HOUSING FIRST FEASIBILITY STUDY:

Expansion of Services in Northern Ireland

Housing Executive

Housing First Feasibility Study Expansion of services in Northern Ireland

Final Report

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The Research team (Fiona Boyle (Fiona Boyle Associates), Imogen Blood (Imogen Blood & Associates) and Professor Nicholas Pleace (University of York, European Observatory on Homelessness) would like to thank all the respondents who gave of their time and professional knowledge to contribute to the discussion on the potential for the expansion of Housing First in Northern Ireland. The input of those with lived experience of homelessness and Housing First was particularly appreciated.

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The content of this report does not necessarily reflect the official opinion of the Housing Executive. Responsibility for the information and views expressed lies with the authors.

Executive Summary

This feasibility study was commissioned by the NI Housing Executive (hereafter NIHE), and conducted by a consortium including Fiona Boyle as the lead researcher, Professor Nicholas Pleace (University of York, European Observatory on Homelessness) and Imogen Blood (Imogen Blood & Associates) and their wider research teams.

The overarching aim of the study was to examine the feasibility of delivering Housing First across Northern Ireland.

The study looked at and reported on the following:
Section 2 – the background and context to Housing First including definitions, UK principles and practice, Housing First development and delivery in the Liverpool City Region, and international evidence on large-scale Housing First services.
Section 3 – homelessness in Northern Ireland including legislation, policy context and level/nature of homelessness, current and previous provision by Depaul and Simon Community NI, Complex Lives and the rationale for Housing First in Northern Ireland and the need for expansion.
Section 4 – definition and estimates of the level of chronic homelessness, and qualitative feedback from service users, stakeholders and providers on the nature and impact of chronic homelessness. This section concludes with an estimation of some 150 to 200 individuals in Belfast who can be described as chronic homeless, with potentially another 50 individuals Northern Ireland wide.
Section 5 – understanding of current homelessness provision including temporary accommodation hostels. This section provides an analysis of quantitative and qualitative feedback from service users, stakeholders and providers on the difficulties and barriers experienced by those who are covered by the definition of chronic homelessness, in temporary accommodation.
Section 6 – qualitative feedback from stakeholders and providers on the component or critical parts of a Housing First model, and an examination of the range of potential options which could provide a housing supply for Housing First. The need to ensure a dedicated consistent and reliable housing supply for Housing First was seen to be critical to any expansion of the service.
Section 7 – qualitative feedback from service users - the service user voice – exploring their homeless story or journey including reasons for moving into chronic homelessness and difficulties in exiting this situation/circumstances, their views on temporary accommodation services and their views on Housing First.
Section 8 – exploration of fidelity within the Housing First model, including what fidelity is and why it matters. In addition, a review of how fidelity is promoted and/or assured in other jurisdictions and areas.
Section 9 – examination of broad areas of cost effectiveness and potential cost efficiencies in implementing Housing First, alongside factors relating to cost savings, cost offsets and outcomes.
Section 10 then outlines the research team's proposed **Housing First model for Northern Ireland**.

This Feasibility study acknowledges that Housing First has existed in Northern Ireland since 2014 through services delivered by Depaul and SCNI. Whilst evaluations show the outcomes this provision has had, they also reference the restrictions placed on Housing First in a Northern Ireland context by the lack of a dedicated housing supply and lack of access to other relevant services in the health and social care sector. It is important to note that Housing First is fundamentally an intensive case management model, which requires strategic integration with public health, mental health, addiction, addiction, social housing and other homelessness services, alongside wider links with welfare and criminal justice systems, if it is to function well.

Based on the quantitative and qualitative analysis in this study, the research team recommend a 4-year expansion of Housing First, taking into account the following factors:

Definition – agreed definition from the Liverpool study[1], and based on the principles outlined in Appendix 3.
"Housing First is a system of support for homeless people with high and complex needs which is designed to deliver a sustainable exit from homelessness, improve health and well-being and enable social integration. Housing First uses ordinary housing, such as private rented or social rented flats and is designed to house formerly homeless people with high needs in their own, settled homes *as quickly as possible* and to provide the support they will need to sustain an exit from homelessness *in their own home."*

Policy context and integration
To move forward in Northern Ireland we suggest that the following is needed, in order to enable the development of an integrated Housing First strategy across all the relevant Government Departments and to ensure the necessary housing supply to make Housing First a reality.

- Political and ministerial endorsement
- Cross- or inter-departmental working and collective involvement of all political parties and Departments to ensure integration with existing resources, services and structures, and to enable the model to develop with full support and the required funding.

Target group for Housing First service
Based on analysis of the current Housing First provision in Northern Ireland and feedback from stakeholders, we recommend that that the chronic homelessness definition is used as the main target group suitable for the uptake of Housing First. This definition describes chronic homelessness as "a group of individuals with very pronounced and complex support needs who found it difficult to exit from homelessness."[2]

Numbers
In this report we have estimated (based on the data available) that the current known population of people experiencing chronic homelessness across Northern Ireland is in the order of 250, with estimations of some 150 to 200 individuals in Belfast, with potentially another 50 individuals Northern Ireland wide. Within the body of the report we also note that there may be another 580

[1] It is acknowledged that this definition used the term 'homeless people'. For any further usage of this definition in a Northern Ireland context, the phrase 'people experiencing homelessness' would be used.
[2] www.crisis.org.uk/media/237173/a_review_of_single_homelessness_in_the_uk_2000-2010.pdf

people who might be 'at risk' of joining this cohort and/or who are currently off-radar, together with figures on the number of people experiencing multiple placements who could be considered to be chronic homeless or moving towards that cohort.

Additional Target groups for Housing First service

During this Feasibility study the drawbacks of this definition and categorisation were acknowledged, and the need for a broader and more flexible inclusion of people in the area of chronic homelessness was noted. We therefore recommend a degree of latitude in assessing the needs of individuals who may be suitable for and benefit from Housing First. Taking this on board, and looking more specifically at repeat homelessness (1,075 individuals in 2022/23) and multiple placements (985 individuals in 2022/23), it is clear that Housing First could be a solution to repeat and multiple/ complex homelessness for a much bigger number of people.

In addition, this study has pointed to the need for dedicated Housing First services for specific groups of people, including young people and women, particularly those who have experienced domestic abuse/violence. Housing First for those outside the two main cities (Belfast and Derry) including those in rural settings is a further key consideration.

Location of Housing First in Northern Ireland

We recommend the following expansion of Housing First, beyond Belfast and Derry, over the 4-year period, which would produce an overall figure of 220 additional units of Housing First delivery across Northern Ireland, in an initial scaling up of Housing First. (See table at end of this Executive summary)

Outline of Housing First service

Our examination points to two clear potential options for the further development and expansion of Housing First in Northern Ireland. The first option is to retain the current model of commissioning Housing First services from homeless providers through the Supporting People budget; with the opportunity for further funding streams for some specific projects e.g. the SCNI example of HF4Y which is funded through HSC Trust budgets.

The second option is to envelope the Housing First delivery options within the wider Complex Lives model, expanding this model within and potentially beyond Belfast, and working with homeless providers to facilitate the housing support element of Housing First. Complex Lives would provide the referral route, the assessment and triage service and potentially ongoing multi-disciplinary support mechanisms. Decisions would need to be made around whether to roll-out a format of Complex Lives regionally, providing multi-disciplinary teams in all suggested locations/hubs, or in contrast to operate through coordinating existing services in regional areas. The latter would take into account 'trusted partners, local context and local service provision. The option of integrating with Complex Lives appears to have considerable promise. It would provide reliable and ongoing funding, a housing supply could be arranged and clear requirements could be put in place around the integration of Housing First services into Complex Lives itself and wider systems and strategies.

Whichever approach is chosen, and it could be an amalgamation of both in different regional areas, the research points to a number of factors which needs to be in place if Housing First is to be effective, both in terms of best outcomes for service users and in relation to the cost-effectiveness of the model. These cover aspects of staffing, caseload, services and referral and assessment processes. The need to include emotional and psychological support, including the use of PIE[3] and trauma informed practice, practical support to set up and maintain home and finances, help and advocacy to access benefits and services, and support in building social networks and meaningful activity were emphasised in the study.

The research also highlighted the following as key principles for Housing First in Northern Ireland:

- If someone refuses or fails to engage with the support, they are not 'struck off', or their tenancy threatened or ended;
- That service users of Housing First have tenants' rights and responsibilities;
- That services users have choice and control in decision-making, and that this enables the rebuilding of trust and self-efficacy around their own journey;
- That the ethos and practice of Housing First delivery is not about 'policing the rules' but more about working with the service user to enable them to get the best out of their tenancy and the support available;
- That the ethos and practice of Housing First delivery is around building strengths and skills, so that the individual's long-term resilience in their tenancy is built up and protected.

Duration and intensity of support

The proposed model, based on a caseload of typically up to five service users per support worker, enables the staff member to provide different levels of support to service users as they come into the service. The model incorporates the opportunity for support to increase or decrease as required, in response to a person's fluctuating needs and/or sudden or extreme incidents or issues.

The model recognises that some individuals will remain in the Housing First service for their lifetime, whilst others will develop the skills and capacity to live more independently with Floating support. No throughput level or resettlement rate is set for Housing First, as in a sense this defeats the ethos of the model.

Workforce development

The proposed expansion of Housing First across Northern Ireland will require a shift in how providers and Complex Lives deliver this model. This will undoubtedly require a targeted focus on skills identification and development in line with the proposed service and team structures, as well as the possibility of the NIHE developing a framework of viable and suitable potential Housing First providers to respond to the expansion.

[3] PIE – Psychologically Informed Environments.

Team structure

The proposed team structure for the development and expansion of Housing First in Northern Ireland, irrespective of whether this is done via Complex Lives, individual housing and homeless services providers or a combination of both, is outlined below based on a caseload of 20 people.

Manager

(may be managing other delivery aspects as well as Housing First – costs are assumed within 15% overheads for staffing below)

Team Leader

(specifically for Housing First)

4 Housing Support workers

based on support of 20 service users (caseload of 3 – 8 per worker at any one time)

Mental Health Support

0.3 FTE – to provide mental health/clinical support across 20 service users, and to act as a support mechanism to Housing Support workers

Based on practice elsewhere in the UK and internationally, it is recommended that the team structure also includes the input or services of a dedicated mental health worker and/or addictions support. It is proposed that this role would require a clinical psychologist or other trained therapeutic practitioner, at 0.3 FTE. This could be further reduced to 0.1 FTE (half day a fortnight) if the role was just providing clinical supervision and occasional training for the team. The above structure and inclusion of different roles will differ based on whether the Housing First model is delivered through (a) Complex Lives or (b) homeless/housing providers.

