating support workers and housing case workers). These roles required additional capacity from skilled staff who could more effectively address housing issues, and who served as 'care navigators' to ensure greater continuity of care. Some tensions were described regarding the implementation of these newly recruited roles, particularly relating to perceived variation in caseloads compared to similar roles within treatment and recovery services.



Partnerships and local adaptation

There was variability in local contexts in the three case study sites, including experiences of previous funding cuts and challenges around staffing levels and expertise, as well as existing partnership working between treatment and recovery and housing services. These were described as influencing implementation by acting as facilitators or barriers. Partnership working between treatment and recovery services and other sectors (e.g. housing providers) also varied. Some initiatives successfully promoted a culture shift in services where engagement with people who use alcohol and/or other drugs was less common, while others struggled to increase awareness and reduce stigma.



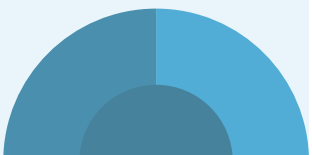
Outcomes and impacts

Our mixed-methods findings show early positive trends among HSG recipients and indicates that the HSG appears to have worked as intended by improving access to housing support services, reducing housing-related barriers and positively impacting health and wellbeing outcomes. Due to the study's limitations, however (a small sample size in the qualitative work, and no control group or complete case analysis against which to compare the quantitative data), no causal attribution to the HSG can be made.



Demand and sustainability

In some LAs, the demand for HSG funding exceeded supply, creating capacity limits for new worker roles and leaving some people unable to access support. This



highlights a tension between what is feasible within the HSG's funding envelope and its aim to meet the housing needs of its recipients, particularly when these needs require more intensive and sustained input. While high demand reflects positive uptake of the HSG, it raises concerns about the sustainability of the programme.



Data and evidence limitations

The research team sought to collect additional data on people receiving the HSG and to link this with their NDTMS records. However, there are several limitations of the data, meaning that some caution should be exercised in its interpretation. It is important to note that many people who received HSG interventions were also in receipt of other interventions for the use of alcohol and/or other drugs and therefore improvements in their circumstances could be due to factors unrelated to the HSG. Further research is required to add clarity on the effectiveness of the HSG.

Recommendations

Central government should continue to fund housing support for those who use alcohol and/or other drugs. The grant was received very positively by staff and people who use alcohol and/or other drugs, and we recommend further funding for housing initiatives to support this group.

Central government should continue to support LAs to tailor housing interventions to the needs of their population and allow LAs to manage financial interventions. This will enable LAs to continue to tailor provision to their local populations and needs, leveraging local knowledge and enabling equitable housing support.

Central government should examine the variation in LAs' interpretation of eligibility for HSG support across the pilot sites, including differing requirements related to abstinence or engagement with treatment. There is a need for central government to review the perception of the HSG brief by LAs and ensure that their understanding is aligned with the primary aim of improving recovery outcomes for people who use alcohol and/or other drugs through housing support, regardless of whether or not they are engaging with treatment and recovery services.

Central government should develop clear guidelines outlining the purpose of reducing caseload sizes for staff providing intensive support. This should include strategies for coping with the potential impacts on caseload management of longer-term support, including processes for discharge back to a 'non-housing-support'-specific case worker. When designing and implementing new roles within treatment and recovery services, such as those funded by the HSG, it is essential to consider the impact on existing staff, particularly of varied caseloads of staff working within the same service.

The current data structure does not support a robust evaluation of the effectiveness of the HSG. **To strengthen future evaluation, HSG monitoring data and NDTMS should be aligned as closely as possible,** to enable comparable information to be collected for all HSG recipients – whether or not they are in structured treatment – and allow for meaningful comparison with the broader treatment population in NDTMS as a control group. The selection of key variables to be included should be determined through consultation with HSG leads, service-level providers, the treatment and recovery workforce and research and evaluation experts to ensure relevance, evaluation feasibility and minimal burden on staff.

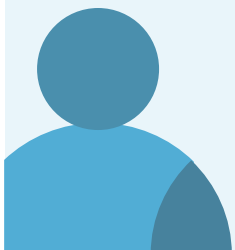


Table of contents

Preface i

Executive summary ii

Figures ix

Tables ix

Abbreviations x

Acknowledgements xi

Chapter 1. Introduction 1
1.1. Background 1
1.2. The Housing Support Grant and its recipients 2
1.3. Research questions 5

Chapter 2. Methods 6
2.1. Research overview and evaluation framework 6
2.2. HSG Plans 8
2.3. Phase 1 interviews and Phase 2 case study site interviews and focus groups 8
2.4. Secondary datasets: HSG monitoring and NDTMS 10
2.5 Mixed-methods integration 12
2.6. Considerations 12

Chapter 3. Results 14
3.1. Individual-level interventions 16
3.2. System-level changes 20
3.3. Service-level changes 26
3.4. Reducing housing-related barriers 29
3.5. Physical health, mental health and social outcomes 32
3.6. What were the wider context influences on implementation? 37

Chapter 4. Discussion 42
4.1. Was implementation carried out as intended? 42
4.2. How have the wider and local contexts influenced delivery? 43
4.3. How did the HSG support people who received HSG interventions? 44
4.4. How have HSG interventions contributed to changes in health outcomes in service users? And for whom? 45

Chapter 5. Strengths and weaknesses **47**
5.1. Strengths *47*
5.2. Weaknesses *47*
5.3. Implications for monitoring the HSG *49*

Chapter 6. Recommendations **51**

References **53**

Annex A. HSG funding (2022-2025) **See supplementary PDF**

Annex B. Implementation research logic model for the Housing Support Grant **See supplementary PDF**

Annex C. SSMTRG Housing Support Grant – Menu of Interventions **See supplementary PDF**

Annex D. NDTMS demographic characteristics for those who received HSG interventions **See supplementary PDF**

Annex E. NDTMS demographic characteristics for all people who accessed drug and alcohol treatment services **See supplementary PDF**

Figures

Figure 1. System-, service- and individual-level changes 15
Figure 2. Graph of cumulative cases by intervention type 17

Tables

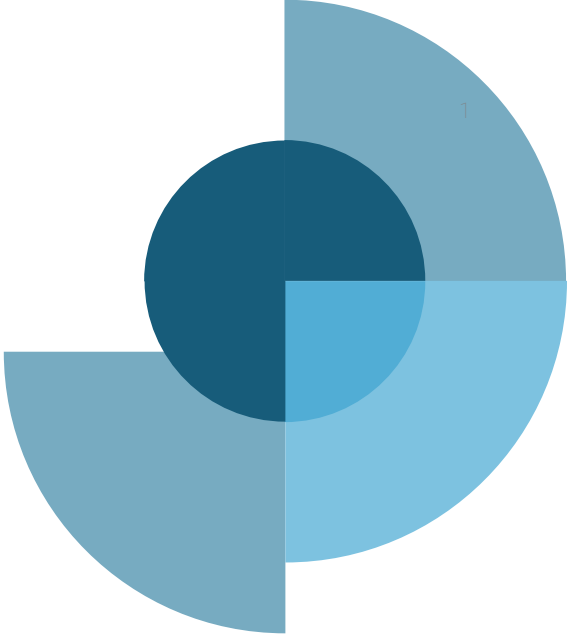
Table 1. Data sources and sample 6
Table 2. HSG monitoring data and NDTMS dataset characteristics 11
Table 3. Type of HSG intervention 17
Table 4. Type of financial intervention 18
Table 5. Type and number of case worker intervention 19
Table 6. Housing-related outcomes 31
Table 7. Health-related outcomes 34
Table 8. Volunteering, education and employment outcomes 35

Abbreviations

CFIR	Consolidated Framework for Implementation Research
DATRIG	Drug and Alcohol Treatment and Recovery Improvement Grant
DHSC	Department of Health and Social Care
D-SITAR	Drug Strategy Investment in Treatment and Recovery
HSG	Housing Support Grant
IPD	Inpatient Detoxification
LA(s)	Local Authority/ies
MHCLG	Ministry of Housing, Communities and Local Government
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NIHR	National Institute of Health and Care Research
OHID	Office for Health Improvement and Disparities
RQ	Research Question
RSDATG	Rough Sleeping Drug and Alcohol Treatment Grant
SSMTRG	Supplementary Substance Misuse Treatment and Recovery Grant
TOP	Treatment Outcomes Profile

Acknowledgements

The D-SITAR team would like to thank the following individuals and groups for their advice and support in delivering this evaluation: commissioning staff at local authorities; staff and people who received HSG interventions at NHS Trusts and third-sector providers in case study sites across England; Phase 1 and 3 interviewees and commissioners who participated in the workshops; members of the Commissioners' Advisory Group, Workforce Advisory Group and Public Advisory Group; and Rosie Beckley, Dame Carol Black, Edward Day, Michelle Cornes, Lauren Crawford, Alex Stevens, Anthony Bullock, Sarah Birch, Martin Smith, Paul Lennon, Brian Eastwood, Simon Robinson, Jez Stannard, Mark Xerri, Jamie Crummy, Cathy Steeghs, Pebbles Buckley, Maria Chisholm, Cristina Sanchez, Mike Nelson, Emma Disley, Joanna Hofman, Nick Fahy, Sonja Marjanovic, Georgina Melia, Frederick Thiede-Merlo, Chris Van Stolk, Stephanie Stockwell, Manon Richard-Sheridan, Ben Horton, Jessica Plumridge, Beth Muldrew, Bethany Elbourne and Victoria Dauvilliers-Nash.



Chapter 1. **Introduction**

1.1. Background

Homelessness is a pertinent issue affecting many people across England, Wales, Scotland and Northern Ireland. Although there are many definitions of homelessness, projected figures typically include people who are living in temporary accommodation arranged by themselves, the council or social services, those staying in hostels who do not qualify as priority need, and those sleeping rough. The devolved countries of the UK have separate housing policies, including the Homelessness Reduction Act (2017) and the Renters' Rights Act (2025) in England, the Renting Homes Act (2016) in Wales, the Housing Act (2025) in Scotland and the Private Tenancies Act (2022) in Northern Ireland. Despite being underpinned by different acts, the devolved nations share a common commitment: to uphold people's rights to safe, adequate and affordable housing; to reduce the barriers to renting and buying a home; to increase the supply of new housing; and to prevent homelessness through early-intervention strategies.

The prevention of homelessness is often emphasised in wider housing policy and drug strategy ambitions, as homelessness and the use of alcohol and/or other drugs[1] are closely linked, with people experiencing homelessness or unstable housing being significantly more likely to experience drug and alcohol dependence (Department of Health & Social Care 2021; Neale et al. 2022; Ministry of Housing, Communities & Local Government 2020; Onapa et al. 2022). Recent data illustrates the scale of this issue. Between 2021 and 2022, 11 per cent of people in England starting treatment for a substance use disorder had a housing problem, with an additional 5 per cent facing urgent housing needs (Office for Health Improvement & Disparities 2023). The COVID-19 pandemic further exposed these vulnerabilities. In the South of England, 36 per cent of residents in emergency accommodation reported needing support for drug use, and 31 per cent for alcohol use (Neale et al. 2022). More recently (2023), homelessness day centres in England reported that 94 per cent of people were drug dependent and 94 per cent were dependent on alcohol (Homeless Link 2024; Ministry of Housing, Communities & Local Government 2020).

---

1 While the Department of Health and Social Care tend to refer to 'drugs and alcohol', we have opted to use this term in keeping with the academic literature on the topic.

While the link between homelessness and the use of alcohol and/or other drugs is well established in the literature, it is not yet understood which housing interventions lead to the best outcomes. Current approaches, such as monetary allowances and direct housing provision, do not show significant differences in reducing substance use, improving mental health and enhancing quality of life (Kerman et al. 2021; Baxter et al. 2019; Miler et al. 2021; Aubry et al. 2020; Moledina et al. 2021). Evidence from a systematic review and qualitative meta-analysis, however, suggests that permanent supportive housing and housing support, not contingent on abstinence, termed a 'Housing First' approach, may reduce mental health symptoms and substance-use-related deaths (O'Shaughnessy et al. 2024), with clients reporting positive changes in their lives (Miler et al. 2022). Furthermore, the housing first approach stipulates continued support for individuals after they have been housed, an important feature that facilitates transition into stable accommodation as research suggests that individuals may face increased isolation and loneliness after leaving temporary accommodation where they were surrounded by staff and peers (Miler et al. 2022). Despite the benefits of the Housing First approach, its implementation is constrained by a lack of available and affordable housing, with Crisis UK reporting that both high rents and a shortage of homes make it difficult for people who are homeless to move into stable housing (Crisis UK, 2026).

Data from 2023 indicated that mental health was the most common support need for people accessing homelessness services, reflecting a 14 per cent increase since 2022 and a 61 per cent increase from 2017 (Homeless Link 2024). People experiencing homelessness are at a higher risk of premature death, often due to non-communicable diseases and substance-use-related causes (Onapa et al. 2022; Kerman et al. 2021; Baxter et al. 2019; Miler et al. 2021; Aldridge et al. 2018). They can also encounter barriers to accessing housing related to social exclusion, stigma and discrimination (Neale 2008). Addressing these interconnected issues requires a comprehensive approach that considers the social determinants of health and reduces barriers to housing access for this population. It is also important to recognise that people who use alcohol and/or other drugs have varied vulnerabilities and may require different types of support.

1.2. The Housing Support Grant and its recipients

In response to Dame Carol Black's 2019–2021 independent review of drug prevention, treatment and recovery, and the importance of safe, suitable and stable housing in the success of treatment and recovery (Department of Health & Social Care 2021), the UK government provided up to £53m across three years to help local authorities (LAs) address the housing needs of people who use alcohol and/or other drugs. In the Office for Health Improvement and Disparities (OHID) and the Ministry of Housing, Communities and Local Government (MHCLG) guidance for implementation, the Housing Support Grant (HSG) is described as 'non-prescriptive in level of engagement': it was designed to support not only people engaged in structured treatment but also those who are not, though are in contact with treatment and recovery services. This is because offering housing support is a potential route to supporting people to engage in structured treatment.

The HSG forms part of the ongoing implementation of the government's 10-year 'From Harm to Hope' drug strategy (HM Government 2021). The HSG was a pilot implemented in 28 LAs that aimed to improve recovery outcomes for people who use alcohol and/or other drugs through housing support, regardless of whether or not they were receiving structured drug or alcohol treatment. The pilot was relatively small scale, with a 'test and learn' approach; it was not intended to provide support to all people who use alcohol and/or other drugs and have a housing need. Rather, learning from this pilot was to inform decision making about future policy development. As outlined in the OHID/MHCLG brief provided to LAs, the aims of the HSG were to:

- Enable more people to retain their tenancies and avoid homelessness, or to access more appropriate housing through early intervention.
- Enable more people to sustain drug and alcohol treatment through supporting housing stability.
- Increase the integration and join up of services for individuals needing support for both their housing and substance use disorder treatment needs.
- Increase the recruitment and retention of skilled staff into housing support services and reduce the occurrences of burnout.