Hours of operation

The Housing First model proposed would include a team operating on a flexible rota Monday to Friday, covering normal working hours with weekend cover at lower levels and emergency only cover at night. Whilst not advocating a full 24/7 type service, stakeholder feedback and learning from other jurisdictions does point to the need to have provision via some sort of system for emergency issues and incidents.

Access to housing and types of housing

During the course of this Feasibility study, access to and availability of suitable housing, has been the most highlighted item, both in terms of being a stumbling block to enabling access to current Housing First provision and in relation to thinking about scaling up and expanding Housing First

across Northern Ireland. Affordable and accessible housing is key to Housing First; without this the service is housing support within temporary accommodation provision.

Feedback from the NIHE and other key stakeholders during the study provided opportunities for frank and realistic discussions on how and where any housing will be provided from. A range of potential options were outlined in detail in Section 6. It is worth repeating the following statement from the NIHE, as their considered proposal to ensure a dedicated consistent and reliable housing supply for Housing First:

"Establishing a supply of accommodation that is both suitable and accessible is central to the challenge of developing the Housing First model, and it is envisaged that a range of mechanisms for sourcing properties will be utilised. To this end NIHE have been exploring several potential routes to secure a sufficient and sustainable supply of accommodation to meet demand and varying need and will involve both private rented sector and social sector properties. NIHE is in the process of seeking Departmental approval for a 3-year programme of private rented sector acquisitions by NIHE's Landlord body. Many of these properties are likely to be former NIHE properties that are now available in the private market. These properties could be used to meet a range of supply pressures, where there will be a focus on increasing the temporary accommodation portfolio, and also the opportunity to directly contribute to the Housing First supply. This initiative could also indirectly contribute to Housing First by reducing the overall pressure within the competing priorities across the Homeless sector though the introduction of more choice and more cost-effective options, potentially allowing more flexibility in budget management.

Within the social housing sector, NIHE have been reviewing the existing stock and are seeking to identify void properties that may be in suitable locations and of suitable size for Housing First clients. NIHE are also exploring how these properties may be allocated specifically to Housing First clients, and are in consultation with DfC in relation to establishing a policy variation that would permit, in a limited number of cases, deviation from the normal allocations process for those identified as chronic homeless and eligible for Housing First[4]*. This approach could also be utilised in relation to Housing Association stock, and in a broader sense, NIHE will seek to engage with Housing Associations to identify opportunities to utilise vacant Housing Association stock with a view to maximising the overall supply that exists which will directly or indirectly contribute to the development of the Housing First supply."*

[4] This would be under Rule 84 of the Housing Selection Scheme; this states: The Board of the Housing Executive may, after consultation with the Department of the Environment, make allocations otherwise than in accordance with this Scheme… In particular the Board may, after consultation with the Department, authorise the making of allocations in specific designated 'difficult to let estates', to Applicants who have not applied for housing in that estate. www.nihe.gov.uk/getattachment/b997e1f4-969f-467b-9e91-03f77c1c6ae9/Housing-Selection-Scheme-Rules.pdf

Access to health & social care and mental health services

The proposed model is based on access to mental health services through mainstream services rather than via a specialist mental health team for Housing First. In other words rather than having ACT[5] teams, the proposed model will operate through an Intensive Case Management (ICM) approach – in this case, we are proposing that this is dovetailed to the Complex Lives team which is already in place in the Belfast setting (and Belfast Metropolitan area) but would need to be expanded as Housing First expands, and is delivered via 'trusted partners' in Derry and regionally. The latter may be homeless services/housing providers or other community organisations. We strongly recommend that the proposed model (either via Complex Lives or separately) has the capacity to handle a psychiatric/personality disorder diagnosis and addiction diagnosis simultaneously (dual diagnosis). We have included the role of mental health support in the model; based on a clinical psychologist or other trained therapeutic practitioner, at 0.3 FTE. This could be further reduced to 0.1 FTE (half day a fortnight) if the role was just providing clinical supervision and occasional training for the team.

The focus of the intensive case management team will be to have a team of generalist housing support workers providing intensive support around tenancy management and sustainment, community integration and wider goals (around training, education and employment). This team will also support individuals to access and engage with wider health and social care services including mental health and addiction services (if required); with support workers providing the additional support of 'brokering' or 'navigating' access. Opportunities for fast-tracking or additional access for service users may be an option.

Lived experience engagement

The research team recommend that service users' views and lived experience is included in the process of service development and expansion of Housing First in Northern Ireland. This may be via the mechanisms noted in the Homelessness Strategy[6] and the proposed development of a Homelessness Lived Experience programme or through a co-production panel, as used in the Greater Manchester Housing First service.

Fidelity of the model

The research team confirmed that services with high fidelity to the principles achieve better outcomes for service users, and ensure the most effective use of resources. Whilst recognising the potential for model drift, discussion with the Research Advisory Group concluded that it would not be helpful to incorporate a full-blown fidelity accreditation system into any planned Housing First expansion in Northern Ireland at this point, albeit that some level of checks and balances should be put in place by the funder (Supporting People) to monitor the integrity of the service.

[5] Assertive Community Treatment teams specifically for Housing First.

[6] *Ending Homelessness Together,* Homelessness Strategy 2022 – 2027, NIHE.
Ending Homelessness Together Homelessness Strategy 2022-27 (nihe.gov.uk)

Costing the Model

All of the cost components were obtained from a range of sources including Supporting People and Housing First providers, and used to build a projected overall cost for the proposed Housing First model, based on the operating model of 20 service users per core staff team, and taking into account the staffing structure and costs relating to the Liverpool study. This is outlined below.

Model component	Cost Assumptions	Projected cost per 20 Housing First service users (per annum)
The 'core' Housing First staffing team[7]	Team Leader - £34,300 (£38,800 including oncosts and 3% pension)	£38,800
	Housing Support Workers[8] - £28,400 X 4 = (31,900 including oncosts and 3% pension)	£127,600
	Organisational overheads – taken as 15% of all salary costs[9]	£24,960
2nd tier mental health support – 0.3 FTE	Clinical psychologist/trained therapeutic practitioner[10] - £43,742.00	£13,122.60
Personalisation budget	Based on costs included in the Liverpool study for on call system – at £450 per service user	£9,000.00
Total		**£213,482.60**

It should be noted that any housing costs associated with the provision of social housing would be subsumed by the NIHE. In addition, the research team acknowledge that these costs may need to be weighted or adjusted for different contexts, e.g. living costs in Belfast may require Housing First salaries to be weighted up compared to some other locations. Equally, there may be pressures around recruiting in certain contexts, e.g. recruitment for Housing First in more rural areas. The research team notes that Housing First projects need to be able to offer a salary level that can attract and retain people with the right mix of qualifications and experience to work effectively as team members.

Review and evaluation

[7] Costings used – Depaul and SCNI salary scales (2024), and work undertaken by the Research team (2024)

[8] Depaul noted £23,683.02. SCNI noted salary scale of £22,869 to £25,059 for Specialist Support worker. In addition, work undertaken by the Research team (2024) based on the Liverpool study and current Housing First provision in Great Britain.

[9] To include costs of Manager and Senior Management.

[10] Costing based on Practitioner Psychologist Band 7, £43,742.00 - £50,056.00.

The research team suggests the inclusion of a formative evaluation throughout the proposed expansion period for Housing First services, rather than a summative evaluation at the end of the delivery period, in order to capture all aspects of project delivery and impact, and to feed back into project delivery. We suggest that the evaluation should focus on impact, fidelity to the principles/process or implementation learning, cost benefit analysis, and should include lived experience voice.

Another key focus of any ongoing review needs to be an examination, as people move out of hostels and into Housing First, of the opportunity to reconfigure any existing hostels and/or the closure of any specific hostels or types of provision. Factors such as occupancy/voids, reduced levels of referrals, reduced uptake as service users indicate a preference for Housing First, should all be taken into account in longer-term planning.

Four-year expansion of Housing First – Northern Ireland

Year	Location(s)	Current Numbers	Proposed Numbers	Rationale
1, and ongoing over all years	Extend provision for Belfast/Derry service users – who wish to have a tenancy outside of these two locations. **For Belfast** – extend to the Belfast Metropolitan area or Greater Belfast area – covering in addition to Belfast – Lisburn, Newtownabbey, North Down, Castlereagh and Carrickfergus **For Derry** – extend to include Strabane and Limavady	Belfast - 28 Derry - 25	Belfast – 100 Belfast Met area – 50 Derry – 35 Derry area - 6	Focus on ensuring people can live where they want to live. Availability of housing supply in these wider areas. Can be delivered from the hubs within Belfast and Derry.
2	Set-up small-scale Housing First provision in two regional areas as hubs covering: **Ballymena** – Antrim, Ballymoney, Coleraine **Dungannon** – Portadown, Lurgan, Armagh, Banbridge and Craigavon	-	Ballymena Hub – 8 Dungannon Hub - 8	Based on rough sleeper numbers, street audits, current homeless provision in areas. Also linking in with current homeless services in these areas
3	Set-up small-scale Housing First provision in two further regional areas as hubs covering: **Newry** – Downpatrick, Banbridge **Enniskillen** – County Fermanagh, Omagh	-	Newry Hub – 8 Enniskillen Hub - 4	
4	Pilot Housing First for different groups: Young people (under the age of 25) Women (including those who have experienced domestic abuse/violence).	No SP current provision	SP funded HF for young people and women – numbers to be agreed	Provision needs to be specific to the needs of the group
Total		**53**	**219**	**Grand total - 272**

Section 1 Introduction

Introduction

This feasibility study was commissioned by the NI Housing Executive (hereafter NIHE), and commenced in April 2023. Whilst Housing First has been in place on a relatively small scale in Northern Ireland since 2013, the aims of the study were to look in depth at the feasibility of delivering Housing First across Northern Ireland, alongside developing an evidence base for the current provision and creating a scalable model for further development. The client indicated an underlying rationale for the study was to enable the NIHE to address the challenges associated with housing people with high needs who were experiencing homelessness within the particular context of Northern Ireland. The study specification also included a request to broadly replicate the *Housing First Feasibility Study for the Liverpool City Region*[11] which informed the development of Housing First in Liverpool with a view to this research providing a similar contribution to the expansion of Housing First in Northern Ireland.

This study is being conducted by a consortium including Fiona Boyle (Fiona Boyle Associates) as the lead researcher; Fiona co-produced a previous evaluation of a Housing First pilot in Northern Ireland[12]. Further expert knowledge and support is provided by Professor Nicholas Pleace (University of York, European Observatory on Homelessness) and Imogen Blood (Imogen Blood & Associates) and their wider research teams (including Mark Goldup, IBA and Joanne Bretherton, UoY), who were part of the research team for the Liverpool study cited above.

About the Feasibility Study

The overall aims of the project were as follows:

- To undertake analysis into the feasibility of delivering Housing First across Northern Ireland, by looking at the client (HE) outcomes, costs and savings to the public purse, development of property portfolio and customer experience;
- To deliver an evidence base on existing Housing First provision that builds on previous commitments made by the HE and sought by key stakeholders from the homelessness sector;
- To explore replication of the Housing First programme in Liverpool, while accounting for the unique characteristics in Northern Ireland;
- To create a Northern Ireland level model for Housing First including:
    - Staffing;
    - Property requirements;
    - Timescales;
    - Associated costs and comparative analysis with existing portfolio, identifying value for money potential as appropriate.

[11] Blood, I., Copeman, I., Goldup, M., Pleace, N., Bretherton, J. & Dulson, S. (2017) *Housing First Feasibility Study for the Liverpool City Region*, London: Crisis.
Housing First feasibility study for Liverpool City Region | Crisis UK

[12] Boyle, F. and Palmer, J. with Ahmed, S. (2016) *Efficiency and Effectiveness of the Housing First Support Service piloted by Depaul in Belfast: an SROI evaluation* (2016), NIHE.
www.nihe.gov.uk/getattachment/ab02a490-e1cb-4b4b-91d0-e63460d83f52/housing_first_evaluation.pdf

The key objectives of the research were:

- To examine the strengths and weaknesses of the existing temporary accommodation portfolio in relation to client outcomes;
- To examine the number of clients that could be targeted by Housing First and estimate future need;
- To provide comparative costs for delivering Housing First versus existing service delivery in the context of clients experiencing chronic homelessness;
- To identify property portfolio requirements and timescales to reach capacity and what are the service requirements for landlords;
- To examine potential for efficiencies and value for money analysis (across all sectors but particularly housing/health and justice);
- To examine the likelihood of achieving specified outcomes with and without Housing First;
- To examine the role of lived experience in Housing First and its impact on success;
- To create a model for Housing First in Northern Ireland.

A Project Advisory Group (PAG) was set up to oversee the feasibility study and in addition a Research Advisory Group (RAG) was established to assist in the delivery of the study including providing guidance to the Research team in terms of data sources and key/emerging issues, facilitating access to datasets and consultations with relevant staff and to act as a sounding board in reviewing key outputs. (See Appendix 1 for membership of PAG and RAG).

Feasibility Study - Methodology

The research specification for this study listed the following key research tasks, which were integrated into the study methodology. Full details of the research methods are outlined at Appendix 2.

1. Review of existing literature on Housing First in particular areas where large scale projects have been implemented e.g., Liverpool and comparable European experience.
2. Conduct interviews with experts in this area to include service delivery agencies and users of those services;
3. Examination of the NI Housing Market using existing data on house prices and the rental market to consider the availability of housing across all tenures and the difficulties in accessing the Private Rented Sector (PRS) etc.;
4. Identification of relevant stakeholders and finance sources required to deliver Housing Frist across Northern Ireland with commissioning options;
5. Collection of qualitative data on the landlord perspective and attitudes to/interest in being involved in the Housing First scheme/programme;
6. Identification of the scale of need for Housing First provision;
7. Identification of requirements (resources, policy, funding etc.) needed to deliver a Housing First programme across Northern Ireland with clear proposals, solutions and recommendations that will form the basis of an action plan and business case that the HE can take forward;
8. Creation of a Northern Ireland Scale model for Housing First including:
    - Staffing;
    - Property requirements;
    - Timescales;
    - Associated costs and comparative analysis with existing portfolio, identifying value for money potential as appropriate.

Section 2 Background & Context – what is Housing First?

Introduction

This section explores what Housing First means, including definitions and service models, with particular reference to the UK principles and practice, and the development of Housing First in Liverpool City Region. In addition, this section provides an overview of the international evidence base on large-scale Housing First services; pointing to learning from other places including successful pilots and an exploration of criticisms of and difficulties in scaling up Housing First elsewhere, with discussion on fidelity and operational realities. This element of the research has been prepared by Professor Nicholas Pleace (University of York, European Observatory on Homelessness), and provides the context and backdrop for exploring the Housing First model in Northern Ireland.

What is Housing First?

Housing First was described as follows in the Liverpool study[13]:

"Housing First is a system of support for homeless people with high and complex needs which is designed to deliver a sustainable exit from homelessness, improve health and well-being and enable social integration. Housing First uses ordinary housing, such as private rented or social rented flats and is designed to house formerly homeless people with high needs in their own, settled homes *as quickly as possible* and to provide the support they will need to sustain an exit from homelessness *in their own home."*

The NIHE has referenced its support for Housing First since the early 2010s; evidenced through the initial and ongoing commissioning of services, the evaluation of the pilot provision[14] and continued commissioning of Belfast Housing First services and the expansion to Derry/Londonderry. Recent policy documentation has pointed to a desire to increase the level and spread of Housing First; the most recent Homelessness Strategy notes: *We want to see a significant shift towards rapid rehousing[15] including Housing First for those it is appropriate for. It provides ordinary, settled housing as a first response for people with multiple needs, i.e., those who are chronically homeless.[16]* This description links the provision of Housing First to the client group of chronic homelessness. In particular the Homelessness Strategy points to the need to look at how clients access the private rented sector within both Housing Led and Housing First models, and how Housing First provision can be extended across Northern Ireland on a cross-tenure basis with a focus on improving access to permanent housing for these clients. The term chronic homelessness is explored in Section 4.

The NIHE documents note that 'Housing Led' applies to lower intensity services (in terms of support intensity, range or duration) which may also be targeted at lower needs groups of people

[13] It is acknowledged that this definition used the term 'homeless people'. For any further usage of this definition in a Northern Ireland context, the phrase 'people experiencing homelessness' would be used.

[14] Boyle, F. and Palmer, J. with Ahmed, S. (2016) *Efficiency and Effectiveness of the Housing First Support Service piloted by Depaul in Belfast: an SROI evaluation* (2016), NIHE.
The Efficiency and Effectiveness Of The Housing First Support Service piloted by Depaul In Belfast, funded by Supporting People: a Social Return On Investment evaluation. (nihe.gov.uk)

[15] Professor Pleace notes: Rapid rehousing - this is American terminology; it refers to housing vouchers (there is no universal housing benefit) and is used as part of homelessness strategy, but is not the same thing as Housing First. The (very broad) equivalent would be the relief duties of Housing Options teams in England, which may or may not become the Main Duty to provide settled housing depending on assessment.

[16] *Ending Homelessness Together,* Homelessness Strategy 2022 – 2027, NIHE, page 37.
Ending Homelessness Together Homelessness Strategy 2022-27 (nihe.gov.uk)

experiencing homelessness who are not chronically homeless. Further information on the comparison between Housing First and Housing Led services in the UK can be found in research by Homeless Link.[17] This research by Homeless Link (2015) noted the following:
"Current practice in England shows that fidelity to the Housing First model is mixed. Whilst there are some services adopting the core philosophy of Housing First, others appear to be drifting from the model and can be described as 'Housing led' approaches due to their lower intensity of support, range and duration and targeting lower needs clients. A small number of projects represent a much greater drift from the model, and appear more akin to floating support with independent accommodation."

Housing First – UK principles and practice
The UK Government provides a Housing First toolkit[18] for planning and implementation of Housing First services. They note that the toolkit was produced by organisations involved in the evaluation of the Housing First pilot programme, was funded by the Ministry for Housing, Communities and Local Government (MHCLG), and draws upon the specialist knowledge of Homeless Link and I-SPHERE (Heriot-Watt University). The website states: *Housing First services are defined through their adherence to an internationally recognised set of principles[19] and require change in the attitude, culture and approach of stakeholders to ensure they are delivered effectively and are sustainable.*

These principles are summarised below, and in full at Appendix 3.

Principle 1: People have a right to a home
Principle 2: Flexible support is provided for as long as it is needed
Principle 3: Housing and support are separated
Principle 4: Individuals have choice and control
Principle 5: An active engagement approach is used
Principle 6: The service is based on people's strengths, goals and aspirations
Principle 7: A harm reduction approach is used

These key principles were launched in England in 2016; more detailed guidance is now available.[20] Evidence suggests that services with high fidelity to the principles achieve better outcomes for service users, which also ensures more effective use of resources.[21]

The origins of the model, what fidelity to the model might mean, and more detail is available on the Housing First Europe hub website[22], the Housing First Guide Europe[23] and in the Canadian Housing First toolkit[24]. At an early stage in this feasibility study the RAG noted that different stakeholders in the development and delivery of Housing First may have very different definitions and

[17] 'Housing First' or 'Housing Led'? The current picture of Housing First in England, Homeless Link (June 2015) Microsoft Word - Housing first report 23.06.2015 (kxcdn.com)
[18] Mobilising Housing First toolkit: from planning to early implementation - GOV.UK (www.gov.uk)
[19] Professor Pleace notes: What is outlined in the UK toolkit is much closer to the picture drawn by Homeless Link: https://housingfirsteurope.eu/wp-content/uploads/2019/10/2019-10-10-HFinEurope_Full-Report2019_final.pdf
[20] Ending Rough Sleeping: What Works? | Crisis UK
[21] The Principles of Housing First | Homeless Link
[22] Housing First Europe hub website - Home - Housing First Europe
[23] Feansta Housing First Guide Europe - PowerPoint Presentation (feantsa.org)
[24] Canadian Housing First toolkit - Housing First Toolkit - Home

understanding of what Housing First is. Feedback from the key informant and provider interviews is outlined in section 6, focusing on what respondents think is important and integral to the Housing First model and service.

The operationalisation of Housing First is also important, based on the key principles above; design and delivery vary greatly in different regions and internationally. Variations include the housing source – including private or social rental markets. The structure of the support team, which is usually commissioned specifically for Housing First, falls into two broad internationally recognised support team structures: Intensive Case Management (ICM) and Assertive Community Treatment (ACT). The Government toolkit describes these as follows:

- Intensive Case Management (ICM) is where a team of generalist support workers provide intensive support around tenancy sustainment, community integration and reaching goals and aspirations. They will support individuals to engage with wider health and social care services by 'brokering' or 'navigating' access. This approach is what is generally used in the United Kingdom; this relies heavily on the development of relationships and partnerships to ensure pathways into services;
- Assertive Community Treatment (ACT) teams are comprised of professionals with a range of specialisms (e.g. psychiatrists, social workers, health professionals and housing workers) who function as a multi-disciplinary Housing First team specifically to meet the needs of individuals supported. ACT teams are typically seen in countries where wider health and social care support is unavailable or difficult to access, or where individuals have significant and chronic mental health needs that cannot be met via ICM. This approach is generally used in the US, Canada and parts of Europe.