Rather than funding housing directly, the HSG funds were allocated to LAs to deliver a menu of housing support interventions. Some of these were financial interventions provided to people who use alcohol and/or other drugs, such as rent deposits and money for white goods (e.g. home appliances), where HSG staff would procure the items on behalf of people who used the housing support service. Other interventions focused on the workforce. These accounted for the majority of the funding, and included:

- **Specialist floating support workers** providing specialist support to people in their homes to improve engagement with treatment services, forge working arrangements with local housing options and services, and support social integration.
- **Specialist housing support workers/case workers** embedded at various points within the system (e.g. LA housing teams or drug and alcohol services) to reduce the number of people in treatment becoming homeless.
- **Strategic posts** embedded within LAs to work across services to support commissioning, monitoring and the design of future services.
- **Training, personal development and workforce support** to upskill and promote the recruitment and retention of staff.

In addition to these workforce interventions, there were a number of service design principles that LAs and their partners were encouraged to incorporate into their plans, including:

- Tailoring support to the needs of the local population.
- Adopting a person-centred, trauma-informed approach.
- Offering longer-term support to follow people through their treatment and recovery journey.
- Reducing caseloads for housing support staff providing intensive support.
- Making improvements to partnership working across the housing system and social care services, enabling relevant services to be better linked (e.g. through co-location and strategic posts that focus on improving partnership coordination).
- Increasing flexibility in service provision, including in-reach and outreach in the community and to people's homes.
- Promoting and creating a culture shift in response to housing support needs, and integrated ways of working.
- Linking with the National Drug Treatment Monitoring System (NDTMS) to improve the evidence base on housing need for people in drug or alcohol treatment.
- Consulting experts by experience and peer workers with a housing support focus.

The 28 LAs included in the HSG pilot were selected based on the highest level of housing need among those in drug or alcohol treatment (Office for Health Improvement & Disparities 2022). Specifically, the two LAs with the greatest housing need in each geographical region were chosen for funding, while the remaining funds were distributed to other LAs, prioritised according to the number of individuals in treatment with the greatest housing need. See Annex A for a breakdown by region, LA and funding amount.

At the time of writing, in line with government policy, funding for the HSG was consolidated into the Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG) in 2025/26 and the Public Health Grant in 2026/27. The DATRIG consolidated a further three previously separate grants: the Supplementary Substance Misuse Treatment and Recovery grant (SSMTRG); the Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG); and the Inpatient Detoxification (IPD) grant.

1.3. Research questions

The overall aim of the evaluation is to understand how the HSG has been implemented, and whom it works for, where it works, and why. We have therefore addressed the following two sets of research questions (RQs). These questions were chosen to explore both implementation processes and early outcomes.

Implementation process evaluation

1. Was implementation of the HSG carried out as intended?
2. What barriers and facilitators were experienced by LAs?
3. How have the wider and local contexts influenced delivery?

Intervention outcome evaluation

4. What did and did not work (for whom, where and why)?
5. How have housing support services contributed to changes in health outcomes among people who received HSG interventions, including the identification of any unexpected outcomes?

Chapter 2. **Methods**

2.1. Research overview and evaluation framework

Data was collected as part of an independent evaluation of the HSG pilot. This study employed a mixed-methods approach, integrating quantitative results to complement and provide additional insights into the qualitative findings. Table 1 presents the data sources analysed and presented in this report.

Table 1. Data sources and sample

Evaluation question	Method	Sample	Data collection period
1. Was implementation of the HSG carried out as intended?	HSG plans	1 plan from each of the 28 HSG pilot sites	N/A existing documents
	Semi-structured interviews	Implementation leads	Phase 1 June 2024 to July 2024
	Case studies: semi-structured interviews and focus groups	Implementation leads, treatment providers, LA commissioners – public health and housing, housing support team leads and workers, people who use the service	Phase 2 October 2024 to March 2025
2. What barriers and facilitators were experienced by LAs? 3. How have the wider and local contexts influenced delivery?	Semi-structured interviews	Implementation leads	Phase 1 June 2024 to July 2024
	Case studies: semi-structured interviews and focus groups	Implementation leads, treatment providers, LA commissioners – public health and housing, housing support team leads and workers, people who use the service	Phase 2 October 2024 to March 2025

Evaluation question	Method	Sample	Data collection period
4. What did and did not work (for whom, where and why)? 5. How have housing support services contributed to changes in health outcomes among people who received HSG interventions, including the identification of any unexpected outcomes?	Case studies: semi-structured interviews and focus groups	Housing support team leads and workers, people who use the service	Phase 2 October 2024 to March 2025
	Analysis of individual-level administrative data (NDTMS data and HSG monitoring data)	NDTMS: 4,838 people who used treatment and recovery services HSG monitoring data: 3,057 people who received HSG interventions	January 2025

The study was informed by input from several advisory groups (Experts, Commissioners, Workforce and Public), along with regular input from patient and public involvement and engagement experts and team members with lived experience of treatment and recovery that contributed to the study during meetings with co-investigators. We sought the involvement of these groups at multiple stages of the evaluation, including:

- **Characterising the intervention:** review of logic model, including identification of missing items considered important to service providers and people who use alcohol and/or other drugs.
- **Evaluation design/conduct:** review of data collection instruments (including participant information sheets and consent forms) and discussion of data collection and analysis protocols to ensure they are acceptable, appropriate and ethical.
- **Synthesis:** discussion of findings and possible interpretations of results in context.
- **Dissemination and impact:** development of plain English summaries for inclusion in reports and creative dissemination.

At the inception and planning stage of this evaluation, the research team and the DHSC HSG team co-created a logic model. This logic model (Annex B) was used to inform the research materials and guide analysis of interviews. It was based on the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 2022). For more information on the CFIR and how it was used to provide a framework to explore the HSG's activities, mechanisms and outcomes, please see the Methods Report (Strang et al 2026). During later stages of analysis, the team referred back to the logic model and CFIR constructs to support the write-up of findings and to identify any potentially relevant themes that had not otherwise been captured. Please see Annex B.

2.2. HSG Plans

HSG Plans were completed by LAs once they were informed they were receiving the funding. These plans include a local assessment of population and housing needs and challenges, existing service provision and gaps, and existing local partnerships. This is followed by details of how the HSG would be used to complement and fill gaps in existing provision within treatment and recovery services and how it would improve access to housing, housing support and treatment for individuals most in need (across the three years of the HSG). These are organised by the Menu of Interventions (Annex C) from the DHSC brief. Plans for the case study sites were reviewed for the purpose of providing context to the local sites and details of what was intended, to characterise sites and assess whether implementation aligned with plans (RQ1).

2.3. Phase 1 interviews and Phase 2 case study site interviews and focus groups

2.3.1. Recruitment and data collection

For Phase 1, we conducted semi-structured interviews with HSG implementation leads from at least a quarter of the 28 LAs receiving the HSG not involved in the Phase 2 case study sites. The identification and recruitment of HSG leads for Phase 1 was supported by consultations with DHSC, who contacted local HSG leads about the research and gained permission to share their contact information. The research team also attended a national HSG Learning Network session to introduce the research. The aim of these interviews was to gain an understanding of the programme's early implementation, as well as barriers and facilitators and how the wider context has influenced its delivery. A total of 14 virtual interviews across 8 LAs were conducted during Phase 1.

For Phase 2, ten diverse case study sites were sampled based on the amount and type of Drug Strategy Investment in Treatment and Recovery (D-SITAR) portfolio funding received, the types of interventions delivered or planned, the population of people who use local treatment and recovery services, and their geographical locations (please refer to the Methods Report for additional details on sampling). Three of the ten D-SITAR case study sites received HSG funding and were therefore included in this study. To reduce the risk of identification of the three sites, this report has used different labelling for each case study site location. While the other five D-SITAR reports label the sites as 1 to 10, this report refers to the three case study sites that received HSG funding as A, B and C. In these three case study sites, the study team conducted semi-structured interviews and focus groups with LA-level stakeholders, housing support team staff, treatment and recovery leads, and people who use alcohol and/or other drugs.

Site leads for the three case study sites were identified, and they facilitated the development of a recruitment and data collection schedule and strategy. At each case study site, commissioners, treatment and recovery leads, treatment and recovery staff, HSG leads and HSG staff were recruited for interviews and/or focus groups. Site leads and members of the HSG teams identified and approached people who use alcohol and/or other drugs about the

study and facilitated their participation.[2] A total of 40 interviews and 14 focus groups across the three case study sites were conducted in Phase 2.

The same topic guides were used for the Phase 1 interviews with HSG leads and for the Phase 2 interviews with staff in the case study sites. At each stage, all participants were given a participant information sheet, and informed consent was obtained prior to data collection. Interviews were audio recorded and transcribed verbatim.

The total number of participants across Phases 1 and 2 included 105 staff and commissioners and 39 people who use alcohol and/or other drugs. Of the 105 staff, 37 were HSG-specific, with 18 housing leads and 19 housing support staff. For the 39 people who use alcohol and/or other drugs, 11 were recruited with a specific focus on discussing housing support.

All authors involved in case study site data collection and data analysis had experience in conducting qualitative research prior to this study and completed a training session before entering the field. Due to the nature of the study, the primary data collection team and the analysis team were offered confidential debriefing sessions with a trained clinical psychologist.

All researchers were at different stages of their career, ranging from early-career to established researchers. While some had prior experience working with people who use alcohol and/or other drugs, others did not. The team represent a range of academic backgrounds, including health researchers, behavioural health researchers and health services researchers. To support ongoing dialogue about reflexivity, the primary data collection team and the analysis team actively discussed how their perspectives, experiences and background could influence data collection and analysis. In addition to this, the data collection team informally debriefed with colleagues during data collection visits, and both teams attended weekly meetings with the wider D-SITAR team.

2.3.2. Qualitative data analysis

The overall method used was framework analysis, a type of thematic analysis whereby a matrix provides a structure for the reduction of data to themes based on difference, commonalities and patterns (Gale et al. 2013). Analysis of the data was both deductive – based on the CFIR framework (Damschroder et al. 2022) and research questions – and inductive, allowing for new themes to be identified and facilitated using the qualitative data analysis software MAXQDA.

---

2 In this report, we refer to service user interviewees collectively as 'people who use alcohol and/or other drugs' because the HSG does not require individuals to be in treatment or recovery services. Where we are aware that interviewees were in receipt of the HSG, we refer to the group as 'people who received HSG interventions.' For the HSG monitoring dataset, we refer to service users as 'people who received HSG interventions', and for the NDTMS dataset, we identify the service users as 'people who use treatment and recovery services.'

For further information about the CFIR and how it was used in this study, please see the Methods Report (Strang et al. 2026). The steps used in the process were:

1. **Creation of a coding framework** by the HSG research team based on CFIR constructs and research questions (for Phase 1, then refined for case study sites).
2. **Preparing for analysis** by adding transcripts to MAXQDA from Phase 1 interviews and Phase 2 case study sites (interviews and focus groups). These were transcripts with HSG staff and leads, as well as people who use alcohol and/or other drugs.
3. **Coding of transcripts by research question and CFIR construct,** conducted by four members of the research team, each with different transcripts, supported by regular discussions about the coding framework.
4. **Auto-coding of transcripts** from Phase 2 case study sites (interviews and focus groups), including commissioners, local leads and treatment provider leads and staff. This was to ensure that we captured relevant data from non-HSG transcripts. The wordsearch conducted in MAXQDA consisted of terms such as 'hous*', 'home*', 'support grant', 'rent', 'accommodation', 'personal budget' and 'floating support'. All text retrieved from these searches was reviewed and relevant text integrated into our analysis.
5. **Deeper analysis** to explore patterns and themes in the data, conducted by two members of the research team. This entailed:

    a. The creation of an Excel spreadsheet compiling summaries of findings along with key quotes. Data sources (i.e. Phase 1 interviews) were presented horizontally, and key themes vertically. The final column presented a summary across all data sources. Findings were organised in tabs by: individual-level; service-level; system-level; HSG at a broader level; and impacts and early outcomes.

    b. Refining certain CFIR constructs and emerging themes with the support of query functions in MAXQDA.

    c. Research team meetings to discuss emerging themes and the prominence of CIFR constructs in the data.

2.4. Secondary datasets: HSG monitoring and NDTMS

Anonymised individual-level data of people receiving the HSG from NDTMS (people in structured treatment, n=4,838) and the HSG monitoring dataset (a mix of people who were and were not in structured treatment, n=3,057) was provided by DHSC via a secure transfer. The HSG monitoring data contains information on the specific types of support people received from the HSG and baseline as well as follow-up housing outcomes. The NDTMS data contain greater detail on the demographic characteristics of HSG recipients and their health, substance-use and housing outcomes over time. The cut of these datasets was taken in January 2025. For more information on the information contained in the two datasets, see Table 2.

Table 2. HSG monitoring data and NDTMS dataset characteristics

HSG monitoring data (n=3,057)	NDTMS data (n=4,838)
• Recipient's baseline and follow-up housing status and suitability.	• Type of intervention received.
• Referral source.	• Individual characteristics and assessment of need.
• Type of intervention received.	• Health outcomes.
• Whether the recipient is in contact with a drug and alcohol treatment provider or accessing non-structured treatment or harm reduction.	• Local Outcome Framework measures (e.g. accommodation status, being in work or education, substance-use needs).

2.4.1. Data analysis

The NDTMS and HSG monitoring data were considered separately as they included different samples of participants. While the NDTMS data included people in structured treatment only, the HSG monitoring data included not only individuals in treatment, but also those not in treatment. Therefore, we decided to analyse the NDTMS and HSG monitoring datasets separately and restrict our analysis to descriptive statistics only. A summary of the approach is provided below; a detailed description of the analysis methods can be found in the Methods Report. The descriptive analysis aimed to:

- Describe the types of interventions provided.
- Characterise the demographic profile of those who received HSG support.
- Examine changes in physical health, psychological health, quality of life and housing status over time.

To provide context, we summarised the characteristics of people receiving HSG support and the main types of interventions they received, offering an overview of the HSG-recipient sample from the 28 pilot sites. This information was primarily summarised using counts, means and percentages.

For health, housing and substance-use outcomes data, we calculated average changes over time by comparing pre-intervention values to fixed follow-up periods after HSG receipt. The most recent assessment within three months before the initial HSG receipt in NDTMS served as the baseline (pre-intervention) value. Follow-up assessments were taken at 6 months and 12 months (closest values within ±3 months). If individuals did not have follow-up assessments at both 6 and 12 months matching these criteria, they were excluded from the analysis, effectively resulting in a complete case analysis.

Logistic regression was used to determine whether there were systematic differences between participants with follow-up data (at 6 and 12 months) and those without, as a means of identifying potential biases and contextualising the results.

2.5 Mixed-methods integration

Insights from the qualitative data were used to inform our interpretation of the quantitative analysis. Emerging themes from the qualitative data provided direction on which specific variables and subgroups to include in the presentation of findings. This allowed the exploration of overlapping patterns, discrepancies and complementary evidence between the two sources, primarily through counts, percentages and mean values. Integration was facilitated through regular team discussions (around ten hours throughout the course of the evaluation) and collaborative writing sessions. This approach fostered a dynamic exchange of ideas, ensuring that both qualitative and quantitative insights were cohesively integrated throughout the analysis and writing process. Phase 1 and Phase 2 data were treated similarly in how they were approached for the analysis and synthesis of findings. This is because they both contain the stakeholder group of HSG leads (across eight LAs for Phase 1 data collection, and in each of the three case study sites for Phase 2).

2.6. Considerations

2.6.1. Flexibility and variability in the implementation of the HSG pilot

The HSG is an adaptive, multi-component pilot intervention across 28 LAs, with local tailoring and variation at the core of its strategy. While this adaptability allows for interventions to be tailored to the specific needs of the local population, it introduces complexities for this evaluation, as LAs implemented the interventions in diverse ways without a standardised model. As a result, findings should be interpreted with this caveat. Further details are provided in Section 3.6.2.

2.6.2. Exploring implementation against what was planned

One of the research questions we address in the report is 'did implementation go as planned?' While we present quantitative data on numbers of people receiving individual-level interventions (see Section 3.1.2), the research team did not have access to data on the specified targets set by the wider treatment and recovery system for each site in this regard (e.g. ambitions for increasing numbers in treatment) for comparison. As previously described, we also did not have quantitative data on the intensity of the interventions received. Similarly, detailed data on recruitment of new roles, compared to HSG Plans, were not available for this evaluation. Nevertheless, this is an important question for any implementation evaluation and one we address in the following ways:

- Providing an overview of what qualitative data suggests about general progress in meeting the aims described in Section 1.3.
- Describing at a high level the approaches taken across the three case study sites regarding each intervention, as described in HSG Plans.
- Describing qualitatively each of the types of intervention/activity (individual-, service- and system-level), what was implemented and how this occurred in practice (e.g. challenges encountered, what helped with these and what went well).

2.6.3. Dissemination

Working closely with our advisory groups, we have developed a dissemination strategy informed by guidance provided by the NIHR (National Institute of Health and Care Research 2019). While these plans are still being confirmed, we expect our dissemination activities for this report to include:

- The creation of an infographic summary, slide decks, policy briefings, blogs and podcasts. These resources will be primarily for those working in alcohol and/or other drug treatment and recovery services, and particularly those working in services related to housing.
- The presentation of key findings to audiences within DHSC, and other local and national policy and practice stakeholders.
- The submission of an academic paper to a relevant peer-reviewed journal.
- The submission of abstracts to present findings at relevant conferences within the drug and alcohol sector.

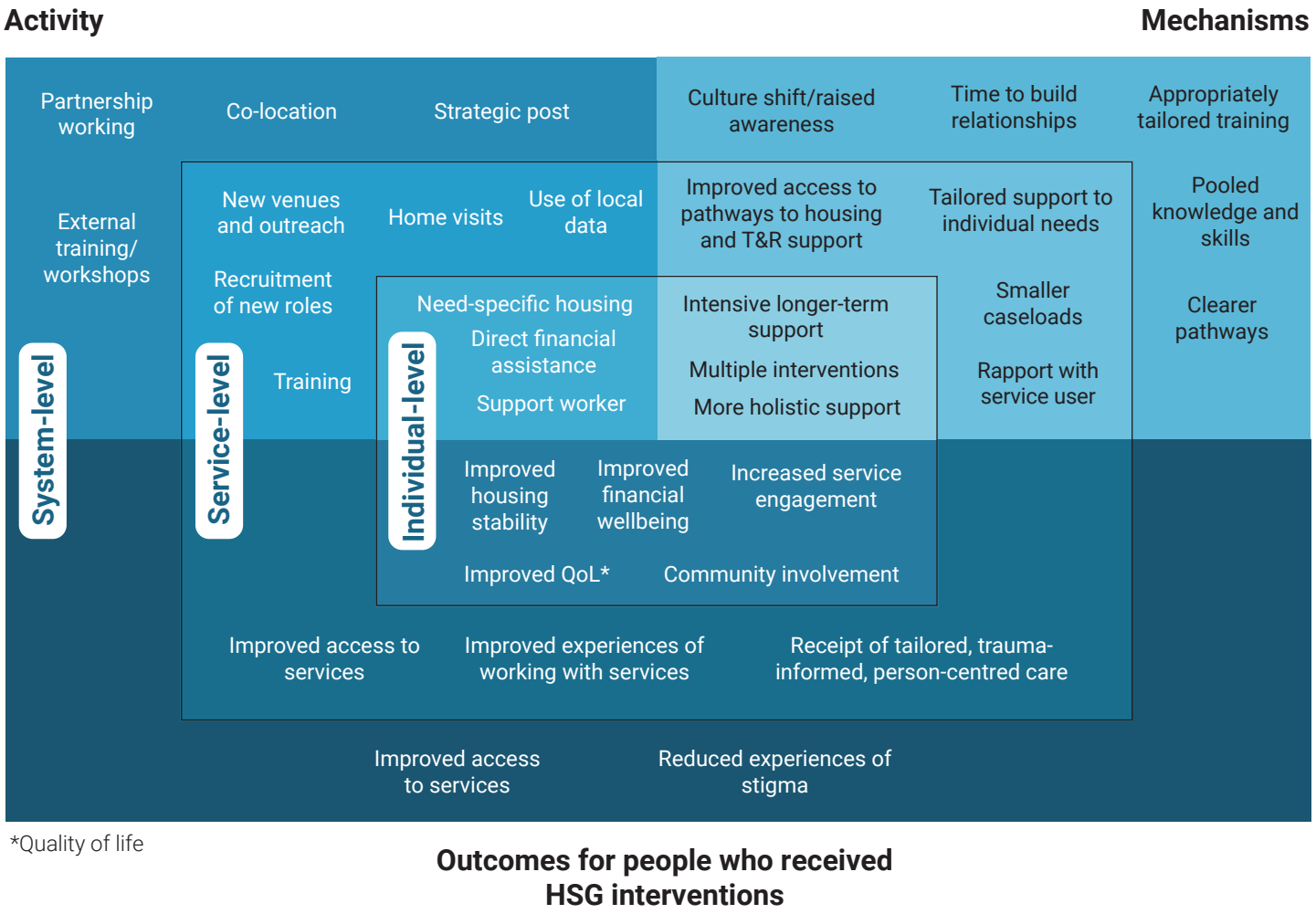
Further information on the dissemination plan for the wider D-SITAR project is provided in Section 7 of the Methods Report.

Chapter 3. **Results**

This results section begins by detailing the implementation of the HSG and its recipients. It then analyses how the HSG functioned, identifying the key mechanisms (RQ2) by which the people who use housing services appeared to be benefiting and the associated early outcomes (RQ5). As many interviewees discussed activities, mechanisms and outcomes concurrently, examples of how the HSG contributed to improvements in housing, treatment and recovery and broader impacts on health, wellbeing and social inclusion are provided throughout the results section. In the latter section of the results, we address the research questions regarding the practical implementation of the HSG and how the facilitators, successes, challenges and barriers shaped the experience of implementing the HSG, including any unintended consequences (RQ2 and RQ3). This includes overarching influences on implementation relating to the characteristics of the HSG, and the local and wider context. We also examined what did and did not work, for whom, where and why (RQ4). As this was crosscutting in nature, throughout the results we provide examples of how people with certain characteristics or needs appeared to be benefiting from the HSG.

Figure 1, which was developed together with the logic model devised for the evaluation (see Annex B), illustrates the main findings from this evaluation, showing what was implemented (activities), how activities worked (mechanisms) and early examples of outcomes (outcomes for people who received HSG interventions). It also illustrates how the components of the HSG are interdependent, with system-wide and service-level activities enabling the implementation of individual-level interventions, and the way in which they interact to support outcomes for people who received HSG interventions. For example, service-level staff recruitment is dependent on system-level activities, including securing funding and creating strategic posts. In turn, staff recruitment affects individual-level support in that people cannot be provided with HSG support without a case worker.

Figure 1. System-, service- and individual-level changes



Source: Research team's internal model.

3.1. Individual-level interventions

3.1.1. Who received the HSG intervention?

According to data from NDTMS, the largest cohort of people who received a HSG intervention (and were engaged in structured treatment) were aged 40 to 49 years of age (36.3 per cent), male (63.0 per cent) and of White ethnicity (91 per cent). Further, 41.3 per cent of the sample identified as having a disability, 16.4 per cent were parents living with their children and 22.5 per cent were parents not living with their children (see Annex D for NDTMS demographic characteristics of those receiving HSG support). The demographic profile is similar to the overall treatment and recovery population recorded in NDTMS: most are aged 40 to 49 years (31.9 per cent), male (68.2 per cent) and of White ethnicity (87.4 per cent) (see Annex E for NDTMS demographic characteristics for all people who accessed drug and alcohol treatment services) (NHS England 2024); however, there was a higher proportion of female HSG recipients (37.0 per cent) compared to those in the broader treatment and recovery population (31.8 per cent).

3.1.2. What interventions did people who used HSG services receive?

People who used HSG services received a number of interventions, which can broadly be classified into three categories:

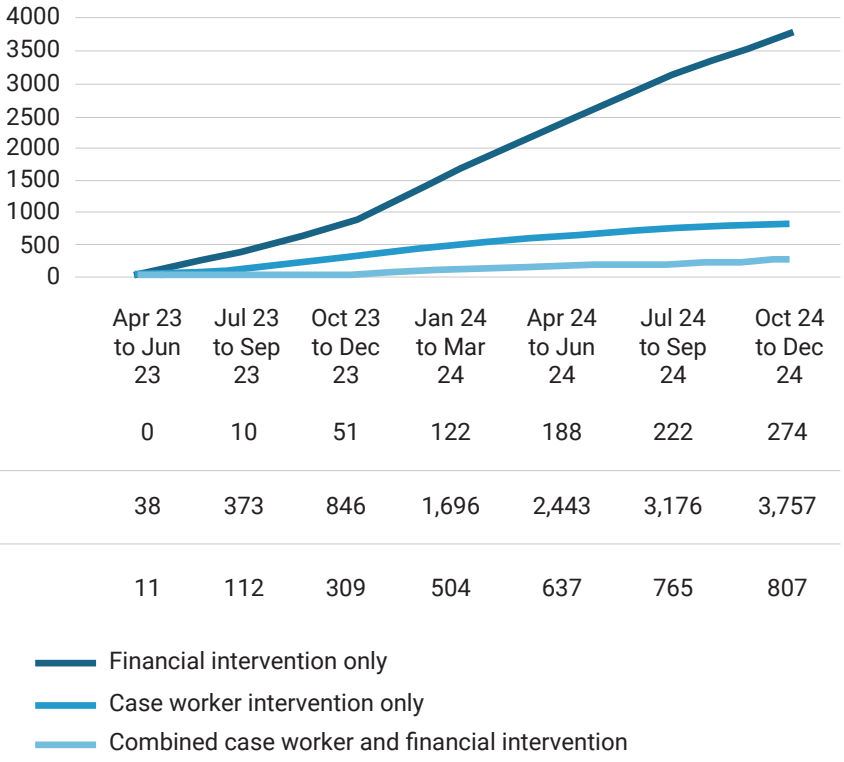
- **Case worker intervention.** This includes different types of support worker, such as floating support, housing support workers, peer support and tenancy sustainment workers. Based on the NDTMS and HSG monitoring data (see Table 3), case worker interventions were provided most often (77.6 per cent and 68.2 per cent respectively).
- **Financial intervention.** This consists of having items and/or services paid for using HSG funding. This can include money to purchase or maintain white goods, house clearing for those who have issues with hoarding, and transportation to enable people receiving HSG interventions to attend appointments and view properties. Based on the NDTMS and HSG monitoring data (see Table 3), financial interventions were delivered the least (5.7 per cent and 7.8 per cent respectively). Across the qualitative interviews and focus groups, the financial interventions were also known as 'personal budgets.'
- **Case worker and financial intervention.** This intervention consists of having items and/or services paid for through the HSG, in addition to having a support worker. The HSG monitoring data indicates that this combined intervention was utilised in nearly a quarter of cases (24 per cent), while the NDTMS data reports a lower figure (16.7 per cent) (see Table 3).

According to the NDTMS data, the most common type of intervention was the case worker only intervention, followed by the combined case worker and financial intervention, and lastly, the financial only intervention. The demographic profiles of people who received these three intervention types were broadly similar. A notable exception to this is regarding disability status, where a greater proportion of people with a disability received the combined case worker and financial intervention (52.6 per cent) compared to those that received the financial only intervention (29.2 per cent). See Annex D for more details on the NDTMS demographic characteristics of those receiving HSG support.

Table 3. Type of HSG intervention

	NDTMS data, n (%)	HSG monitoring data, n (%)
Case worker intervention only	3,757 (77.6)	2,086 (68.2)
Financial intervention only	274 (5.7)	238 (7.8)
Combined case worker and financial intervention	807 (16.7)	733 (24)
Any HSG intervention – total	4,838	3,057

Figure 2. Graph of cumulative cases by intervention type



	Apr 23 to Jun 23	Jul 23 to Sep 23	Oct 23 to Dec 23	Jan 24 to Mar 24	Apr 24 to Jun 24	Jul 24 to Sep 24	Oct 24 to Dec 24
Financial intervention only	0	10	51	122	188	222	274
Case worker intervention only	38	373	846	1,696	2,443	3,176	3,757
Combined case worker and financial intervention	11	112	309	504	637	765	807

Source: NDTMS data, those receiving the HSG in structured treatment only.

As shown in Figure 2, the HSG interventions were implemented on a consistent basis, with the largest change taking place in the first quarter of 2024. This observation relates solely to those who received both the HSG and were in structured treatment. Implementation of these interventions that included people who received the HSG alone may differ.

Financial interventions

The HSG funded several financial interventions (see Table 4). These interventions included financial assistance for acquiring or retaining accommodation (e.g. rent deposits and payments), practical items (e.g. white goods), furniture, repairs and household items, as well as funds for personal hygiene supplies, leisure pursuits and travel costs. The flexibility of the DHSC brief enabled these interventions to extend beyond the traditional perception of housing-related costs: leisure pursuits, for example, were described in interviews as supporting mental wellbeing and fostering social inclusion. As shown in the HSG monitoring data, 971 people received either a financial intervention or the combined case worker and financial intervention; however, 1,853 financial interventions were provided. Among the 971 people who received some form of financial intervention, 244 (25 per cent) received multiple interventions, while 727 (75 per cent) received only one. Those that received more than one financial intervention received an average of 4.6 interventions each.

Table 4. Type of financial intervention

Category in HSG monitoring data, n (%)		Examples from the qualitative data
n (%)		
Household items	295 (15.9)	Essential household items such as cookware (saucepans, frying pans), dining sets (bowls, plates, mugs, cutlery), cleaning supplies and kettles.
Activities/leisure	232 (12.5)	Gym memberships, gardening and fishing.
Travel costs	205 (11.1)	Taxis and bus fares.
White goods	160 (8.6)	Cookers, fridges and washing machines.
Furniture/bedding	111 (6)	Towels, duvets and bed sheets.
First month's rent	42 (2.3)	For those moving into a new property.
Rent deposit	39 (2.1)	For those moving into a new property.
Personal hygiene	31 (1.7)	Shower gel, shampoo, toothbrush and toothpaste.
Home repairs/maintenance	31 (1.7)	Repairs, painting and decorating, transportation when moving and skips for decluttering.
Other	707 (38.1)	Currently unknown what this may include.
Total number of financial interventions received	1,853	

Source: HSG monitoring data.