However, outside of the three countries with nationally supported Housing First programmes (referred to as full or 'full fat' Housing First), that is Canada, Denmark and France, it is debatable how far the above models are used. Services in Great Britain tend to raise the intensity of the floating support practice and services that have been followed for decades, by concurrently drastically lowering the caseload, but these are not essentially mental health models as described above. ICM-only (which tends to be a flexible mix of support and case management) pre-dominates at a global level and certainly at a European and UK level[25].

Housing First – Liverpool City Region

As noted earlier the NIHE requested that this feasibility study should reference and incorporate the approach taken for the feasibility study for the Liverpool City Region. It is important to note the context of this Northern Ireland feasibility study; as a comparator there was no Housing First provision in Liverpool at the time of the feasibility study looking at the Liverpool city region (2016/ 2017). The starting point in Northern Ireland is different – with a track record of delivery and cognisance of the term in the housing and homelessness sectors since 2013, as a model and service had been delivered in Northern Ireland over the last ten years – in certain urban settings (Belfast and Derry/Londonderry) and for specific clients including specialist provision for younger people.

[25] Information provided by Professor Pleace.

Housing First has been commissioned by local authorities in England since 2010; the pattern of provision included local responses to meet an identified gap in homelessness service provision for those with very high and complex needs, and generally comprised services delivered across a single local authority area, were small scale in terms of the number of people served, and were delivered with local partners coming together. An early evaluation (2015) of nine small scale pilots in England found that Housing First is effective in the context of English housing, health and benefit systems[26]. In 2018, research[27] was published about the implementation of Housing First in England and included in-depth case studies of five different services[28].

In the autumn of 2017, the Government announced a £28 million investment to test the delivery of Housing First at scale and the regional pilot programme was established. This comprised three devolved regional authorities; Greater Manchester Combined Authority (GMCA), Liverpool City Region Combined Authority (LCRCA) and West Midlands Combined Authority (WMCA). Together these encompass 23 individual local authority areas. The delivery of services emerging from this is different for each of the regional authorities; the services developed and commissioned for Liverpool are outlined below.

Liverpool City Region

- **Commissioning**: CA[29] are delivering in-house following recruitment of service delivery teams.
- **Management and control**: CA have a central management team with a strong focus on system-wide change who oversee service delivery.
- **Delivery model**: In-house delivery teams working across the CA area and divided geographically.
- **Housing supply**: Primarily social housing initially (CA has above national average share of socially rented properties), but in the longer-term private landlords will also be a key source of properties.
- **Lived experience involvement**: Through lived-experience group for research, Pilot design and development, and recruitment.
- **Cross-region support delivery**: All working for CA at present, team structure based on feasibility study. Two pan-region psychologists recruited by CA as part of Pilot team.
- **Local authorities covered**: The 6 authorities of Liverpool, Sefton, St Helens, Wirral, Halton and Knowsley.

[26] Bretherton, J. and Pleace, N. (2015) Housing First in England: An Evaluation of Nine Services London: Homeless Link.
[27] Homeless Link (2018). Understanding the implementation of Housing First in England. London: Homeless Link.
[28] ACTion Lincs, delivered by P3
Cambridgeshire CEA, delivered by Cambridgeshire Local Authority
Inspiring Change Manchester Housing First, delivered by Shelter
Hammersmith and Fulham Housing First, delivered by St Mungo's
North Tyneside Housing First, delivered by Home Group
[29] CA: Combined Authority.

Overview of the international evidence base on Housing First

Successful pilots

In the last decade, the number of policy research projects, academic research papers and evaluations of Housing First, including experimental (randomised control) trials and quasi-experimental trials has greatly increased. Google Scholar reports that in 2005, 14 articles and reports were published with 'Housing First' in their title, by 2010 that had risen to 34, while by 2015 it was 109, with a further 85 appearing last year. Collectively, the evidence base on Housing First covers some 1,640 pieces of written policy and academic research, covering dozens of studies and evaluations.[30]

Until the mid-2010s, the experience of Housing First in Europe and the UK was relatively new. Research and analysis tended to be reporting on the results of pilot programmes. In England, Housing First services were likely to be small scale pilots with only start-up funding attached, i.e. funding would sunset after 2-3 years unless a local authority, the NHS or another source could be persuaded to continue supporting a service.[31]

Sometimes the funding for Housing First pilots came from regional government like the Greater London Authority and sometimes from philanthropic sources. Housing associations or charities, who were convinced by the arguments about Housing First, invested in pilots in the hope that local authority commissioners would ultimately be persuaded to commission services. In other cases, including the first service in England, it was local authority commissioners (in this instance the London Borough of Camden) who made the decision to undertake a pilot and see what benefits Housing First might bring.[32] At European level, the pattern was very similar, while some Housing First services in the Netherlands and Denmark were more established and had been running for several years, a lot of Housing First services were relatively recent, small-scale pilots.[33]

All the UK and European research in the 2010s reported the same thing, which was that around 80-90% of the people experiencing long-term or repeated homelessness associated with multiple and complex needs were still housed after one year with Housing First. However, these studies tended not to be comparative, they looked at Housing First services but not the existing services that Housing First was operating alongside.[34] Nevertheless, claims were quite often made that UK and European Housing First was 'more effective' than existing services and sometimes this was taken to the point of arguing for total replacement of existing services with Housing First.[35]

In practice, these claims that Housing First should replace everything else were rather dubious for three reasons. First, the evidence base for superior effectiveness was North American and compared

[30] Source: Google Scholar, June 2023.
[31] Bretherton, J. and Pleace, N. (2015) *Housing First in England: An Evaluation of Nine Services* York: University of York/Homeless Link.
[32] Pleace, N. and Bretherton, J. (2013) *Camden Housing First: A 'Housing First' Experiment in London* York: University of York.
[33] Busch-Geertsema, V. (2016) *Peer Review in Social Protection and Social Inclusion: Housing First* Synthesis Report (Belgium) Brussels: European Commission
[34] Pleace, N. (2018) *Using Housing First in Integrated Homelessness Strategies* London: St Mungo's.
[35] Centre for Social Justice (2021) *Close to Home: Delivering a National Housing First Programme in England* London: Centre for Social Justice.

Housing First with housing-ready/staircase services. These services have strict regimes, they were abstinence-based and required many boxes to be ticked and hurdles to be jumped, i.e. someone had to be drug and alcohol free and in treatment before being offered housing, which was very different from the largely harm-reduction based and increasingly co-productive nature of many UK and Northern European homelessness services. Second, even based solely on the North American evidence, Housing First was not universally effective, there were 10-20% of people for whom it did not work, and the housing-ready/staircase services were not simply ineffective, i.e. they worked for around 40-60% of service users. Third, there was growing evidence that integrated homelessness strategies, in which Housing First could play an important role, *alongside* other forms of homelessness services and significant use of prevention services, provided the most effective response to preventing and reducing homelessness. [36]

Early doubts and criticisms

Doubts and criticisms of Housing First initially emerged in the USA, where the model had been operating for a longer period than elsewhere, having been adopted as part of Federal homelessness policy under the last Bush Administration. This criticism took three main forms:

- That Housing First was not actually inherently superior to staircase/housing-ready services, because those services still helped four to six of the people they worked with into stable housing. Moreover, those people had their support and treatment needs and addiction issues addressed by the point they moved in. Housing First was portrayed as getting more people out of homelessness, but as not addressing their other needs as comprehensively, because a harm reduction approach combined with immediately providing housing meant people were moving in with addiction and other treatment and support needs, still present.[37]
- That Housing First, while presenting as progressive, i.e. using a 'consumer-led' (co-productive) and trauma informed approach combined with harm reduction, actually had very strict ideas about how homelessness should be ended, i.e. by modifying someone's behaviour in set ways. The argument here was that claims that Housing First worked co-productively with people experiencing homelessness were exaggerated, i.e. it was a slower and more sensitive, housing-based version of the housing ready/staircase models it was supposedly replacing.[38]
- That claims of cost effectiveness were exaggerated, i.e. high-cost savings only occurred if someone was a very high cost, high risk individual who was experiencing long-term homelessness and making high frequency and sustained use of emergency medical, mental health and addiction services, plus high rates of contact with the criminal justice system.[39]

[36] Pleace, N. (2018) op. cit.

[37] Rosenheck, R. (2010) Service Models and Mental Health Problems: Cost Effectiveness and Policy Relevance in I.G. Ellen and B. O'Flaherty *How to House the Homeless* pp.17-36. (New York: Russell Sage Foundation).

[38] Willse, C., 2010. Neo-liberal biopolitics and the invention of chronic homelessness. *Economy and Society*, 39(2), pp.155-184; Hansen Löfstrand, C. and Juhila, K (2012) The Discourse of Consumer Choice in the Pathways Housing First Model, *European Journal of Homelessness* 6(2) pp.47-68.

[39] Kertesz, S.G. and Johnson, G. (2017) Housing first: Lessons from the United States and challenges for Australia. *Australian Economic Review*, 50(2), pp.220-228.