The flexibility of the HSG meant that people receiving interventions were likely to benefit in some way from the provision to support their housing needs, as indicated in the qualitative findings. Components of the HSG were, however, described as being particularly suited for people who experience cuckooing[3] and people with pets, as well as people at transition points, such as leaving hospital, prison or a rehabilitation facility, as these groups are particularly vulnerable to housing instability and homelessness. In this section we provide examples of where particular interventions were valuable for a specific need or group, where there was evidence to support this.

Floating support workers and housing case workers

The DHSC brief outlines three categories for recruitment through the HSG funds: 'specialist floating support workers', 'specialist housing support workers/case workers', and 'strategic posts'. Housing support worker roles were recruited to either existing or newly created teams of support workers. These roles sat within treatment and recovery services or were positioned elsewhere in the system (e.g. housing providers, council housing teams and third-sector organisations, including a peer-led organisation).

Across the qualitative and quantitative data sources, the specific names of housing support roles differed. For example, Table 5 shows the types of case worker and the number of interventions provided to people who received HSG interventions according to the quantitative data; however, roles named in the qualitative data, such as 'specialist cuckooing worker', 'housing support peer mentor' and 'housing and recovery worker', do not appear in the dataset. It could be presumed that these form part of the 'Other' category in Table 5. This variation illustrates how the new roles were operationalised to meet the specific needs and priorities of local populations. It also highlights potential differences in interpretations of the DHSC brief for these roles, reflecting the flexibility employed to align funding with local contexts and existing resources.

Table 5. Type and number of case worker intervention

Type	HSG monitoring data, n (%)
Floating support worker	1,358 (48.2)
Housing support worker	669 (23.7)
Housing options case worker	243 (8.6)
Tenancy sustainment worker	158 (5.6)
Peer support	84 (3)
Supported housing worker	72 (2.6)
Other	235 (8.3)
Total number of case worker interventions received	2,819

Source: HSG monitoring data.

3 Cuckooing refers to organised crime groups or perpetrators moving into properties through force, deceit or coercion. The properties are then used to store, supply and produce illicit materials, among other illegal activities (Spicer et al. 2020).

Housing support workers were described by most staff and many people who received HSG interventions as providing practical support around and beyond finding and securing stable housing. They offered financial guidance, including support with managing debt payments, addressing issues with bailiffs and eviction threats, and support in obtaining benefits. Additionally, they supported the development of life skills for independent living, such as maintaining a tenancy, setting up bills, and assisting with house cleaning. They also offered emotional support to help people who received HSG interventions with personal challenges, and connected them to mental health services as well as programmes for employment, volunteering and education.

> He's [support worker] always supported me. All the time, he's always been there and I've had him for, I'd say maybe about two or three years, on and off. Even while I was in jail, he still supported me. He even had a place for me to move into while I came out, out of the jail. (People who use treatment and recovery services HSG focus group 2, Site B, Phase 2)

The new support worker roles, along with the intensive support provided through home visits, were highlighted by HSG teams as enabling the initiation and fostering of authentic relationships with people who use the service. These roles were reported to facilitate trust-building through trauma-informed engagement, help safeguard and identify risks such as cuckooing, and create a safe space for recipients of the HSG to engage with staff. Once a support worker was able to better understand the individual's living conditions, they reported that they could often select a more targeted intervention for that individual, and ultimately positively impact treatment and recovery outcomes.

> A surprisingly large number of people have got hoarding or issues with the way that their home is, making it not very liveable. So, actually, being able to understand what's really going on for somebody, to help them, and that removes the… It builds the trust, it means that they come to the service because of some of the work that you've been able to do with them, and it means they can't hide behind, "Yes, I'm fine, everything's fine, I just want my script," because that's not going to happen. They know, when you walk into somebody's home, where they're at, in a much more detailed way. (Local lead 2, Site B, Phase 2)

3.2. System-level changes

The HSG had ambitions for system-wide integration through partnership working between treatment and recovery services and the housing sector. Although not discussed during interviews and focus groups, HSG Plans suggested that the case study sites set up formal arrangements, structures or documents to support partnership working. For instance, planned partnership arrangements were mentioned in Site A and 'combating drugs partnerships' were specified as part of shared governance of the HSG in Site C. In Site B, there were descriptions of plans to produce signed 'partnership protocols' and to agree local joint working protocols to avoid duplication across services.

Interviewees, particularly HSG leads and commissioners, reported that they had used the HSG to strengthen their networks of partners and increase levels of partnership working across the treatment and recovery and housing sectors, such as adult social care, private housing providers, council housing teams, landlords, leisure centres and care homes. For example, some HSG leads reported that partnership working enabled organisations and staff to triangulate their understanding of how best to support people who use alcohol and/or other drugs, and in some instances conduct joint assessments during home visits.

> We do a lot of joint visits…we do an awful lot of partnership working with, obviously, housing so in [company name], come along with us. Whether it be mental health in the [company name] properties, come along with us rather than bouncing people between services and signposting, referring and all the rest of it. (HSG lead, Site B, Phase 2)

The system-level changes of the HSG were enabled through a number of activities, such as the co-production of HSG Plans, co-location of staff across housing and treatment and recovery sectors, and education and training for staff and agencies outside of drug and alcohol services. These activities were described as supporting knowledge transfer and learning both in terms of information about the needs of people using alcohol and/or other drugs and housing regulation and processes, strengthening pathways for people who received HSG interventions and reducing evictions.

> The fact that we've prevented evictions is just like, I just find that incredible. It's just like wow, people have actually – and also getting, working outside the box, working with like I said, like estate agents. We've got solicitors working with us, [name], and then people that aren't health and social care providers are working with us. (HSG lead 1, Phase 1)

Examples of these system-wide activities in practice included attempts to build relationships, such as training of staff in the housing sector, and repairing miscommunication or friction between staff in different organisations responsible for supporting people receiving HSG interventions.

3.2.1. Co-location

An explicit aim of the HSG was to increase workforce co-location, with new HSG staff placed in other services such as council housing services, adult social care, social services and homelessness intervention teams. Co-location was described by interviewees as a potential enabler to dealing with the challenge of the short time period for implementing the HSG, particularly in terms of bringing providers together.

> So there were some challenges in terms of the short time available from saying "this is the funding that you've got and we need a plan to turn around very, very quickly", so there were challenges around those timescales. So what we wanted to put in place was a system whereby there was a lot of co-working. (HSG lead 2, Phase 1)

In another site, co-location was reported to support the upskilling of treatment and recovery staff on housing processes, and improve access to this expertise for people who use alcohol and/or other drugs.

> When we do a duty to refer, the ones who take on the assessments, like the housing assessments, they're going to be based here on a Tuesday and Thursday morning as well. So, it's just even more accessible to us and hopefully improves that communication for the rest of the service to have that visibility as well and maybe talk to them a bit more about what they do... So that if one of the team's not around, there's someone else that they can speak to about housing. (HSG staff focus group 1, Site C, Phase 2)

However, during a focus group with staff from another site, negative experiences of co-location were described, such as housing support staff being treated as 'guests' and spoken to with hostility by staff from the wider treatment and recovery services, rather than core staff working towards a unified goal. Housing support staff in this case study site also encountered practical issues such as there not being enough rooms available for them to see people who receive HSG interventions, impacting the number of appointments they could provide.

Examples were found of instances where planned co-location had not taken place, reportedly resulting in a missed opportunity for improvements in data sharing and cross-agency communication.

> Being co-located within the actual treatment service, so you got that open dialogue…that's never happened. (HSG lead 4, Phase 1)

HSG leads reported that co-location had not taken place in this site due to reticence from partner organisations. In one instance, partners doubted that co-location was necessary, with existing remote partnership working perceived as adequate. Negative attitudes towards partnership working were also found in the data, with one HSG lead explaining that they perceived housing services and treatment and recovery services as being different in ways that were not conducive to co-location, describing them as 'different entities.'

> We're all in separate buildings…most providers just put the posts in their treatment service. I don't think that works because having worked in both treatment services and housing services, they're very different entities. (HSG lead 6, Phase 1)

3.2.2. Training and external workshops

Funds from the HSG were reported by participants to be used to upskill related services and organisations through training and educational workshops. This was to ensure the housing provided was suitable to the needs of people who use alcohol and/or other drugs,

and that housing-related issues were resolved in a way that was not inhibited by stigma. One interviewee highlighted that these workshops provided an opportunity to help staff from housing organisations (and beyond) understand how their actions can both positively and negatively impact people who receive HSG interventions.

> [The HSG has] also funded the Workforce Development Programme, which is a programme that [name of provider] is delivering to different services all across [site name]. And that's to upskill them around drugs and alcohol, around treatment, around stigma, which is a massive issue, so stigma and discrimination. We have one that's around escalating behaviours and staff welfare, so it covers lots of different elements, but it's in terms of upskilling other services on how to work with our service users, because what we often find is massive amounts of stigma evictions. (HSG lead, Site C, Phase 2)

'Stigma evictions' and discrimination against people who use alcohol and/or other drugs were described by some HSG staff interviewees as a barrier to obtaining and retaining tenancies. A HSG lead in one site spoke about a case where a local authority would not house a vulnerable woman who was experiencing domestic violence due to a prior eviction from temporary housing for anti-social behaviour. In this instance, the HSG was used to fund time for advocacy and relationship-building between services to enable the woman to be safely housed.

Training to educate surrounding organisations (e.g. housing providers) on the symptoms of less well-known substances (e.g. a novel stimulant whose users were described as more likely to cause damage to housing) and de-stigmatising people who use alcohol and/or other drugs was described as particularly important. Challenges such as low attendance and a general sense of a lack of buy-in, however, were described at some sites.

> I think the biggest challenge has just been getting the buy-in from housing and their providers in terms of the benefits of this. We've had hardly any housing options officers come to our training, hardly any housing providers. (HSG lead, Site C, Phase 2)

For those experiencing or at risk of cuckooing, efforts in one case study site were made to educate relevant organisations with the aim of improving the likelihood of these individuals receiving appropriate support. This collaboration among community services was described as essential for being better equipped to identify and respond to cases of cuckooing, supported by raising awareness and educating other frontline workers.

> An emerging issue that was rising in [name of site] and linked to the county lines issue was cuckooing, and the city's response primarily was if somebody was being cuckooed, they weren't being viewed as a victim. They were being viewed as an anti-social problem and they'd lose their tenancy. So, we've done an awful lot of work in [name of site] to educate other

> providers that actually, if somebody is being cuckooed, they are a victim of cuckooing… So, we've got a dedicated worker who works in very close partnership with the police and other providers. (Provider manager, Site C, Phase 2)

3.2.3. Strategic posts

As recommended in the HSG programme brief for LAs, some sites recruited a strategic coordinator, or a facilitator to support partnership working, to ensure system-wide learning and integrated ways of working for better coordinated housing support. These roles focused specifically on building relationships and addressing barriers to multi-agency working, for instance, by enabling easier communication of information about people who received HSG interventions.

> And the other thing that I think we did very well, given that we didn't have one organisation doing this for us, we spent a little bit of money, not a lot, a person to be a systems facilitator and do that systems learning, really kind of getting people together… To help systems work you need systems facilitators. (HSG lead 8, Phase 1)

Benefits of improved partnership working as part of the HSG appeared to go beyond the treatment and recovery service: for instance, surrounding agencies benefited from gaining more knowledge and skills for interacting with people who use alcohol and/or other drugs. In some examples, a system-wide approach included co-location, making it easier to engage and offer support, reducing delays in accessing treatment.

> Partnership working with [name of council] Housing Teams has been very good. They've been very supportive of the programme, despite its limitations…. we're in situations where the team do co-locate sometimes with the District and Borough Housing Teams. They co-locate with the main treatment provider. So, they have regular drop-in spots. (HSG lead 7, Phase 1)

3.2.4. Barriers and enablers to system-wide ambitions of the HSG

When partners reportedly worked well together through strategies employed as part of the HSG, there were accounts of benefits to staff, HSG recipients, staff within treatment and recovery services, and wider stakeholders. This was facilitated, in some instances, by the maturity of existing partnerships, 'champions' with long-standing roles within a service, and a history of existing partnerships and knowledge exchange between local services.

> And then really the [name of charity partner] and [name of health and social care service provider], they've already got really good interfaces. So yeah, I think that dovetailing, so that organisations are playing to their strengths and easy, good, warm handovers to each other kind of thing. Yeah, I think we've paid good attention to that. (HSG lead 8, Phase 1)

Systems and processes for communication between partners were described by some interviewees across HSG staff, leads and a central government lead, however, as sub-optimal. A primary example of this was difficulty in getting data-sharing agreements in place, which was said to have halted progress at a national level during the establishment of the HSG. This issue was also reportedly experienced at the service level. Issues described included extended periods of time required to get paperwork in place, long privacy notices and numerous consent forms to be signed by people using HSG services, reducing the ability of HSG workers to mediate between people using the HSG and other organisations.

The effectiveness of a system-wide approach to tackling barriers can be dependent on the service and the care approach. Across the case study sites, it was notable that HSG services would adopt either a trauma-informed approach, giving people who use alcohol and/or other drugs more control over their treatment and recovery, or a paternalistic approach, whereby staff impose consequences for non-abstinence. The excerpts below demonstrate the different approaches taken.

> [It's] about giving service users options in terms of what their treatment looks like, being able to meet them where they are and working with them around what they want rather than what we think they should achieve….It's about also offering them that opportunity to be able to choose their worker. So, what suits your needs? If someone has had specific trauma, we're able to provide them with a worker that suits their needs. (HSG lead, Site C, Phase 2)

> I don't give anything away for nothing, but it is about surprisingly when you give or do some bits…I remember I had to carry a washing machine up three flights of stairs. Somebody done really well in treatment and you do a bit, if you don't do that well, I'll come and take it back, you know that don't you. (HSG lead, Site B, Phase 2)

There were several instances of staff working in housing organisations being praised for their enthusiasm for supporting people who use alcohol and/or other drugs. Overall, however, attitudes in the housing sector towards people who use alcohol and/or other drugs were described as having a negative influence on how well system-wide changes were implemented. HSG leads and staff spoke about challenging expectations (e.g. expectations of maintaining cleanliness or at least not exhibiting behaviour that suggests alcohol and/or other drug use), rigid processes (e.g. requirements to attend an in-person appointment at a set time) and a lack of a trauma-informed approach in the sector as impacting access to housing services. Specific instances raised include individuals experiencing evictions related to stigma, and in several interviews, there were accounts of negative attitudes from council and private housing providers being an obstacle to recipients of the HSG who were in a position to move into private housing.

> We are advocating for our service users a lot because, in [case study location], they can face an awful lot of discrimination…not for all professionals, but for some of the professionals we work with, that is their attitude. (Provider manager, Site C, Phase 2)

Some staff highlighted the value of the HSG here, especially in enabling strategies to educate partner organisations about discrimination and address stigma around substance use and mental health, as well as enabling the provision of outreach as a way of bringing services to the individual rather than expecting individuals to engage with services in a standard way (see Section 3.3.3). This was something some HSG staff described as being central to their approach, in particular, meeting people where they are at and having realistic expectations of their engagement.

3.3. Service-level changes

Service-level activities relate to changes made to treatment and recovery services as a result of the HSG, and span across the individual-level interventions (e.g. adaptations to ways of working to facilitate a more person-centred, trauma-informed approach to care), increases in service flexibility (e.g. home visits), and tailoring support to local needs. In this section, we focus on the recruitment and training experiences of new housing support worker roles, with the other topics covered in Section 3.6.

3.3.1. Recruitment, characteristics, and challenges of the new housing worker roles

There were differences in the staffing models of new staff recruited in the case study sites. One case study site recruited a new specialist floating support team, while the other two recruited new roles and embedded them into existing treatment and recovery services or related areas (e.g. Adult Social Care). Two of these sites targeted specific groups for HSG interventions, including individuals experiencing cuckooing, vulnerable women (including those engaging in sex work) and people leaving prison. Additionally, one case study site focused on individuals not currently in treatment, while another offered some interventions exclusively for those in treatment.

There were also recruitment challenges that were influenced by national and local factors. Central government stakeholders noted that delays at the national programme level complicated local recruitment by shortening timelines. Furthermore, services faced competition for candidates due to the simultaneous recruitment for multiple grants (e.g. the RSDATG), with new housing support roles and recovery workers often drawn from the same workforce pool. This competition highlighted wage disparities between treatment service roles and comparable but higher-paid roles for the council, which led to challenges for HSG staff recruitment.

Despite challenges and delays at the national level, it was common across sites for interviewees to state that most positions were successfully filled through internal or external recruitment methods and hiring trainees, or funds were reallocated to other components of the HSG without any substantial issues. This is reportedly because sites employed methods of recruitment such as using recruitment agency staff, launching national advertising campaigns and broadening the applicant pool.

> With the team leader, the recruitment that took place, and with myself recruiting [name of staff member], we've had the real success in terms of being able to recruit for the team. So it's gone really, really well. It took a while to get up to the full cohort of seven. (HSG lead 5, Phase 1)

The majority of treatment and recovery leads and staff welcomed the recruitment of new staff and were positive about the HSG funding. HSG staff often reported the appeal of working intensively with vulnerable individuals, and the reward of delivering a service to those in need. The responsibilities and expectations of being a floating support worker, however, had taken time to understand.

> It's taken a while for other people and us ourselves, I think at times, to figure out right, what exactly is floating support? Who fits it, who doesn't fit it? (HSG staff focus group 1, Site C, Phase 2)

There were some tensions described, too, around differences in job requirements, in particular the smaller caseloads for newly recruited roles. In one site, once the quota for the HSG support workers' caseload had been reached, individuals with housing needs were directed back to the core service staff. Although an explicit aim of the HSG was to reduce caseloads so that housing support staff could provide more intensive support, the approach was reported to create some tension between teams as core service staff had uncapped caseloads and were expected to manage high numbers of individuals without any additional funding.

> We've taken on a couple of clients from the floating support team but because they're still at capacity they are unable to take any others on. So that is a frustration that I have because we don't have a cap in the core service. We don't have restrictions on how many clients we have; we are here to provide a service and we have to provide that service. (Staff focus group 2, Site C, Phase 2)

3.3.2. Training

Training for housing support workers was often described as 'intense', with some staff reporting feeling an expectation from others to be experts in drugs, alcohol and housing. Some HSG leads noted that induction programmes covered topics such as substance dependence, housing law, trauma-informed practice and techniques such as motivational interviewing and risk management, depending on the expertise of the recruited staff.

> Training is intense. You've got a lot of things that you've got to make sure that you're able to do, like needle exchange, doing BBV (blood-borne virus) tests, making sure you've gone round to each of the different teams, so the alcohol team, the non-opiate team, the opiate team...you've got to learn the pathways. So, rehab pathways, detox pathways, [and] making sure that you've got a level of understanding of each of them...because we do the drug and alcohol and we do the housing as well. (Staff focus group 1, Site C, Phase 2)

While an intensive training programme could be considered beneficial, interviewees noted that the demand to maintain expertise in substance-use issues alongside housing expertise could surpass the typical responsibilities of a housing support worker, and they may only be expected to provide additional support due to the trust and rapport established with recipients of HSG interventions. Furthermore, one case study site noted that it could only offer training to staff for part of the year due to budget constraints.

> We only had budget for the first [part of the] financial year, which meant by the time we had other people in the second part of the financial year, they didn't get access to the training other people did. (HSG lead, Site C, Phase 2)

3.3.3. Outreach

As shown in the service-level section of Figure 1, HSG funds were used to increase treatment and recovery services' capacity to proactively reach people with unmet housing needs by providing home visits and offering new social venues in the community. The reintroduction, or increase, of home visits was described as a key change in service provision, which had previously been impacted by the COVID-19 pandemic and spending cuts.

> On the housing floating support side, I think we weren't doing home visits hardly before. So, since that, we've been able to do home visits, see people in their homes, and it gives you a good and clear picture about what's going on for them. (Provider lead 3, Site B, Phase 2)

Home visits involved delivering support directly to people who use alcohol and/or other drugs, addressing their current life situations and challenges, and choosing appropriate interventions. This sometimes required using HSG funds in a variety of ways that were supportive of enabling people to remain housed or in treatment and recovery services.

> In one case, [it was] flea treatment for a cat, because that was the issue that was making the tenancy a problem, or one of the issues. So small things like that, but recognising that that is a challenge in somebody maintaining that tenancy. (HSG lead 3, Phase 1)

Home visits were described by HSG teams as particularly valuable both for addressing housing needs and for enabling vulnerable groups to access treatment and recovery services. This includes individuals at risk of being unable to access in-person services, those with learning difficulties or neurodiverse needs, individuals detoxing from alcohol, older individuals with limited mobility, parents with involvement from social care, and those in palliative care. Several staff

interviewed noted that people who received HSG interventions who may have been victims of cuckooing could have gone unnoticed in the absence of home visits.

> We went and did a home visit on someone, rung on the buzzer. They'd not turned up. It was unlike them. They'd not answered their phone. Someone answered the buzzer but never said anything. We thought, that's very strange. They were quite vulnerable, and I think they were autistic as well and we thought, that doesn't sound right. We gave the police a call. They went round there because we had that kind of feeling and found two blokes selling drugs out of there. They'd been cuckooed. (HSG lead, Site B, Phase 2)

Furthermore, staff noted that home visits were characterised as a person-centred and proactive conversation tailored for people who use alcohol and/or other drugs who may hesitate to seek help but still require assistance, with the goal of encouraging them to accept the support available to them.

> Because we offer home visits, we get to see the state of their living arrangements.... The home visits are big for us, because then we know how to talk to them in a way where actually, they're not asking for help, we're offering it. (Local lead 2, Site B, Phase 2)

New community venues were established so that people with a housing need could connect with a member of the HSG team without having to travel to a treatment and recovery service. These venues included community centres, breakfast clubs and specialised hubs designed to support specific populations, and were either created by the treatment and recovery service or developed through partnerships with local companies and community groups. These venues were identified as a step between home visits and in-service appointments, targeting individuals who may feel reluctant to attend clinic sessions and those concerned about the judgement and stigma associated with attending a treatment and recovery service.

> But the first few appointments, we can go out to them and then it can be, "Can we meet you at the [venue A] or [venue B] or somewhere, a community space that's not necessarily [venue C]," and then actually, can we start getting them to come in for appointments for breakfast club, and get them confident coming out into the community and actually, that has such a powerful impact. (HSG staff focus group 1, Site C, Phase 2)

3.4. Reducing housing-related barriers

The HSG funding was used to help prevent evictions by fostering better relationships with landlords. This could include, for example, maintaining the upkeep of a property and addressing damage caused by people who use alcohol and/or other drugs. In other cases, it provided

reassurance to landlords and housing associations, making them more receptive to providing housing to people who were known, or thought, to be using alcohol and/or other drugs.

> If the client caused damage to the property, there was enough money in that budget to be able to pay for those repairs and that was absolutely key to those providers actually agreeing to take this on. (HSG lead 2, Phase 1)

Financial interventions were described as valuable for people transitioning into new properties (e.g. from temporary accommodation), addressing travel-related barriers for people who use alcohol and/or other drugs with mobility issues, and prison leavers. In addition, they supported people in overcoming pet-related barriers before seeking treatment, for example installing a cat flap so a person who used alcohol could attend residential rehabilitation.

> They were doing a home visit with a lady. They wanted her to go to rehab, but she had a cat.... But she didn't want the cat to not be able to come and go on its own and be stuck in the house all the time. So, they put a cat flap in, you know? £60 or something...and that was the last barrier that was needed to actually get her to rehab, and she went. But she wouldn't have gone otherwise. (Local lead 2, Site B, Phase 2)

Support from the HSG was highlighted by HSG staff as particularly important for people leaving hospital or a detox facility, as these individuals are at particular risk of losing tenancies while away from their home. This raises challenges for individuals living in different types of housing (including housing provided by both LAs and private landlords).

> We've got a hospital liaison worker who will pick up…the drug and alcohol work and then we can carry on working in the background on the housing and make sure they've got somewhere to go, especially if they've been in hospital for a long time. Sometimes they might lose their housing because… That's just a whole other issue. Yes, you'll evict someone who's in hospital. It's shocking. (HSG staff focus group 1, Site C, Phase 2)

In the examples below, an interviewee who uses treatment and recovery services and a HSG lead reported the challenges to accessing housing after leaving residential treatment.

> And also, what would happen to me if I did end up going into rehab, because I've asked for the referral programme…for them to fund rehab for me, but obviously I wouldn't want to then come out of rehab and be homeless all over again. (Person who uses treatment and recovery services 7, Site C, Phase 2)

> We have a lot of people who are returning from residential treatment. We send a lot of people from here but if you think, we are paying £20,000 for them to go to residential treatment and then you're actually put back in a shared house where most of the people are using. (HSG lead, Site B, Phase 2)

The introduction of housing support worker roles had assisted people who received HSG interventions in navigating the housing processes and pathways by signposting to relevant services and ensuring they had digital access and appropriate support to accurately complete housing applications. Strong collaboration and effective communication across agencies within the housing system was described by interviewees as a facilitator to pathway improvements.

> Go down to the social housing loop, so they have to give us assistance with filling out forms, dealing with the council because obviously the waiting list and other things are quite high…that sort of support that's given to us by both charities. (Person who uses treatment and recovery services HSG focus group 2, Site B, Phase 2)

> I think having that kind of coordination from the local authorities…because we've got three providers here obviously with separate contracts…and it's a lot of goodwill needed on all sides really. (HSG lead 2, Phase 1)

Quantitative data from NDTMS for people in structured treatment supports the qualitative data demonstrating the benefit of the HSG in addressing housing needs, indicating a change in housing-related outcomes one year after receiving the HSG, including a six percentage point reduction in risk of eviction, an eight percentage point decrease in acute housing problems, and a five percentage point drop in unsuitable housing (See Table 6).

Table 6. Housing-related outcomes

	Baseline before HSG receipt (n=3,597)	6 months after HSG receipt (n=3,597)	1 year after HSG receipt (n=3,597)
All intervention types, % (n)			
At risk of eviction			
Yes	22 (798)	17 (621)	16 (583)
No	78 (2,799)	83 (2,976)	83 (3,014)
Acute housing problem (homeless, no fixed abode)			
Yes	31 (1,125)	26 (927)	23 (843)
No	69 (2,472)	74 (2,670)	77 (2,754)
Unsuitable housing			
Yes	32 (1,163)	28 (1,025)	27 (969)
No	68 (2,434)	72 (2,572)	73 (2,628)

Source: NDTMS data.

These findings should, however, be interpreted with caution. This analysis includes only individuals with recorded outcomes both at baseline (shortly before HSG receipt) and at both 6- and 12-month follow-up for all three housing-related outcomes (resulting in a complete case analysis). Consequently, it excludes many HSG recipients in NDTMS who lack follow-up data.[4] Reasons for a lack of follow-up data are mainly twofold. First, many people received HSG interventions in late 2024, meaning their 6- and 12-month outcomes were not yet due, given our cut of the data was taken in early 2025. Secondly, many of those who received HSG interventions earlier did not have follow-up outcomes because they were discharged before this data would have been collected. The most common reason given for discharge was 'incomplete/other' (60 per cent), but other reasons included moving away (11 per cent), death (9 per cent), imprisonment (10 per cent) and successful treatment completion (10 per cent).

After accounting for these two circumstances, only a small number of cases for which we would expect follow-up data, given that NDTMS policy is for outcome data to be collected at least every six months, did not have it.[5] These individuals are likely those who did not formally discharge but may have disengaged from treatment, or their status could reflect a measurement or recording error. In addition, the analysis reflects only those in structured treatment (hence they have an NDTMS record). Finally, we cannot determine whether improvements in outcomes are due to the HSG itself, the presence of other interventions, or simply the effects of being in treatment. Therefore, these results do not imply that improvements were a direct result of HSG receipt.

3.5. Physical health, mental health and social outcomes

3.5.1. Quality of life and mental wellbeing: a 'step-change'

Interviewees noted that HSG interventions were supporting, or contributing to, improvements in self-esteem, quality of life and mental wellbeing. These improvements were attributed either directly or indirectly to HSG interventions, though in some instances, the link between the intervention and the reported improvements was not clear. These reported improvements are particularly relevant as 60.6 per cent of those receiving support from the HSG were also receiving treatment for mental health needs (e.g. community mental health services, talking therapies or GP support). Some staff who were interviewed reported being able to support people who use alcohol and/or other drugs to make changes to their living arrangements that improved their quality of life or mental wellbeing.

> We've been able to do like a couple of house clearances. So, that's been new. So going over to someone's house. It was making him so unhappy. He was depressed. He was talking about it in the group, check-in after check-in. It

4 This is approximately 1,241 people. The exact number differs depending on the specific question within the Treatment Outcomes Profile (TOP), albeit differences are negligible.

5 Again, the exact number differs depending on the specific question within the TOP, ranging from 28 for "acute housing problem" to 67 for 'at risk of eviction', for example.

> was just an absolute state… So, we went over there and just basically got rid of it all, took a day and a half, I think. But yeah, he's been really happy since. In fact, he's got off his methadone, but yeah, he said it made a massive difference. (Staff focus group 3, Site B, Phase 2)

It is also important to consider the perspective of those who do not receive housing support, as the lack of assistance can have a negative impact on their wellbeing, reinforcing that access to housing support could improve their quality of life and provide a sense of purpose.

> I need a bed and a foundation; do you know what I mean? To get somewhere, and at the moment I'm going from pillar to post, sofa surfing, staying on the street. There's no light at the end of the tunnel at the moment. It feels like it's three steps forward and six back and then one step forward and two back into a situation. (Person who uses treatment and recovery services 3, Site B, Phase 2)

Interventions such as leisure activities, volunteering opportunities and home visits were praised by people who use treatment and recovery services for their ability to offer both direct support for wellbeing and indirect support for recovery. One interviewee that had received a home visit highlighted that the change was an improvement on previous service activities, and that it helped reduce the feeling of isolation.