However, two national-level randomised control trials (RCTs), one in Canada (*At Home/Chez Soi*)[40] and in France (*Un chez-soi d'abord*)[41], alongside quasi-experimental work in Denmark[42] and a large number of small-scale individual studies began to produce a lot of evidence showing Housing First performing very well, including in relation to the different mix of homelessness services found outside North America.[43]

As the global evidence base grew, particularly around the Canadian and French experimental evaluations of Housing First, it became apparent that the picture was more complex than these three criticisms suggested. First, Housing First did end homelessness among people with multiple and complex needs at a higher rate than comparable services and that basic statistic, that more homelessness among very vulnerable people was brought to a lasting end, could not really be disputed. Second, while Housing First did reflect American ideas about creating robust, self-contained individuals who could fend for themselves as the 'solution' to homelessness, the model was much more complex and nuanced than that, recognising and responding to the systemic, as well as individual, factors associated with homelessness. In addition, European and UK versions of Housing First reflected the cultural differences with the USA, i.e. there was often significantly more emphasis on co-production, on enabling someone to reach a better position in way that they defined for themselves, rather than working towards a standardised 'ideal person' who is enabled to leave homelessness behind them.[44] Debates around cost effectiveness were also more complex than these criticisms suggested, with evidence that while Housing First could not guarantee savings, it tended to represent an effective use of public funds because it frequently ended homelessness among people with multiple and complex needs.[45]

Questions surrounding fidelity

An important part of the response to early criticism of Housing First centred on the idea of fidelity. The argument from Sam Tsemberis, the originator of Housing First, and others was that homelessness services – particularly in the US – were often 'changing the sign' and calling themselves Housing First, but not really following the model.[46] The initial experimental and quasi-experimental trials of Housing First had tested Housing First using a mix of intensive case management (ICM) and assertive community treatment (ACT), immediate access to housing, harm reduction and a consumer-led (broadly co-productive) approach to service delivery. Shortfalls in Housing First performance were explained largely in terms of low fidelity to the original approach, an argument that appeared to be supported by high fidelity services being used in the French *Un chez-soi d'abord* and Canadian *At Home/Chez Soi* experimental trials, both of which showed high-fidelity

[40] Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D., and Aubry, T. (2014) National at Home/Chez Soi Final Report (Calgary, AB: Mental Health Commission of Canada).
[41] DIHAL (2016) The Experimental Programme Un chez-soi d'abord Housing First Main Results – 2011 / 2015 (English summary) (Paris: Délégation interministérielle à l'hébergement et à l'accès au logement). http://housingfirst.wp.tri.haus/assets/ files/2016/04/un- chez-soi-dabord-EN.pdf
[42] Allen, M., Benjaminsen, L., O'Sullivan, E., and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* Bristol: Policy Press.
[43] Pleace, N. (2018) op. cit.
[44] Aubry, T.(2020) Analysis of housing first as a practical and policy relevant intervention: the current state of knowledge and future directions for research. *European Journal of Homelessness* 14(1), pp.13-26.
[45]
[46] Greenwood, R.M., Stefancic, A. and Tsemberis, S. (2013). Pathways Housing First for homeless persons with psychiatric disabilities: Program innovation, research, and advocacy. *Journal of Social Issues*, 69(4), pp.645-663.

Housing First performing strongly in ending long term and recurrent homelessness among people with multiple and complex needs.[47]

Particular emphasis on fidelity to the original Housing First model has also been pursued in some other European Housing First services, including the adoption of Housing First in Ireland and Portugal.[48] However, the European picture is more complex, as implementations of Housing First did not always fully reflect the original American model, but were influenced by the circumstances, culture and systems of different countries. In Italy, the pursuit of Housing First has been led by the Italian Federation of Homelessness Organisations, fio.PSD through a collaboration called *Housing First Italia*,[49] while in England, Homeless Link, the Federation of English Homelessness Organisations and the national homelessness charity Crisis have advanced the case for Housing First.[50] The Italian and English approaches have stressed the operation ethos of Housing First, i.e. housing as a human right, harm reduction and choice and control for people using the services, but they have not replicated much of the detail of the original American approach. The American model, while dependent on collaboration with other services directly offers several elements of health, addiction and mental services, because these services are not universally available. However, the cost of providing more services within the Housing First team is unnecessary (even illogical) in countries which, unlike the USA, have universal health, social care and welfare systems.[51]

There is evidence that these other forms of Housing First, with high fidelity to the core philosophy of Housing First, but with lower fidelity to many aspects of the original model, generate very similar results in sustainably ending homelessness among people with multiple and complex needs. This is important because these services, lacking the full range of integrated services seen in the original ACT/ICM model, have significantly lower operating costs. There are rarely the qualified social workers, specialist addiction worker, mental health professionals or dedicated staff focusing on housing supply seen in the original approach.[52]

Another important dimension of the European experience of Housing First has centred on Finland. Sometimes – inaccurately – portrayed as a successful 'import' of Housing First to a European country, which has resulted in a sustained reduction in long-term and recurrent homelessness, the reality of Finland is rather different. Finnish Housing First is quite distinct and originated in Finland itself, not the USA. Finnish Housing First is also a *strategy*, not one service model, referring to a housing-led approach across all dimensions of a highly integrated homelessness national approach

[47] Culhane, D.P. (2008) The Cost of Homelessness: A Perspective from the United States *European Journal of Homelessness* 2, pp. 97-114; Pleace, N. and Bretherton, J. (2019) *The Cost Effectiveness of Housing First in England* London: Homeless Link.
[48] Aubry, T., Bernad, R. and Greenwood, R. (2018) A Multi-Country Study of the Fidelity of Housing First Programmes: Introduction. *European Journal of Homelessness*, Volume, 12(3), pp. 15-31.
[49] Lancione, M., Stefanizzi, A. and Gaboardi, M. (2018) Passive adaptation or active engagement? The challenges of Housing First internationally and in the Italian case. *Housing Studies* 33(1), pp.40-57.
[50] Pleace, N. and Bretherton, J. (2019) op. cit.
[51] Pleace, N. and Bretherton, J. (2017) 'What Do We Mean by Housing First? Considering the Significance of Variations in Housing First Services in the European Union' in J. Sylvestre; G. Nelson and T. Aubry (eds) *Housing for People with Serious Mental Illness: Theory, Research, Practice and Policy* Oxford: Oxford University Press, pp. 287-299.
[52] Pleace, N. (2018) op. cit.

that includes extensive prevention systems, coordination with health and social care services and an array of fixed site and housing-led homelessness services.[53]

Within the Finnish strategy, there are services that use ordinary housing and intensive, mobile case management. However, while these Finnish services share the ideas of Housing First, they have separate and distinct origins and, crucially, are part of a national homelessness strategy called 'Housing First' and it is that integrated, housing-led, approach. The evidence is that it is the integrated Finnish strategy, including creating a dedicated social housing supply for people experiencing homelessness, is what has driven homelessness down in Finland. Finland has recently announced a 'Housing First 2.0' approach that is designed to intensify integration of health and social care services within homelessness strategy. This includes experiments with new forms of mixed-use development, increasing dedicated social housing supply for people experiencing homelessness and further development of what can be broadly translated as housing social work roles, including in preventative services.[54]

The question of fidelity and examples of systems developed and used in other UK jurisdictions is explored in more detail in Section 8.

Operational realities

Housing First is transitioning from a series of pilot programmes and other experiments into a mainstream element of homelessness services and strategies across much of Europe. The process is uneven, national programmes exist in Denmark, France and Ireland, with Housing First still entering the mainstream in Germany, Italy, Sweden and Spain, but Housing First has a momentum across much of Europe, and within the UK, in Scotland and Wales, which is now arguably outpacing developments in North America.[55] In England, no clear policy at national level is in place. There has been central government funding of three pilot programmes, but these were focused on people sleeping rough, which is the only aspect of homelessness receiving any sort of systematic attention. However, local authority commissioning of Housing First, focusing on the intended group of people experiencing long-term and repeated homelessness associated with multiple and complex needs, has become widespread.[56]

In countries like Denmark and France, Housing First is an integral part of homelessness strategy. However, in some other countries, both Sweden[57] and England being examples, Housing First has struggled to fully transition from a series of pilots and smaller scale initiatives into mainstream homelessness policy.

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[53] Y Foundation (2017) *A Home of Your Own: Housing First and ending homelessness in Finland* Helsinki: Y Foundation; Allen, M.; Benjaminsen, L.; O'Sullivan, E. and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* Bristol: Policy Press.

[54] https://www.feantsa.org/public/user/Activities/events/2022/Policy_Conference_Presentations/Juha_Kahila_Presentation.pdf

[55] Pleace, N.; Baptista, I. and Knutagård, M. (2019) *Housing First in Europe: An Overview of Implementation, Strategy and Fidelity* Brussels: Housing First Hub Europe.

[56] Homeless Link (2020) *The Picture of Housing First in England* London: Homeless Link

[57] Knutagård, M. and Kristiansen, A., 2019. Scaling up housing first pilots–drivers and barriers. *Nordic Journal of Social Research*, 10(1), pp.1-23.

When Housing First is operating outside an integrated homelessness strategy, this can have several negative effects. While Housing First is an intensive case management service model, it is not designed to function alone and requires good coordination and collaboration with health, mental health, addiction and social care services, as well as services like occupational therapy and the criminal justice system. Case management is not effective when the necessary package of housing, health, social care and other services, alongside the support that Housing First provides itself, cannot be assembled. In England, this has manifested as Housing First services finding it challenging to end support. Housing First can find it very difficult to coordinate a reduced package of support for people who no longer require the service, and very difficult to escalate support when someone's support needs are beyond the level that Housing First can meet.[58]

Scaling-up Housing First has proven challenging in contexts in which the funding of homelessness services is relatively low and unpredictable. Successful Housing First pilots have collapsed as a result of short-term funding sunsets in England and Housing First services are often precariously funded at low levels, creating issues around staff retention, planning and integration with other services.[59] In the context of wider cuts and increased demand for health, social care/work services, mental health and addiction services, Housing First can struggle to function well. For example, if someone using Housing First and their Housing First worker agree it would a good idea to refer them to the local Community Mental Health Team (CMHT), only to be told that service has a very long waiting list - or is effectively unavailable - overall effectiveness is likely to be lower than if the CMHT is available to start working with someone within a few days. While no system is perfect, this would generally not be the pattern for an equivalent service working in the integrated strategic responses to homelessness seen in a country like Denmark or Finland.[60]

Housing supply is an issue almost everywhere that Housing First services operate. In England, considerable work has gone into local and regional efforts that have secured partnerships with social and private sector landlords (sometimes both) in order to get access to enough affordable, adequate and secure housing options to enable Housing First to work effectively. Local authorities have also entered into partnerships with housing associations and used their own social rented housing in order to support the functioning of the Housing First services that they are commissioning. Nevertheless, the operational realities of Housing First in England are often those of having to use temporary accommodation because not enough of the right sort of housing can be acquired at a sufficient rate. In overheated housing markets like London, this has also resulted in Housing First services sometimes having to secure housing in different parts of the city, creating logistical challenges for Housing First as it has to cover a wider area than was originally envisaged.[61]

[58] Blood, I.; Birchill, A. and Pleace, N. (2021) *Reducing, changing or ending Housing First support* London: Homeless Link/Housing First England

[59] Blood, I.; Pleace, N.; Alden, S. and Dulson, S. (2020) *A Traumatised System: Research into the commissioning of homelessness services in the last 10 years* Leicester: Riverside.

[60] Pleace, N. et al (2019) op. cit.

[61] Pleace, N. and Bretherton, J. (2013) op. cit.