> Years ago, when we were going through it [treatment], they wouldn't come to your house and try and help you like they do now. I think over the years it's got a lot better, hasn't it? Now, I can be in my room when I don't want to come out for a couple of days. They can come knocking on my door, "Are you alright?" And that feels good, in a way. At least someone cares about you, doesn't it? (People who use treatment and recovery services opioid focus group 1, Site B, Phase 2)

The provision of white goods, such as a cooker and a fridge, were described as facilitating healthier routines and improved care for children.

> The ripple effect impact of getting a £500 cooker for someone…you're not just talking about the cost of the cooker. You're saying, one, something about belief in the person that "you've done really well and we want to do this for you," and you also have belief for the two kids then, and that will have a long-lasting impact. (Staff mixed focus group 1, Site B, Phase 2)

Table 7. Health-related outcomes

	Baseline before HSG receipt (n=3,716)	6 months after HSG receipt (n=3,716)	1 year after HSG receipt (n=3,716)
All intervention types, mean (standard deviation)			
Self-reported psychological health score	9.7 (4.3)	10.7 (4.3)	10.8 (4.2)
Self-reported physical health score	10.5 (4.2)	11.1 (4.2)	11.2 (4.2)
Self-reported quality of life score	9.9 (4.4)	11 (4.2)	11.1 (4.2)

Source: NDTMS data.

For quality of life, psychological health and physical health, each variable was measured on a 0-to-20-point scale (Marsden et al. 2008). There was a positive change in self-reported quality of life, psychological health and physical health across the HSG cohort at 6- and 12-month follow-up (see Table 7). However, these improvements were modest on average: approximately a 1-point increase at the 12-month follow-up, with quality of life and psychological health showing slightly greater gains (just over one point) than physical health. Deacon and colleagues (Deacon et al. 2023) interpret a change in outcomes of four points or more as meaningful, hence the results on average do not meet this threshold. However, a quarter or more of the individuals in this cohort did meet the thresholds for being clinically meaningful (28 per cent for quality of life, 28 per cent for psychological health and 25 per cent for physical health at 12-month follow-up), indicating that for a substantial minority, improvements were clinically meaningful. It is important to note that the same limitations described for Table 6 above apply here too. These findings are based on complete case data and therefore may not be representative of the entire HSG recipient population, and any observed improvements could reflect the general effects of being in treatment and recovery rather than the specific impact of the HSG itself. Interestingly, there did not appear to be particular differences between subgroups.

3.5.2. Social inclusion

Although fostering social inclusion was not a specific focus of the new HSG roles, HSG staff and leads reported that interventions were contributing to improvements beyond housing. For instance, financial interventions that improved personal hygiene (e.g. the provision of a washing machine) or access to appliances to cook food were acknowledged as supporting other aspects of life. New venues in the community (where people with housing needs could speak to a HSG worker about support) were described as improving opportunities for engaging with peers, participating in activities and building social confidence. A bi-directional relationship between

improved social inclusion and engagement in treatment and recovery was reported by some staff and people who use alcohol and/or other drugs.

> So that person who's got a washing machine, that problem is solved for them and their quality of life improves…it makes engagement in substance-use services better…. Because of what we can offer, through the housing grant, people have engaged much better in the treatment. (HSG lead 3, Phase 1)

Volunteering, education and employment were mentioned by a small number of HSG staff and leads as possible 'next steps' for some people receiving HSG intervention. Quantitative data suggests that there were negligible increases in those engaging in volunteering, education and employment (0.1, 0.3 and 0.3 percentage points, respectively) across all intervention types from baseline to 12-month follow-up (see Table 8).

Table 8. Volunteering, education and employment outcomes

	Baseline before HSG receipt (n=3,743)	6 months after HSG receipt (n=3,743)	1 year after HSG receipt (n=3,743)
All intervention types, % (n)			
Volunteering or structured work placement			
Yes	1.3 (48)	1.3 (49)	1.4 (52)
No	98.7 (3,695)	98.7 (3,694)	98.6 (3,691)
In education			
Yes	0.9 (34)	0.9 (34)	1.2 (45)
No	99.1 (3,709)	99.1 (3,709)	98.8 (3,698)
In employment			
Yes	8.1 (303)	8.1 (305)	8.4 (313)
No	91.9 (3,440)	91.9 (3,438)	91.6 (3,430)

Source: NDTMS data.

One interviewee described securing a place in a recovery house as a pivotal point in their recovery journey. They explained that the support from staff helped them rebuild their confidence and sense of self-worth, giving them a purpose in life and enabling them to begin volunteering.

> I got clean through coming here, signing up with them and prescribing. You know, I have never done treatment before, but I ended up getting to one of their houses. Well, the support here from day one has been amazing…they helped build me up and get a bit of confidence back, a bit of self-worth. They're a purpose in my life. I started volunteering with them as well. I've built up a lot of good relationships with the staff here today…you have to still put the work in and I'm very lucky to have got a place with them in the recovery house I'm in now. I've been there for seven or eight months. (Person who uses treatment and recovery services HSG focus group 2, Site B, Phase 2)

3.5.3. Safety

HSG leads and staff described the HSG as fostering a sense of safety in those who received it, particularly for vulnerable women who were fleeing domestic violence or were currently, or previously, engaging in sex work. Of the women receiving HSG intervention (n=1,788), over half (65.2 per cent) reported experiencing domestic violence, either currently or in the past. Additionally, 10 per cent indicated that they were currently or had previously engaged in sex work. Notably, 34.1 per cent of the women either declined to answer or data were missing or inconsistent.

> We feel safe. We've got a home to go to. Aren't freezing cold. We don't have to sit outside and take drugs. (Person who uses treatment and recovery services 3, Site C, Phase 2)

> There should be more houses like what we're in…100%, for women, because there are a lot of women that ain't safe out there. (Person who uses treatment and recovery services 3, Site C, Phase 2)

In one case study site, funding had been allocated to provide safe, stable housing for vulnerable women that are often sexually exploited for accommodation. This intervention was described by interviewees as increasing an individual's engagement with healthcare and stabilising their financial capacity to pay rent, in addition to making them feel safer and consequently reducing their drug use.

> We have a very large cohort of [vulnerable women][6] in [case study location] and, unfortunately, they're quite often exploited for accommodation. So, we were able to work in partnership with a local housing association to

6 Term was modified under the direction of the interviewee for the reason of confidentiality.

> have a house which we staffed in the daytime. It was staffed by a security company at nighttime. It was used to house [number] of the most vulnerable females…. Since they've all been in accommodation, they've all engaged in healthcare. They've all been paying their rent charges. (Provider manager, Site C, Phase 2)

Furthermore, the use of HSG funds to secure emergency accommodation was described by interviewees at one case study site as alleviating strain on ambulance and police services through preventing people who use alcohol and/or other drugs from resorting to harmful activities to find accommodation.

> They will say to me because also part of this funding that you're talking about, we can claim emergency funding to get them overnight accommodation…they'll say to us like, "Well, that means I don't have to go and rob a shop tonight to get arrested. So I've got a warm place to sleep tonight." And that means that we've been able to, through our funding, get them an accommodation…. And so in addition to that, our service also pulls it from the resources from other services like the ambulance service, the police service (HSG staff focus group, Site A, Phase 2).

3.6. What were the wider context influences on implementation?

The three case study sites varied in their characteristics. Two of the sites are classed as urban (a city and a town), while the third is largely rural, and all the providers of treatment and recovery services were third-sector organisations. Furthermore, the three case study sites varied in terms of local context, financial position and competing priorities, and experienced varying challenges, such as geographic location, availability of housing and external partnerships. Financial constraints stemmed from the severity of historical cuts, with some services restoring what had been lost, while others expanded on existing provisions.

3.6.1. Housing stock

Although the HSG was not intended to increase housing stock, a national lack of available suitable housing (council and private) was in some instances described by interviewees as a direct barrier to implementing components of the HSG. Staff interviewees at one case study site identified that the early release scheme for prisoners, combined with demand for student housing, created a surge in the number of individuals with housing needs competing for accommodation in a situation where demand was already surpassing supply.

> Thirty thousand students that are residing here in [location]. So, the people who are finding themselves homeless who can only pay basic housing benefit rates, where you've got these students coming from affluent families nationwide. (HSG staff focus group, Site A, Phase 2)

These challenges were described by participants as making some HSG interventions unfeasible – specifically, rent deposits and first month's rent. They were also identified as limiting new support workers' ability to secure appropriate housing; if they did manage to secure accommodation, the rent was often unaffordable for people who use alcohol and/or other drugs. This was said to be a particular issue for individuals with specific needs, such as those who require accommodation in which residents do not use alcohol and/or other drugs ('dry accommodation') or vulnerable women who need a secure and women-only space. This also meant that it was difficult for staff to secure alternative housing if current accommodation was unsuitable (e.g. because of conflict with the landlord).

> They'll put us in places where we've got to pay stupid money. I get £132 every two weeks, that's all I get.... Half these places, you have to pay £80, mate. I can't afford that. What, and leave myself with £30? No thank you...and that's why we end up homeless, because we can't afford to live in those properties. (Person who uses treatment and recovery services 4, Site C, Phase 2)

Where these challenges were described as a substantial barrier for some teams implementing the HSG, others placed this wider challenge as a justification for the need for the HSG, to ensure that there are resources that can help people navigate pathways to accessing housing and reducing the risk of them being evicted from the housing that they do have.

> So there's a fella who just hadn't travelled on public transport, too anxiety-provoking. And actually helping him do that. And then the avenues that open up when you're able to do that, and when people understand and communicate with you better, that reduces your chances of the tenancy breakdown stuff. So that's been another, something you can do even with the housing crisis as it is. People can do, understanding people, yeah, and the personal budgets, helping people move forward with their recovery. (HSG lead 8, Phase 1)

Several people who were in receipt of the HSG said they needed to be verified by the council as sleeping rough on at least three separate occasions. This was consistent across the three case study sites, although the specific eligibility criteria varied. In one case study site it was reported by interviewees that situations such as living in a car or sleeping on a friend's sofa did not qualify as rough sleeping. Although sleeping on a friend's sofa is not aligned with the definition of rough sleeping,[7] staff and people who use alcohol and/or other drugs raised concerns that

7 MHCLG defines rough sleeping as: (1) 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 (2) 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) (Public Health England 2020).

this policy, or the interpretation of the policy, can create systemic barriers as the verification process could last months, delaying access to housing support while people remained in unstable, unsafe living conditions.

> We've got quite a strict criteria of who we can help…If they're sleeping in a car, they're not technically homeless. Or if they're sleeping on a couch, they're technically not homeless as well. (HSG staff focus group, Site A, Phase 2)

> They [the council] don't care about where you are or if you're homeless…. I was homeless for seven months, sleeping outside Paddy Power, and they reckoned they didn't find me, but I'm right in the middle of town. (Person who uses treatment and recovery services 4, Site C, Phase 2)

3.6.2. Characteristics of the HSG

The flexibility in local autonomy and decision making in the HSG was described by interviewees as supporting local teams to target the needs of their local population and plan spending around existing resources and gaps. For example, in one site where physical space to meet with people who use alcohol and/or other drugs was a challenge, commissioners focused on bolstering their outreach capacity. Another site focused their spending on addressing the consequences of issues around the quality of and reliance on temporary accommodation. This flexibility extended to the re-profiling of underspends (i.e. redirecting planned HSG funds not spent in a financial year).

Flexibility was also identified by HSG leads as supporting its value as a whole-system approach that incorporates a number of partners in a local area.

> They [OHID] gave us an allocation and basically said "go away and think about what you want to do with it and write a plan", so I think that was really good and it enabled us to go and talk to all our partners and providers and all our colleagues in the council (HSG lead 2, Phase 1).

3.6.3. Interpretations of the HSG programme brief

As identified in Section 3.2.4., there appeared to be some misinterpretations or 'clashes' in terms of eligibility for the HSG regarding active engagement with treatment. For instance, one case study site's HSG Plan detailed interventions that were specifically for individuals in the treatment and recovery service who had successfully completed residential rehabilitation. This meant that individuals not engaging in residential treatment, or not reaching certain treatment and recovery goals, would not have received support from the HSG.

3.6.4. Relationship to the wider Supplementary Substance Misuse Treatment and Recovery Portfolio

All 28 sites receiving the HSG were also receiving other DHSC grants that overlapped with housing, such as the RSDATG, which are characterised by distinct yet complementary activities for people who use alcohol and/or other drugs, and the wider system. Some participants were responsible for setting up multiple grants, and 'grant fatigue' was described by some local leads.

> All of those different funding pots I mentioned have some links, actually they often come back to the same small pool of people who have to juggle how it all fits together, and often with different pots of money that we've had happening sort of at the same time but not quite…. Public health are happy to put their proposals in by whatever date, and then actually, three weeks later, there's a different funding pot…and everybody's rushing around to try to meet those deadlines in different departments and to try and work really hard to knit them together as far as possible. (Local lead 2, Site C, Phase 2)

Sites faced competition for candidates due to the simultaneous recruitment for multiple grants and competing services across neighbouring areas. Some staff reported that competition highlighted wage disparities between treatment service roles and similar council positions.

> If somebody's got the option to go for a job in [company name] or the local authority, they're probably going to go for the local authority because the pay is higher, and we're in a cost-of-living crisis. People have families, mortgages. (HSG lead, Site C, Phase 2)

This disparity was described as benefiting services that can offer higher salaries. A HSG lead in one case study site identified the ability to pay a higher salary than other local areas as a factor contributing to their relatively easier recruitment and why, in many interviews and focus groups, participants from this case study site described housing staff retention as high, or housing staff turnover as low.

> The reality is if you live in [place name], this means we've been able to pay some higher wages or advertise it at a higher rate where we needed to. (Provider lead 3, Site B, Phase 2)

However, despite the initial challenges and complexities related to working with people who use alcohol and/or other drugs, implementation of the HSG was described by stakeholders across sites and of different professions (e.g. commissioners, HSG leads, HSG staff) as generally going to plan.

> It's [the HSG] been implemented for a while. I would say we've been delivering… Obviously, it's a test-and-learn model, which means that things have changed and things can change, but I would say the pathway is embedded within our service and we're delivering as a drug and alcohol service what we've been commissioned to deliver. (HSG lead, Site C, Phase 2)

While implementation of the HSG was reported to provide support to people with housing needs accessing this pathway, its broader implementation is contingent on securing continued funding. Staff raised concerns about how the HSG fits within the wider SSMTRG and existing core services. A key issue was the inconsistency in access to financial interventions, and whether this was dependent on a person's assigned case worker. This disparity was described as needing to be dealt with swiftly and delicately.

> There is one thing, I've just thought of a consequence that's not so good, is that we ended up having a bit of a postcode lottery in terms of if you were grant-funded by the housing support grant, you could have personal budget activities, if you were funded through [SSMTRG], you weren't, you couldn't, so that was something we had to sort out. (HSG lead 2, Phase 1)

Uncertainties around the continuation of funding impacted the women-only housing mentioned in Section 3.5.3, which was discontinued during this study. The project lead attributed the decision to operational costs, particularly the financial burden of 24-hour security. The decommissioning of this house was perceived as having a detrimental impact on the vulnerable women it housed, with safety concerns for one of the women cited.

> One was fleeing domestic violence. That's why she was here anyway. When she knew the house was being decommissioned, she got really worried because her partner's just got two years, but he still has contacts in [case study location]. (Specialist support worker, Site C, Phase 2)

This highlights the unintended consequence of implementing an intervention as part of a pilot, when continued funding is not guaranteed.

Chapter 4. **Discussion**

This research, the first to explore the impacts of the HSG, shows that the initiative was widely welcomed and had some key impacts for people who received HSG interventions and the staff who supported them. A key objective of the HSG was the provision of support for people who use alcohol and/or other drugs, as these individuals are more likely to have unstable, unsafe and temporary housing, be at risk of eviction, or be at points of transition into new accommodation (e.g. leaving hospital, prison or a rehabilitation facility) with a higher risk of homelessness (Department of Health & Social Care 2021; Neale et al. 2022; Ministry of Housing, Communities & Local Government 2020; Onapa et al. 2022). Findings from this research suggest that the HSG pilot was understood and implemented by most sites as an intensive, person-centred approach to supporting individuals who use alcohol and/or other drugs. Further, our research has identified the complexity and interrelated components of the HSG, as shown in Figure 1, demonstrating its holistic and wide-ranging impacts and influences. The multiple components of the HSG (individual-, service- and system-level) highlight its holistic approach and appropriateness in addressing the interconnected challenges related to both housing and treatment and recovery experienced by people who use alcohol and/or other drugs. While the components of the HSG, such as financial interventions and housing support workers, are not new interventions, they appear to be filling important gaps in service provision, building upon existing services and in some instances replacing what had been removed through previous cuts. In this section we reflect on the HSG in relation to the aims and objectives of the research, while also considering the evaluation findings in relation to previous research.

4.1. Was implementation carried out as intended?

In relation to the ambitions outlined in the HSG brief, implementation of the pilot appeared to have generally gone to plan, with most sites reporting that the interventions had been put in place (e.g. roles had been recruited and embedded or new teams formed, and financial interventions had been provided to a sample of people who use alcohol and/or other drugs). Sites were able to effectively use local data to design approaches that were tailored to the specific needs of their populations and leveraged existing resources in their local areas. Woodhall-Melnik and Dunn (2016), in their review of Housing First approaches in several countries, have emphasised the importance of approaches that consider the needs of local populations. Issues or deviations in implementation were not described as substantial in comparison to written plans (e.g. planned activities may

experience delays or adjustments, rather than not being implemented at all). Some interventions, such as home visits, were described as being relatively easy to implement and represented an improvement in access for people who use alcohol and/or other drugs. Others, such as recruiting and embedding new roles and teams, came with some challenges and tensions.

First, the recruitment of new HSG staff created some tensions, especially where those in HSG roles had a reduced caseload to ensure more targeted and person-centred approaches, while generic support workers had uncapped caseloads. This was a particular stressor in sites where HSG staff and non-HSG staff worked closely alongside each other. Secondly, there were also quality limitations in the HSG monitoring dataset that meant the population of people who received HSG support were not represented in the quantitative data (see Section 5.2.2). This may compromise the ability to demonstrate the benefits of the HSG and its implementation. Thirdly, some sites appeared to expect recipients to engage with treatment and recovery services in order to be eligible for the HSG, with examples of paternalistic reward-based provision of housing interventions, which were not stipulations of the brief (Ministry of Housing, Communities & Local Government 2024).

In terms of receipt and uptake of the HSG, there were indications from staff and people who use alcohol and/or other drugs that the HSG was welcomed. In some sites it was noted that demand exceeded supply, and the new worker roles operated at full capacity. While indicative of the value of the HSG, this highlights challenges for its sustainability and the need for strategies around caseload management, including processes for discharge back to a 'non-housing-support'-specific case worker for treatment and recovery needs beyond housing.

4.2. How have the wider and local contexts influenced delivery?

The local context in which the HSG was implemented differed across sites, potentially influencing choices of which interventions to implement, challenges and enablers of implementation, and outcomes for services and people who use alcohol and/or other drugs. For instance, some sites were 'building back' what had been cut in preceding years while others were building on existing housing provision, and there were also descriptions of a middle ground between these scenarios. We also noted variations across the three case study sites in how interventions were implemented and embedded within organisations, for example whether HSG support worker roles were separate to generic support worker roles or all support workers received training to give housing support advice. Many interviewees – staff and people who use alcohol and/or other drugs – praised the adaptability of the HSG to local and individual need, which has enabled treatment and recovery services to align with wider local priorities and support people using particular substances or experiencing or at risk of cuckooing.

While the HSG funding has the potential to assist people who use alcohol and/or other drugs in overcoming initial barriers to affording housing, the ongoing financial realities faced by these individuals (e.g. the cost of rent, food and general living expenses) limits the effectiveness of the intervention. The availability of housing stock was also described as a challenge to the

implementation of elements of the HSG, for example being able to find housing or housing with an appropriate rent. An evaluation of three Housing First pilot sites similarly found that securing accommodation, particularly one-bedroom properties, was a challenge due to a reduction of tenancy turnover since the COVID-19 pandemic (Ministry of Housing, Communities & Local Government 2024). In the present study, however, although the HSG was not intended to be used to increase housing stock, we found one example of housing being obtained through partnerships with housing providers facilitated through a strategic post funded by the HSG. A second example, although not a direct purchase of a house through the HSG, demonstrated how the HSG enabled the acquisition of a women-only house through partnerships with other organisations, with the funds from the HSG used to pay for 24-hour security staffing.

4.3. How did the HSG support people who received HSG interventions?

The HSG provided tailored support to remove barriers to engagement in treatment and recovery. For instance, housing support workers acted as 'care navigators', and services were brought directly to people via outreach services. This was often achieved through a holistic approach of combining multiple interventions for people with complex needs. This approach was taken as evidence suggests that people with complex needs benefit from a case management approach whereby a case worker can facilitate access across multiple services depending on the needs of the individual (Savic et al. 2017).

As we summarise in Figure 1, system-wide changes were required to prepare treatment and recovery systems for individual-level and service-level components of the HSG, and partnership working appeared to be a central element of what was implemented. There were some accounts of how the HSG had been designed to encourage the promotion of a culture shift in organisations surrounding treatment and recovery services, to better meet the needs of the population. This included various implementation activities (e.g. training, closer partnership working), with examples of raising awareness of the needs of people who use alcohol and/or other drugs via education and improved knowledge exchange. The use of closer partnership working and external training programmes to reduce stigma and discrimination for people experiencing homelessness have been used within the literature, as discrimination is systematically reproduced by professionals and service providers in public and private settings (Canham et al. 2024), and interventions to change attitudes and behaviour towards those that are homeless can help reduce those systematic biases. Within this study, there was some early evidence that strategic posts for multi-agency working can facilitate the reduction of systematic biases by carving out the necessary time for relationship-building.

The HSG has commonalities with models of integrated care, as it aimed for system-wide improvements and implemented activities to support changes across the treatment and recovery and housing sectors, through building or improving partnerships across agencies (e.g. council, third-sector). The implementation and evaluation of models of integrated care have been described in the literature as inherently complex, as demonstrating impacts across the system

can be particularly challenging (Baxter et al. 2018). Nevertheless, findings from this research point to some examples of how support received through the HSG might contribute to a reduction in the need for or intensity of support from other services (e.g. ambulance and police). The number of examples were relatively small, and we did not have access to data from surrounding services to explore the validity and scale of these observations. Further research with longer-term data that link records across systems could also explore whether improvements in housing situation, both independently and via changes in alcohol and/or other drug use, is having wider impacts, such as on healthcare utilisation and social care.

4.4. How have HSG interventions contributed to changes in health outcomes in service users? And for whom?

On balance, there was some evidence of positive changes in service users' housing-related outcomes one year after receiving the HSG. There were also several reported examples in the qualitative data of improvements to overall health, wellbeing and social inclusion, with home visits cited as reducing feelings of isolation. In addition, there were examples of the provision of white goods improving care for children who lived with those in receipt of the HSG. This is particularly important as housing challenges negatively impact children and young people's health and wellbeing (Hock et al. 2024). It should be reiterated that these changes cannot be causally attributed to the HSG, and, on balance, the observed changes are relatively modest. While there is an indication that the programme serves to improve outcomes, further analysis of quantitative data is required to establish whether this is the case.

For those who received HSG intervention, staff were able to support, resolve or reduce the severity of their housing issue, with wider social and psychological impacts reported. These examples included an improved sense of safety, or motivation and opportunity to be more socially active. The benefits of safe and appropriate housing for social inclusion of people who use alcohol and/or other drugs is well-established (Nord-Baade et al. 2024; Quilgars and Pleace 2016; Nubani et al. 2022), as are the impacts of improvements in housing and social inclusion on engagement with treatment and recovery (O'Shaughnessy et al. 2024). People who use alcohol and/or other drugs often face multiple interacting challenges, such as a lack of adequate housing, financial challenges due to not working, and sometimes mental and physical health needs. As a result, any intervention that supports treatment and recovery is likely to need to cater to individual needs and be adaptive in nature. Other housing interventions for this group, such as Housing First approaches, have identified similar challenges in achieving success for this population (Saldanha et al. 2024), although others have reported it to be a beneficial approach (Padgett et al. 2011).

Although the connection between homelessness, unstable housing and substance-use interventions is now well-established in the literature (Magwood et al. 2020), it is not yet understood which housing interventions will lead to the best outcomes. Our data did not enable an exploration of whether certain individual interventions were more effective than others, or more suited for some individuals over others. The data in this evaluation does not

enable comment on whether any interventions were or were not suited to specific groups or characteristics. There was, however, an indication from the qualitative data that home visits were particularly suited for people whose non-housing-related needs put them at a greater risk of being unable to engage with services, particularly if this meant attending appointments in-person (e.g. people with mental health problems). Further research is needed to better understand the extent to which some interventions were more beneficial for some people than others.

Chapter 5.
Strengths and weaknesses

5.1. Strengths

This was a mixed-methods evaluation, which combined qualitative and quantitative data sources. The evaluation was able to draw from multiple sources and diverse stakeholders to provide a comprehensive perspective on the implementation of the HSG, strengthening the credibility of the findings through the triangulation of data sources. The qualitative insights were supported by integrating the NDTMS and HSG monitoring data, providing additional information on the demographics of people who use alcohol and/or other drugs receiving the HSG, and some evidence around potential early outcomes. The mixed-methods approach enhanced the research findings by ensuring a breadth-and-depth analysis of the dataset. Although the evaluation was primarily qualitative-led, the iterative process was also guided by quantitative data, allowing researchers to identify trends in specific demographics that may have been overlooked in the qualitative analysis. This was important for determining the most relevant outcomes to discuss, especially given the complexity of the dataset.

5.2. Weaknesses

5.2.1. Balance of qualitative data from staff and people who use alcohol and/or other drugs

Due to the focus of this evaluation's research questions on understanding the early implementation of a pilot, we have predominantly drawn on data gathering the views and experiences of staff (e.g. commissioners, providers, HSG leads and staff). In our qualitative work, it was evident that many people who use alcohol and/or other drugs were not aware whether their support was funded by the HSG or other funds, making it difficult to attribute outcomes to HSG interventions. This could lead to an underestimation of the benefits of the HSG. Although we conducted a large number of interviews and focus groups with people who received HSG interventions, much of the data describing outcomes was reported by staff. Furthermore, as we were recruiting through treatment and recovery services by meeting people who were at the service in-person and currently engaging with the service, our sample consists of people most likely to be actively engaging in structured treatment, representing a potential bias.

5.2.2. Limitations in quantitative analysis

Initially, we had hoped to conduct analysis comparing outcomes of those who received HSG support (intervention group) with a suitable comparator group that did not receive HSG support (control group), over time. Several limitations, however, precluded us from undertaking such a quasi-experimental, control-matched analysis.

First, there was substantial variation in how HSG support was allocated across LAs, making it challenging to identify suitable criteria to determine a usable control group. Secondly, the outcome data of greatest interest (on health) was only available in the NDTMS dataset, which records information solely on individuals in structured treatment. This meant we had no outcome data for a large proportion of people who received HSG support but were not in structured treatment. Any analysis would therefore have been biased towards those in structured treatment, excluding the potentially more vulnerable group who were not engaged in such services. Thirdly, when individuals drop out of treatment, by design, NDTMS does not obtain follow-up data. As a result, the dataset over-represents people who remain in treatment over time. Given the known benefits of engagement in treatment and recovery, this inevitably biases results in favour of those who stay engaged, providing limited insight into the outcomes of those who disengage. This is an unavoidable limitation of the way the NDTMS is structured and has prevented more sophisticated analyses from being undertaken.

Given the above limitations, any observed changes in outcomes (or lack thereof) cannot be directly attributed to the HSG. This is particularly true as many participants were also receiving other interventions to address alcohol and/or other drug use, as recorded in the NDTMS dataset, meaning improvements among those in treatment may have resulted from non-HSG interventions.

HSG monitoring data

The HSG monitoring data does not represent the entire population of people who received HSG support, as it only covers 22 of the 28 LAs that received HSG funding. The reasons for data completeness issues are unclear and likely differ across LAs. Even among the data that was provided, there were a variety of quality issues, such as the inclusion of people who did not have an assigned HSG intervention or were recorded as having a financial intervention value of £0.

Further, the HSG monitoring dataset lacks potentially important information such as recipient demographics, broader treatment details and health outcomes. An attempt was made to link HSG monitoring records with NDTMS data to address these gaps, but this was not possible for individuals not in structured treatment, as they had no NDTMS record. Even among those with an NDTMS record, data quality issues hindered accurate matching in some cases, preventing some records from being linked despite referring to the same individuals.

NDTMS data

The NDTMS dataset, while larger in sample size, has different limitations. In comparison to the HSG monitoring dataset, it provides limited detail on the type of HSG intervention received, recording only whether a case worker, financial intervention or combined financial intervention

and case worker was provided. Although the NDTMS dataset aims to collect follow-up outcomes regularly (NDTMS guidance says once at the start, then at three months, then at six months and six-monthly thereafter, with one at exit if it is a planned exit),[8] this is not always consistently achieved. This may skew our analytical sample towards people more likely to remain in treatment and attend appointments, potentially leading to an overestimation of positive outcomes.

We conducted multiple logistic regression to examine whether there were systematic differences between participants with and without follow-up data. The model included a set of core participant characteristics to assess their association with the likelihood of having follow-up data. We did not find evidence that any sociodemographic factors were associated with the presence (or lack) of follow-up data, except for having children, which was positively associated with not having data at follow-up timepoints, and therefore leaving structured treatment.

5.3. Implications for monitoring the HSG

At present, there is insufficient information to robustly evaluate the HSG from a quantitative perspective. We do not know how individuals were selected to receive it, the available data does not capture all recipients and suffers from quality issues, and the core HSG monitoring dataset lacks key variables – particularly health-related measures – that are critical for assessing outcomes of interest. To enable meaningful comparison across these diverse approaches: (i) NDTMS should be adapted to include additional detail on HSG interventions; and (ii) HSG monitoring data should be expanded to incorporate key variables aligned with NDTMS. This will help ensure that the two datasets are comparable and support more robust evaluation.