Beyond the UK, housing supply is a challenge for many Housing First services. At European level, there is a shortage of affordable homes, just as is the case in much of the UK. There is often not enough housing for Housing First because there is not enough housing in general.[62]

Long-term use and evaluation of Housing First has also raised some operational questions about the model. Housing First is not a panacea, stable housing does not mean a rapid reversal of what could be years of poor mental and physical health and in reality, Housing First services are often dealing with premature deaths among the people using them.[63] While there is clear evidence of sustained exits from homelessness among people with multiple and complex needs, the picture around gains in health, wellbeing, social support and economic activity is more mixed. Part of the issue here was early hype about Housing First, which has been portrayed as the (relatively simple) 'solution' to all aspects of homelessness. This was never a realistic proposition, Housing First is a case management model, designed to work with other services and the most successful implementations of Housing First are within integrated homelessness strategies, never through uncoordinated use of standalone services.[64]

Housing First does not, in itself, deliver consistent improvements in mental health, addiction, physical health and wellbeing, nor can it consistently address social isolation, alienation and disconnection from economic activity. [65]There are many success stories, where Housing First has been instrumental in enabling people to exit homelessness on a sustained basis and created a general and significant boost to wellbeing and, of course, Housing First does end recurrent and sustained homelessness associated with multiple and complex needs, typically in eight or nine out of every ten cases. However, Housing First does not simply fix everything, and the realities of working with people with multiple and complex needs is important, they will not suddenly and dramatically 'get better' because of Housing First. However, through ending homelessness and offering co-productive support, Housing First is on current evidence, likely to produce at least some benefits for most of the people using it and certainly seems unlikely make things worse.

New forms of Housing First have been appearing. One of the most notable are Housing First services for women, which is focused on the particular needs of women experiencing long-term and recurrent homelessness. Evidence here is still developing, but there are initial signs that Housing First designed and run by women for women can generate very positive results. This is all the more important as the numbers of women that Housing First services are supporting are often greater than some analysis of long-term and recurrent homelessness had suggested, essentially as a result of undercounting women's experience of these forms of homelessness.[66] However, Housing First for women often seems to face challenges for which the original model was not designed, centring on the degree of ongoing abuse most women using these services are experiencing, i.e. Housing First

[62] Eurofound (2023) *Unaffordable and inadequate housing in Europe* Publications Office of the European Union: Luxembourg; Barton, C. and Wilson, W. (2023) *Tackling the under-supply of housing in England* House of Commons Research Report London: Parliament Number CBP-7671
[63] Blood, I. et al. (2021) op. cit.
[64] Allen, M. et al. (2020) op. cit.
[65] Aubry, T. (2020) op. cit.
[66] Bretherton, J. and Mayock, P. (2021) *Women's homelessness: European evidence review* Brussels: FEANTSA.

for women has to be able to safeguard and protect the people using it in ways not thought about in the original design, which presupposed largely lone adult male caseloads.[67]

Housing First for youth (HF4Y) has been experimented with in Canada and the UK. This is another modification of Housing First that is designed to work with highly vulnerable young people, including care leavers. Again this is a specialisation of Housing First, in which alongside meeting support needs in a trauma informed and co-productive way, Housing First is also providing support with difficult transitions to adulthood. There have, both in the UK and the wider world, been a series of only partially successful service models and strategies designed to break the link between being a looked-after child and a high risk of experiencing youth homelessness. Early results look broadly positive, but as with Housing First for women, the line between what is Housing First and what is actually another kind of specialised homelessness service could be seen as rather blurred.[68]

There has been a backlash against Housing First even as the model continues to gain momentum in the UK and Europe. Criticism has come from elements of the political Right, using a framework that explains homelessness in terms of addiction, crime and mental illness, rather than looking at social, economic and structural causation. In North America, Housing First has been portrayed as a 'failure' because it is not, unlike housing ready/staircase models treating the 'causes' of homelessness before housing is provided. While there is evidence that long-term and recurrent homelessness is associated with the emergence of addiction, mental health and disability and limiting illness, i.e. issues like addiction can emerge during homelessness, rather than 'causing' it, and that Housing First is effective in ending these forms of homelessness, these arguments against Housing First have not gone away.[69]

[67] Quilgars, D., Bretherton, J. and Pleace, N. (2021) Housing First for Women: A five-year evaluation of the Manchester Jigsaw Support Project York: University of York.
[68] Blood, I.; Alden, S. and Quilgars, D. (2019) *Rock Trust Housing First for Youth Pilot Evaluation Report* Brussels: Housing First Europe Hub and the Rock Trust; Gaetz, S. (2017) *This is Housing First for Youth: A Program Model Guide* Toronto: Canadian Observatory on Homelessness Press.
[69] O'Sullivan, E. (2020) *Reimagining Homelessness for Policy and Practice* Bristol: Policy Press.

Section 3 Homelessness in Northern Ireland, and Housing First services since 2013

This section provides an overview of homelessness legislation and policy context, the homeless situation and the rationale for expansion of Housing First in Northern Ireland. This section also provides background information and context on the Complex Lives project in Belfast and an overview of current and previous Housing First services in Northern Ireland since the first pilot in 2013. All of this provides a backdrop to the context in which this study has explored the potential for scaling up Housing First in Northern Ireland.

Homelessness in Northern Ireland – legislation and policy context

The NIHE's statutory duties in relation to homelessness were enshrined in primary legislation, namely the Housing (NI) Order 1988. This established the definitions and the duties surrounding homelessness (homeless/threatened with homelessness, priority need and intentionality), making enquiries, temporary accommodation and decision letters[70]. The Housing (NI) Order 2003 amended the provisions of the 1988 Order, introducing changes to the definitions of homelessness and to the provisions regarding becoming homeless intentionally[71], and introduced the additional requirement on the NIHE to assess an applicant's eligibility for housing assistance.

For the purposes of this research the following legislative definitions are important:

- a person is homeless if he or she has no accommodation available for his or her occupation in the United Kingdom or elsewhere;
- A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him or her to continue to occupy;
- The following have a priority need for accommodation:
    - A pregnant woman or a person with whom a pregnant woman resides or might reasonably be expected to reside;
    - A person with whom dependent children reside or might reasonably be expected to reside;
    - A person who is vulnerable as a result of old age, mental illness or handicap or physical disability or other special reason, or with whom such a person resides or might reasonably be expected to reside;
    - A person who is homeless or threatened with homelessness as a result of an emergency such as a flood, fire or other disaster;
    - A person without dependent children, who satisfies the NIHE that he or she has been subject to violence and is at risk of violent pursuit or, if he or she returns home, is at risk of further violence;
    - A young person who satisfies the NIHE that he or she is at risk of sexual or financial exploitation.

[70] Information on the Housing (NI) Order 1988 and the Housing (NI) Order 2003 from the NIHE *Homelessness Guidance Manual,* December 2017, Chapter 1

[71] Ibid, paragraph 1.2.4 – *A person becomes homeless intentionally if he or she deliberately does or fails to do anything in consequence of which he ceases to occupy accommodation, whether in Northern Ireland or elsewhere, which is available for his or her occupation and which it would have been reasonable for him or her to continue to occupy.*

The NIHE has a statutory duty under the provisions of the Housing (NI) Order 1988, as amended, to investigate the circumstances of all applicants presenting as homeless. In carrying out its statutory duty to make enquiries into homelessness applications, the NIHE should consider whether the applicant is:

- Homeless/threatened with homelessness
- Eligible for homelessness assistance[72]
- In priority need[73]
- Unintentionally or intentionally homeless

Where an applicant meets all of the legislative criteria, the NIHE awards Full Duty Applicant status (FDA), and undertakes a housing need assessment, with the award of relevant points in line with the rules of the Housing Selection Scheme. Any household that meets the four tests outlined is therefore accepted as having FDA status; the housing duty to them includes ensuring that accommodation is made available for the household as well as the provision of temporary accommodation where necessary with the protection of the household's furniture and possessions. The policy and definition in relation to chronic homelessness is explored in Section 4. It is also worth noting that the homelessness legislation has diversified across the UK since the late 1990s; with a current position where in Scotland there is a near universal duty[74], to a duty focussed more on prevention in Wales and to a lesser extent in England[75].

The homeless situation in Northern Ireland

Homelessness remains at a consistent level in Northern Ireland; last year (2022/23) 15,965 households presented as homeless to the NIHE (table 1), with 10,349 (65%) accepted as having FDA status (tables 2 and 3). Appendix 4 provides tables of presenters and acceptances by age and gender breakdown. Table 4 outlines expenditure on homeless services via the Supporting People budget indicating that this has increased steadily over the last six years. This sub-section analyses the type and nature of temporary accommodation and Floating Support services across Northern Ireland in more detail.

[72] To establish eligibility for homeless assistance the NIHE first investigates if the applicant, or any member of the applicant's household, has been involved in any unacceptable behaviour. The NIHE must also establish the applicant's eligibility for housing assistance under immigration/asylum regulations.

[73] The following homeless presenters are considered to have priority need: persons with dependents, pregnant women or persons with whom a pregnant woman resides, persons who are vulnerable for specified or other special reasons, persons made homeless as a result of an emergency, persons subject to violence or at risk of violence and young persons at risk of sexual or financial exploitation.

[74] The initial legislation was the Housing (Scotland) Act 1987. The Homelessness etc. (Scotland) Act 2003 outlined the provision that, by 2012, anyone finding themselves homeless through no fault of their own must be entitled to settled accommodation in a local authority or housing association tenancy or a private rental. This became law in 2012 along with the Homeless (Abolition of Priority Need Test) (Scotland) Order 2012.

[75] The governing legislation for homelessness in England can be found in Part 7 of the Housing Act 1996 (as amended). Homelessness Reduction Act, 2017.

Table 1: Homeless Presenters by reason for homelessness, 2018/19 – 2022/23

Reason	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
Sharing breakdown/family dispute	3,890	3,650	4.166	3,606	3,505
Marital/ relationship breakdown	1,804	1,683	1,752	1,611	1,559
Domestic abuse	1,174	1,147	1,222	1,110	1,128
Loss of rented accommodation	2,779	2,327	1,689	2,463	2,892
No accommodation in Northern Ireland	1,245	1,304	1,012	966	1,107
Intimidation[76]	481	335	286	180	167
Accommodation not reasonable[77]	4,588	4,239	3,576	3,781	3,732
Release from hospital/prison /other institution	339	361	366	311	315
Fire/ flood or other emergency	54	44	63	30	60
Mortgage default	123	89	37	47	56
Neighbourhood harassment	1,448	1,415	1,639	1,435	1,221
Other reasons	218	134	134	92	94
No data on reason for presentation	59	74	49	126	129
TOTAL	**18,202**	**16,802**	**15,991**	**15,758**	**15,965**

Source: NIHE

Table 2: Homeless Acceptances (FDA) by reason for homelessness, 2017/18 – 2022/23

Reason	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
Sharing breakdown/family dispute	2,307	2,135	2,173	1,956	1,929
Marital/ relationship breakdown	929	846	748	734	704
Domestic abuse	1,124	1,088	1,101	1,006	1,061
Loss of rented accommodation	1,681	1,375	985	1,586	1,808
No accommodation in Northern Ireland	710	707	430	481	561
Intimidation	374	255	256	171	212
Accommodation not reasonable	3,995	3,606	2,794	3,096	3,099
Release from hospital/prison /other institution	236	240	217	190	196
Fire/ flood or other emergency	38	24	30	19	33
Mortgage default	65	51	21	15	26
Neighbourhood harassment	931	899	1,067	830	653
Other reasons	162	97	67	51	67
TOTAL	**12,512**	**11,323**	**9,889**	**10,135**	**10,349**

Source: NIHE

[76] Intimidation as a reason for homelessness is broken down into different types of intimidation – paramilitary, Anti-social behaviour, racial, sectarian, sexual orientation and disability.

[77] Accommodation not reasonable as a reason for homelessness is broken down into different headings – generic, financial hardship, mental health, overcrowding, physical health/disability, property unfitness, violence and other.

Table 3: Level of Full Duty Applicant (FDA) status by year, 2017/18 – 2022/23

Year	Nr households presenting as homeless	Nr households accepted as statutorily homeless - FDA	%age accepted as FDA
2017 – 18	18,180	11,877	65%
2018 – 19	18,202	12,512	69%
2019 – 20	16,802	11,323	67%
2020 – 21	15,991	9,889	62%
2021 – 22	15,758	10,135	64%
2022 – 23	15,965	10,349	65%

Source: NIHE

Table 4: Supporting People Homeless Expenditure 2017/18 to 2022/23

Year	Total SP Homeless Expenditure (£k)	Total Floating Support Expenditure (£k)
2017 – 2018	27,561	6,026
2018 – 2019	26,683	6,024
2019 – 2020	26,847	6,084
2020 – 2021	27,207	6,078
2021 – 2022	27,526	6,351
2022 – 2023	29,720	6,914

Source: NIHE

The rationale for Housing First in Northern Ireland – and the need for expansion

As noted earlier Housing First has been in existence in Northern Ireland in some format over the last 10 years. The key driving forces for the expansion of Housing First include concern that many service users defined under chronic homelessness are bouncing between temporary homeless accommodation services, with limited long-term or positive outcomes, and this relates directly to high temporary accommodation costs, including the provision of single lets. A recent question in the NI Assembly (AQW 5781/22-27 - May 2024)[78] indicated a financial spend by the NIHE on the provision of single let temporary accommodation of £21.37M in 2023/24, an increase from £3.36 M in 2014/15. Outcomes and the potential for better use of public funds are therefore two drivers in looking at the potential for expanding Housing First.

The pilot programme delivered by Depaul was evaluated in 2016[79]; the evaluation and Social Return on Investment (SROI) found:

- Of the 24 people who were found permanent accommodation through Depaul's Housing First service in Belfast in 2014: 19 (79%) maintained their tenancy for a significant period of time, developed reasonable or good self-care skills, and showed a positive increase in self-confidence and their ability to budget and manage money. Other improvements noted were in physical health and improved social and family relationships;

[78] AQW 5781/22-27 - To ask the Minister for Communities to outline the financial spend by the Housing Executive on the provision of single let temporary accommodation in each of the last ten financial years, including 2023/24.

[79] Boyle, F. and Palmer, J. with Ahmed, S. (2016) *Efficiency and Effectiveness of the Housing First Support Service piloted by Depaul in Belfast: an SROI evaluation* (2016), NIHE.
www.nihe.gov.uk/getattachment/ab02a490-e1cb-4b4b-91d0-e63460d83f52/housing_first_evaluation.pdf

- In many cases, their acceptance into the Housing First service was the first time that service users had ever been given an opportunity to sustain a tenancy, or been able to sustain a tenancy for any length of time. In some cases, their difficulties went back a number of decades;
- Service users said in their interviews with the research team that they had been told many times in the past that they would not be capable of obtaining or sustaining a tenancy. They pointed to their background as being an insurmountable hurdle in finding and sustaining accommodation;
- The type and location of accommodation coupled with the support and brokerage of other services that service users received from the Housing First staff team were cited as the key to tenancy sustainment;
- Significant progress against all the criteria was made by those service users for whom initial assessment and Outcomes Star data were provided. 'Managing the tenancy and accommodation' showed the most progress. Other criteria against which significant improvement was shown were 'use of time', 'motivation and taking responsibility' and 'improved social networks and family relationships'.

Other evaluations and reviews of Housing First models in Northern Ireland are outlined below under the sections on the two providers – Depaul and Simon Community NI, together with information on the Complex Lives service.

While Housing First was first noted as a commitment in the Homelessness Strategy published in March 2022 and engagement was already taking place, the deaths of six rough sleepers in Belfast in June 2022 brought external interest in the model[80]. All of the individuals had a history of homelessness and other factors. In late June that year officials from across the relevant Departments (DfC, DoH and DoJ) met to discuss how work could progress in this area, with reference to the potential for the Housing First model and approach. In July 2022 the Lord Mayor of Belfast held a meeting with relevant stakeholders to discuss concerns regarding vulnerable people experiencing homelessness. The three ministers at that time (Minister Long – DoJ, Minister Swann – DoH and Minister Hargey – DfC) then met in October 2022, and gave their ministerial commitment for work to progress on a Housing First model. A Task and Finish Group was established to explore the model with an initial meeting in August 2023; the work of this group is ongoing. In addition, Belfast City Council supports the Complex Lives project, noting an aim of reducing chronic homelessness by 5% within their agenda.

Data from Belfast City Council, Safer Neighbourhood Officers for the period January 2021 – September 2022[81] indicated the frequency and range of behaviours and situations relating to individuals defined under headings including people sleeping rough, chronic homelessness and street activity:

- 236 instances of drug/substance use;
- 214 instances relating to homelessness and/or begging;
- 721 instances of assistance, support, advice given – relating to people suffering from mental ill health, in housing distress or at crisis point;

[80] Belfast: Six men who were homeless die of drug overdoses in fortnight - BBC News

[81] This data was provided by Depaul. Based on the work undertaken by Belfast City Council: Safer Neighbourhood Officers – a team of 10 SNOs providing 7-day coverage across the city centre and neighbourhoods.

- 42 instances of suspected overdose[82];
- 1,868 individual instances of discarded needles, equating to 10,023 discarded needles uplifted[83].

Before turning to Housing First services in Northern Ireland, it is important to reference the development of the Complex Lives project in Belfast.

Complex Lives, Belfast

The Complex Lives project was established in 2021, following review of the situation above relating to issues of drug and alcohol use, mental health and homelessness across Belfast, by the Belfast Partnership's Strategic Leadership Group on Drugs, Alcohol and Mental Health. An initial meeting was held in January 2020, leading to a further meeting in March 2020 at which the Doncaster Council Complex Lives Alliance was outlined, as a potential model of good practice. Work was undertaken by Chris Marsh of Marsh Public Service Solutions, alongside a Project Steering Group comprising the key agencies, to develop a Whole System Approach within Belfast aimed at supporting the most vulnerable within Belfast City Centre. This resulted in the formation of a Multi-Disciplinary Team (MDT) in October 2021; this included Belfast City Council, the NIHE, Probation Board NI, Police Service of NI (PSNI), Belfast Health & Social Care (HSC) Trust, Depaul, Extern, Homeless Connect, the Simon Community NI and the Welcome Organisation. The service is referred to as Complex Lives.

The service includes the MDT referenced above, a nomination and assessments process, and works within the definition of chronic homelessness, which is outlined in detail in Section 4.

The Complex Lives service was evaluated for the period October 2021 to end of January 2022. This 4-month period was part of the 'prototyping phase' of the project which lasted from October 2021 to end of March 2022. In this initial 4-month period the Complex Lives service received 104 nominations. The majority of these were from two sources: the NIHE (44 service users) and Extern's Street Injecting Support Service (SISS) (35 service users). Other service users were put forward by the other partners outlined above. 68% of nominations were male, with 50% of the cohort being males aged between 25 and 59 years old. The support needs identified by the MDT included: chronic addiction, poor mental health, complex physical health issues and mobility difficulties, blood born viruses, learning disability, behaviours that challenge, social isolation, exploitation, paramilitary threats, suicidal ideation and histories of offending[84].

The evaluation of this initial roll-out of the Complex Lives service found the following:

- By 31st January 2022 the MDT had offered some level of support to approximately 20 people, with half of these individuals being supported to access and sustain a stay in a more appropriate form of accommodation;

[82] From 2018 to June 2023 SNOs have administered Naloxone around a dozen times.
PSNI pilot (September 2022 to June 2023) – 17 officers trained to use nasal version of Naloxone, administered 12 times during this period.
Extern Street Injecting Service (SISS) – administered naloxone 44 times from April 2021 – March 2022.

[83] Noted that the most prolific (Needle & Syringe Exchange) NSE premises are within Belfast city centre and most drops were around them and certain hostels.

[84] Complex Lives staff noted that needs fluctuate throughout the year; for example, exploitation is a higher level in the summer period than at other points in the year.

- Several individuals were supported to link with existing services including the Extern Floating Support teams, the Drug Outreach team and the Health Hub and Substitute prescribing team;
- Within the core cohort more than 95% of service users maintained some level of engagement with the MDT. This fell to under 60% for the wider cohort highlighting the need for more intensive wraparound support for this service user group.

The evaluation of Complex Lives concluded: *at a very basic level the enhanced communication across services has allowed customers in chaotic situations to be made aware of, reminded of and assisted to attend key appointments while in terms of support for a customer's mental health and motivation levels, support across services have been able to align focus on specific support needs at critical times.* Further the evaluation noted: *the MDT has been effective in securing and maintaining some level of positive outcome for the majority of individuals it has supported. These outcomes have most often involved smoother transitions to more appropriate accommodation aligning closely with the Housing First principles which the project aims to work to. Additionally, through improved communication and flexibilities in referral processes, the MDT have then been able to link several of these service users to appropriate support with both statutory and voluntary agencies.*

In addition, the evaluation noted other positive consequences from the Complex Lives service, namely an easement of pressure on the statutory services and a reduced need for repeat, and in some cases daily referrals to multiple providers, of those working in the sector with the client group. Both the PSNI and the Belfast City Council Safe Neighbourhood Officers reported a reduction in disruption in the city centre.

The Complex Lives service has further developed through the addition of Intensive Support workers. Table 5 indicates nomination sources for 142 potential clients to date (end of June 2023). None of these service users were in either of the Housing First services, at this point in the delivery of Complex Lives[85].