For (i), this would involve adding several fields to NDTMS to capture information currently collected in the HSG monitoring data regarding the intervention received. This would provide greater detail on the scope and characteristics of the intervention, including the number of appointments, intensity and types of activities delivered over time. For (ii), the HSG monitoring dataset could be adapted so that the questions are fully aligned with existing variables in NDTMS – for example, core sociodemographic characteristics (age, gender, ethnicity) and key outcomes from the Treatment Outcomes Profile, such as quality of life, physical health and psychological health. This alignment would ensure consistency with the outcome measures already captured in NDTMS.

Making these changes would remove the need to collect the same information separately in the HSG monitoring dataset for individuals who already have an NDTMS record, meaning that the HSG monitoring dataset would only need to cover those without an NDTMS record. Hence, on balance, the added workload on staff is kept to a minimum. The HSG monitoring dataset could then function as a streamlined, supplementary version of NDTMS, ensuring comparability between HSG recipients in structured treatment (recorded in NDTMS) and those not in structured treatment (captured through the HSG monitoring dataset). It would allow for meaningful comparison with

8 For more details of the data available in NDTMS, see Office for Health Improvement & Disparities (2026b).

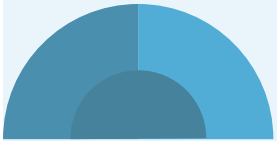
the broader treatment population in NDTMS as a control group. The usefulness of this approach for evaluation is somewhat limited, as NDTMS only covers individuals in treatment, and it is not possible to determine how representative they are of the wider population. This is a common limitation across addiction research more broadly, as far less is known about people who are not engaged in treatment, and could still serve as an improved monitoring tool at a minimum.

To do this in practice, it is recommended to work collaboratively with HSG leads, service-level providers, the treatment and recovery workforce and research and evaluation experts to ensure the resulting process is optimal for all involved. Implementing such a system could support future evaluation of service delivery.

Chapter 6. **Recommendations**

- **Central government should continue to fund housing support for those who use alcohol and/or other drugs.** The grant was received very positively by staff and people who use alcohol and/or other drugs, and we recommend further funding for housing initiatives to support this group.
- **Central government should continue to support LAs to tailor housing interventions to the needs of their populations and allow LAs to manage financial interventions.** This will enable LAs to continue to tailor provision to their local populations and needs, leveraging local knowledge and enabling equitable housing support.
- **Central government should examine the variation in LAs' interpretation of eligibility for HSG support across the pilot sites, including differing requirements related to abstinence or engagement with treatment.** There is a need for central government to review the perception of the HSG brief by LAs and ensure that their understanding is aligned with the primary aim of improving recovery outcomes for people who use alcohol and/or other drugs through housing support, regardless of whether or not they are engaging with treatment and recovery services.
- **Central government should develop clear guidelines outlining the purpose of reducing caseload sizes for staff providing intensive support. This should include strategies for coping with the potential impacts on caseload management of longer-term support, including processes for discharge back to a 'non-housing-support'-specific case worker.** When designing and implementing new roles within treatment and recovery services, such as those funded by the HSG, it is essential to consider the impact on existing staff, particularly of varied caseloads of staff working within the same service.
- The current data structure does not support a robust evaluation of the effectiveness of the HSG. **To strengthen future evaluation, HSG monitoring data and NDTMS should be aligned as closely as possible,** to enable comparable information to be collected for all HSG recipients – whether or not they are in structured treatment – and allow for

meaningful comparison with the broader treatment population in NDTMS as a control group. The selection of key variables to be included should be determined through consultation with HSG leads, service-level providers, the treatment and recovery workforce and research and evaluation experts to ensure relevance, evaluation feasibility and minimal burden on staff.



References

Aldridge, Robert W., Alistair Story, Stephen W. Hwang, et al. 2018. 'Morbidity and Mortality in Homeless Individuals, Prisoners, Sex Workers, and Individuals with Substance Use Disorders in High-Income Countries: A Systematic Review and Meta-Analysis.' *The Lancet* 391 (10117): 241–50. doi:10.1016/S0140-6736(17)31869-X

Aubry, Tim, Gary Bloch, Vanessa Brcic, et al. 2020. 'Effectiveness of Permanent Supportive Housing and Income Assistance Interventions for Homeless Individuals in High-Income Countries: A Systematic Review.' *The Lancet Public Health* 5 (6): e342–60. doi:10.1016/S2468-2667(20)30055-4

Baxter, Andrew J., Emily J. Tweed, Srinivasa Vittal Katikireddi & Hilary Thomson. 2019. 'Effects of Housing First Approaches on Health and Well-Being of Adults Who Are Homeless or at Risk of Homelessness: Systematic Review and Meta-Analysis of Randomised Controlled Trials.' *Journal of Epidemiology and Community Health* 73 (5): 379–87. doi:10.1136/jech-2018-210981

Baxter, Susan, Maxine Johnson, Duncan Chambers, Anthea Sutton, Elizabeth Goyder & Andrew Booth. 2018. 'Understanding New Models of Integrated Care in Developed Countries: A Systematic Review'. *Health Services and Delivery Research* 6 (29): 1–132. doi:10.3310/hsdr06290

Canham, Sarah L., Rachel Weldrick, Morgan Erisman, et al. 2024. 'A Scoping Review of the Experiences and Outcomes of Stigma and Discrimination towards Persons Experiencing Homelessness.' Health & Social Care in the Community 2024 (1): 2060619. doi:10.1155/2024/2060619

Crisis UK. 2026. 'Housing Models and Access.' As of 4 March 2026: https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/housing-models-and-access/

Damschroder, Laura J., Caitlin M. Reardon, Marilla A. Opra Widerquist & Julie Lowery. 2022. 'The Updated Consolidated Framework for Implementation Research Based on User Feedback.' *Implementation Science* 17 (1): 75. doi:10.1186/s13012-022-01245-0

Deacon, Rachel M., Llewellyn Mills, Raimondo Bruno, et al. 2023. 'Identifying Thresholds for Clinically Meaningful Change among Clients of Drug and Alcohol Services Using the Australian Treatment Outcomes Profile.' *Addiction* 118 (12): 2457–65. doi:10.1111/add.16295

Department of Health & Social Care. 2021. *Review of Drugs Part Two: Prevention, Treatment, and Recovery*. As of 4 March 2026:
https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

Gale, Nicola K., Gemma Heath, Elaine Cameron, Sabina Rashid & Sabi Redwood. 2013. 'Using the Framework Method for the Analysis of Qualitative Data in Multi-Disciplinary Health Research.' *BMC Medical Research Methodology* 13 (1): 117. doi:10.1186/1471-2288-13-117

HM Government. 2021. *From Harm to Hope: A 10-Year Drugs Plan to Cut Crime and Save Lives*. As of 4 March 2026:
https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

Hock, Emma S., Lindsay Blank, Hannah Fairbrother, et al. 2024. 'Exploring the Impact of Housing Insecurity on the Health and Wellbeing of Children and Young People in the United Kingdom: A Qualitative Systematic Review.' *BMC Public Health* 24 (1): 2453. doi:10.1186/s12889-024-19735-9

Homeless Link. 2024. *Annual Review 2023: Support for Single Homeless People in England*. As of 4 March 2026:
https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Link_2023_Annual_Review_of_Single_Homelessness.pdf

Kerman, Nick, Alexia Polillo, Geoff Bardwell, et al. 2021. 'Harm Reduction Outcomes and Practices in Housing First: A Mixed-Methods Systematic Review.' *Drug and Alcohol Dependence* 228: 109052. doi:10.1016/j.drugalcdep.2021.109052

Magwood, Olivia, Ginetta Salvalaggio, Michaela Beder, et al. 2020. 'The Effectiveness of Substance Use Interventions for Homeless and Vulnerably Housed Persons: A Systematic Review of Systematic Reviews on Supervised Consumption Facilities, Managed Alcohol Programs, and Pharmacological Agents for Opioid Use Disorder.' *PLOS ONE* 15 (1): e0227298. doi:10.1371/journal.pone.0227298

Marsden, John, Michael Farrell, Colin Bradbury, et al. 2008. 'Development of the Treatment Outcomes Profile.' *Addiction* 103 (9): 1450–60. doi:10.1111/j.1360-0443.2008.02284.x

Miler, Joanna Astrid, Hannah Carver, Wendy Masterton, et al. 2021. 'What Treatment and Services Are Effective for People Who Are Homeless and Use Drugs? A Systematic "Review of Reviews".' *PLOS ONE* 16 (7): e0254729. doi:10.1371/journal.pone.0254729

Miler, Joanna Astrid, Rebecca Foster, Kristina Hnizdilova, Helen Murdoch & Tessa Parkes. 2022. '"It Maybe Doesn't Seem Much, but to Me It's My Kingdom": Staff and Client Experiences of Housing First in Scotland.' *Drugs: Education, Prevention and Policy* 29 (3): 231–44. https://doi.org/10.1080/09687637.2021.1926429

Ministry of Housing, Communities & Local Government. 2020. *Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People Who Sleep Rough in England: Initial Findings from the Rough Sleeping Questionnaire.* As of 4 March 2026:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944598/Initial_findings_from_the_rough_sleeping_questionnaire_access.pdf

Ministry of Housing, Communities & Local Government. 2024. *Evaluation of the Housing First Pilots: Final Synthesis Report.* As of 4 March 2026: https://assets.publishing.service.gov.uk/media/671a70221898d9be93f75db4/Housing_First_Final_Synthesis_Report.pdf

Moledina, Aliza, Olivia Magwood, Eric Agbata, et al. 2021. 'A Comprehensive Review of Prioritised Interventions to Improve the Health and Wellbeing of Persons with Lived Experience of Homelessness.' *Campbell Systematic Reviews* 17 (2): e1154. doi:10.1002/cl2.1154

NIHR (National Institute for Health Research). 2019. 'How to Disseminate Your Research: Getting your message heard – and used.' As of 4 March 2026: https://arc-swp.nihr.ac.uk/uploads/attachments/NIHR%20Dissemination%20Guidance.pdf

Neale, Joanne. 2008. 'Homelessness, Drug Use and Hepatitis C: A Complex Problem Explored within the Context of Social Exclusion.' *International Journal of Drug Policy* 19 (6): 429–35. doi:10.1016/j.drugpo.2007.09.001

Neale, Joanne, Stephen Parkin, Laura Hermann, et al. 2022. 'Substance Use and Homelessness: A Longitudinal Interview Study Conducted during COVID-19 with Implications for Policy and Practice.' *International Journal of Drug Policy* 108 (October): 103818. doi:10.1016/j.drugpo.2022.103818

NHS England. 2024. 'National Drug and Alcohol Treatment Monitoring System Data Set.' January 11. As of 4 March 2026: http://standards.nhs.uk/published-standards/national-drug-and-alcohol-treatment-monitoring-system-data-set

Nord-Baade, Silje, Ottar Ness, Camilla Bergsve Jensen, Michael Rowe, Elin Opheim & Anne Landheim. 2024. 'Barriers and Facilitators for Social Inclusion among People with Concurrent Mental Health and Substance Use Problems. A Qualitative Scoping Review.' *PLOS ONE* 19 (12): e0315758. doi:10.1371/journal.pone.0315758

Nubani, Linda, Alaina De Biasi, Marie A. Ruemenapp, Lisa D. Tams & Robert Boyle. 2022. 'The Impact of Living in an Un- or Under-furnished House on Individuals Who Transitioned from Homelessness.' *Journal of Community Psychology* 50 (8): 3681–99. doi:10.1002/jcop.22865

Office for Health Improvement & Disparities. 2022. 'Additional Drug and Alcohol Treatment Funding Allocations: 2022 to 2023.' As of 4 March 2026: https://www.gov.uk/government/publications/extra-funding-for-drug-and-alcohol-treatment-2022-to-2023/additional-drug-and-alcohol-treatment-funding-allocations-2022-to-2023

———. 2023. *Adult Substance Misuse Treatment Statistics 2021 to 2022: Report*. As of 4 March 2026: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2021-to-2022/adult-substance-misuse-treatment-statistics-2021-to-2022-report

———. 2026a. 'National Drug Treatment Monitoring System (NDTMS).' As of 4 March 2026: https://www.ndtms.net/

———.2026b. 'NDTMS data collection resources.' As of 4 March 2026: https://www.ndtms.net/ResourcesAndTraining/Documentation

Onapa, Hebaat, Christopher F. Sharpley, Vicki Bitsika, et al. 2022. 'The Physical and Mental Health Effects of Housing Homeless People: A Systematic Review.' *Health & Social Care in the Community* 30 (2): 448–68. doi:10.1111/hsc.13486

O'Shaughnessy, Branagh R., Paula Mayock & Aimen Kakar. 2024. 'The Recovery Experiences of Homeless Service Users with Substance Use Disorder: A Systematic Review and Qualitative Meta-Synthesis.' *International Journal of Drug Policy* 130: 104528. doi:10.1016/j.drugpo.2024.104528

Padgett, Deborah K., Victoria Stanhope, Ben F. Henwood & Ana Stefancic. 2011. 'Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs.' *Community Mental Health Journal* 47 (2): 227–32. doi:10.1007/s10597-009-9283-7

Public Health England. 2020. *Health Matters: Rough Sleeping.* As of 4 March 2026: https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping

Quilgars, Deborah, & Nicholas Pleace. 2016. 'Housing First and Social Integration: A Realistic Aim?' *Social Inclusion* 4 (4): 5–15. doi:10.17645/si.v4i4.672

Saldanha, Susan, Natalie Tavitian, Elizabeth Lehman, Lindsay Carey & Peter Higgs. 2024. 'Effectiveness of the Housing First Model among Substance Users: A Scoping Review.' *Housing, Care and Support* 27 (2): 90–105. doi:10.1108/HCS-09-2022-0024

Savic, Michael, David Best, Victoria Manning & Dan I. Lubman. 2017. 'Strategies to Facilitate Integrated Care for People with Alcohol and Other Drug Problems: A Systematic Review.' *Substance Abuse Treatment, Prevention, and Policy* 12 (1): 19. doi:10.1186/s13011-017-0104-7

Spicer, Jack, Leah Moyle & Ross Coomber. 2020. 'The Variable and Evolving Nature of "Cuckooing" as a Form of Criminal Exploitation in Street Level Drug Markets.' *Trends in Organized Crime* 23 (4): 301–23. doi: 10.1007/s12117-019-09368-5

Strang, Lucy, Katherine Morley, Beth Muldrew, et al. 2026. *D-SITAR Methods Report*. Santa Monica, Calif.: RAND Corporation. RR-A4735-7. As of 8 April 2026: https://www.rand.org/pubs/research_reports/RRA4735-7

Woodhall-Melnik, Julia R., & James R. Dunn. 2016. 'A Systematic Review of Outcomes Associated with Participation in Housing First Programs.' *Housing Studies* 31 (3): 287–304. doi:10.1080/02673037.2015.1080816