Table 5: Number of nominations to Complex Lives by June 2023

Nomination organisation	Numbers
NI Housing Executive	55
Extern Street Injectors Support Service	43
Depaul	11
Extern Multi-disciplinary team	10
Simon Community NI	6
Probation Board NI	6
The Welcome Organisation	5
Extern Criminal Justice Floating Support	3
Belfast City Council	2
PSNI	1
TOTAL	**142**

Source: Complex Lives

[85] This is an important point and could be viewed as a disconnect between Complex Lives and Housing First services in Northern Ireland. It is worth noted parallels with the Fulfilling Lives programme where there was variable engagement with Housing First services, e.g. https://eprints.whiterose.ac.uk/142270/2/Inspiring_Change_Manchester_Housing_First_Final_Report_2018.pdf

To date there have been no nominations via the Belfast Health Inclusion Service or the Drug Outreach service. Of the 142 nominations, 96 were male and 46 were female. The majority of potential clients were aged over 25 (121) with 21 aged 25 and under. In addition, 13 of the those nominated to Complex Lives have since passed away (8 males/5 females, 7 over 25/6 under 25)[86].

Table 6 indicates what accommodation individuals had at the point of referral.

Table 6: Accommodation at point of referral to Complex Lives by June 2023

Nomination organisation	Numbers
Temporary accommodation - Non-standard	46
Temporary accommodation - Hostel	21
Rehoused – tenancy	18
Rough sleeping	18
Own arrangements	12
Prison	10
Unknown	8
Temporary accommodation – Single let	3
Sofa surfing	3
Hospital	2
Private rented sector tenancy	1
TOTAL	**142**

Source: Complex Lives

The type and range of needs are recorded by the Complex Lives team. Although exact figures by number of clients was not available, the team provided the following list of needs, which is roughly in order of the numbers of Complex Lives clients affected by these additional needs[87]. The team also note that in most cases service users have multiple needs and it is not always possible to pinpoint what their primary need is.

- Substance use – drugs
- Mental health
- Injecting drug user
- Offending behaviours
- Exploitation
- Substance use – alcohol
- Brain injury
- Wheelchair user
- Registered sex offender
- Arson conviction
- Risk of violence
- Learning difficulties/disability

[86] This highlights a high mortality rate associated with chronic homelessness: https://www.insidehousing.co.uk/home/home/homeless-deaths-surge-by-80-in-two-years-74915

[87] The relative order of needs can fluctuate during the year, with the Complex Lives noting the example of 'exploitation' which moves higher up the list over the summer period.

Data from April 2024 provides a comparison of accommodation at the point of referral to the last point of engagement, for the core cohort of people who the MDT have assessed and are currently offering support to (see table 7). The core cohort as of April 2024 is 123 individuals[88].

Table 7: Accommodation at point of referral to Complex Lives and at present/last engagement (as of April 2024)

Accommodation	At point of referral	Current situation (at point of last engagement)
Temporary accommodation - Non-standard and single let	24	8
Temporary accommodation – Hostel/DIME	13	29
Temporary accommodation – Crash	7	4
Housed – social rented sector	7	28
Housed – private rented sector	-	1
Rough sleeping	35	8
Making own arrangements[89]	5	11
Prison	12	18
Unknown[90]	11	6
Sofa surfing	5	3
Hospital	4	4
Rehabilitation services	0	1
Supported living	0	1
Care home	0	1
TOTAL	**123**	**123[91]**

Source: Complex Lives

Table 7 indicates that Complex Lives interventions result in significant changes in individual's accommodation situations. For example, a reduction from 35 to eight individuals sleeping rough, and smaller reductions in the numbers sofa surfing or using Crash facilities. Table 7 also highlights increased numbers accommodated in hostels and the DIME[92] provision and a reduction in individuals in non-standard or single let provision. Importantly there is a significant increase (from seven to 28) of individuals who are in their own tenancy.

Complex Lives personnel noted that at point of referral many individuals are moving between rough sleeping, crash facilities and no accommodation, and that those who are listed as housed at point of referral were either at serious risk of or in the process of losing their tenancy and moving into chronic homelessness or were not using the property at all.

The Complex Lives team have provided the following case-studies to highlight the type and nature of the service, and the impact of this intervention on service users. All identifying details have been removed.

[88] The core cohort number varies across the timespan of the Complex Lives service.
[89] This covers circumstances where the individual is with family and friends, and the Complex Lives staff believe they are safe and the situation is sustainable, at least in the short term.
[90] Of the six listed as unknown accommodation as of April 2024, three of these had left Northern Ireland.
[91] This number includes those who have passed away; this was their accommodation at the last point of contact.
[92] Dispersed Intensively Managed Emergency Accommodation.

Case Study 1

Nomination

Between his initial homeless presentation and referral to Complex Lives he experienced more than 15 placements with significant periods of rough sleeping and hospital admissions over a 2-year period.

At time of initial MDT discussion, he was experiencing a lengthy stay in hospital due to multiple health issues/health deterioration and continued to leave hospital grounds to use. There were now serious concerns that there would be a risk to his life should he return to rough sleeping.

Interventions

He was inducted onto SPT while in hospital and a Discharge Planning Meeting was arranged between the trust Extern, NIHE, DOT, Inclusion Hub and De Paul to ensure appropriate support was in place. Initially he was placed in non-standard accommodation with wraparound until an appropriate bed became available. Even with additional support A found it difficult to sustain placements in hostel environments and so a single let was secured for him.

He continued to receive coordinated support from the health hub, DOT and PBNI as well as intensive floating support from De Paul and Extern which supported him to sustain his stay in single let accommodation until he was rehoused and sustained this tenancy for 14 months.

The Outcomes

- Partners were able to coordinate support during hospital stays where there was serious concern regarding A's health, and he did not return to sleeping rough on discharge.
- Now in tenancy and despite some issues has been able to sustain the current tenancy.
- Ongoing engagement with SPT.
- Mr A has not returned to prison during this time and is engaging well with PBNI.

Case Study 2

Synopsis

B was entrenched in homelessness and drug addiction and had significant physical disability which impacted mobility as well as mental health issues. Behaviors had made it very difficult for any placements to be sustained. In a period of less than a year B had experienced almost 100 placements – many of which were crash meaning he had no accommodation during the day. With Complex Lives Wraparound Support B went on to sustain a temporary placement and has since been rehoused with support.

Interventions

- Due to history with temporary accommodation providers, it took the Complex Lives Team several months to secure an appropriate placement with sufficient support.
- A placement was secured in a self-contained, accessible accommodation which B's support could easily access, and advice and support were provided to improve suitability.
- Prior to move in an intensive support package was put in place with the aim being for some level of support to be provided daily.
- This included the Health Hub providing care and support, 2 Extern teams coordinating in providing floating support along with harm reduction advice, support and safe disposal equipment, regular support from his housing advisor and welcome and Homecare provided additional support as needed on site.
- DOT, SPT and Welcome coordinated to ensure B had access to his script and was supported to and from appointments were required.
- B sustained that placement for 10 months before moving to a more appropriate site and quickly being rehoused from there within 3 months.

The Outcomes

- Appropriate and supported temporary placement which was sustained for 10 months – partners worked with B's preferences and motivation levels.
- Given that B had almost 100 placements in a 12-month period there is a reduction on stress in services.
- B continues to engage with support and his physical health has improved during this time.
- Complex Lives have put a rota in place re support keeping B's preferences central and are working closely with B and the housing association on initial issues and to ensure that support is flexible and there for as long as needed.

Housing First in Northern Ireland – Previous and current services

To date Housing First services have been delivered by two providers: Depaul and Simon Community NI.

Depaul - Housing First

Depaul established the first Housing First service in Northern Ireland in 2013, following an approach by the HE Supporting People programme. A pilot project in Belfast was funded. The aim of this service was: *to identify, assess, place and support individuals into permanent housing from a range of temporary accommodation sources and to coordinate support and care packages to these individuals.*

The rationale for developing Housing First in Northern Ireland had been building through the wider homelessness literature. Depaul referenced work commissioned by Housing Rights, *Meeting the housing needs of vulnerable homeless people in the private rented sector in Northern Ireland* (January 2012).[93] This report examined the capacity of the private rented sector to meet the needs of the most vulnerable people experiencing homelessness, citing those with complex needs and chronic exclusion. In addition, through their wider service provision Depaul had identified the need for such a programme; citing their work in low threshold services such as the Stella Maris wet hostel in Belfast and Sundial House in Dublin. In 2014 Depaul agreed a revised contract with the NIHE, enabling the further expansion of the Belfast Housing First service (2014) and the extension of the service to include Derry/Londonderry (2015).

Depaul note that they take a Case Management and Case Coordination approach to delivering Housing First, and that the service operates with a high level of fidelity to the internationally recognised standards along with its 8 core principles. At the time of publication (2024) the Depaul service is the only Housing First provision funded through the Supporting People programme.

Depaul has sought to develop and further refine their Housing First service over the last 10 years. This has included undertaking an internal self-assessment[94] of their programme using the Fidelity scale designed for the Pathways Housing First Programme[95]. This assessment took place in 2018, covering three years of Housing First provision in both locations (2015 – 2017 inclusive). The Fidelity scale provides a series of tests across five key areas as follows:

1. **Housing process and structure** – this looks at how decisions are made about where the service user will live, who determines this, the affordability of the housing provided or sourced, length of time to access and type of accommodation;

[93] *Meeting the housing needs of vulnerable homeless people in the private rented sector in Northern Ireland,* Ellison et al, January 2012.

[94] Depaul, Housing First: Leading the Way Together: Report on Fidelity Assessment of Depaul, Belfast and Derry/Londonderry Housing First Services, June 2018.

[95] Stefancic, A., Tsemberis, S., Messeri, P., Drake, R. and Goering, P. (2013) The Pathways Housing First Fidelity Scale for Individuals with Psychiatric Disabilities, American Journal of Psychiatric Rehabilitation 16(4) pp.240-261
Gilmer et al, 2013 Gilmer, T. P., Stefancic, A., Sklar, M. and Tsemberis, S. (2013) Development and Validation of a Housing First Fidelity Survey, Psychiatric Services 64(9) pp.911-914
Goering, P., Veldhuizen, S., Nelson, G. B., Stefancic, A., Tsemberis, S., Adair, C. E., Distasio, J., Aubry, T., Stergiopoulos, V and Streiner, D. L. (2016) Further Validation of the Pathways Housing First Fidelity Scale, Psychiatric Services 67(1) pp.111-114.

2. **How housing and services are related** – looking at what conditions (if any) are required of service users in order to access and stay in the accommodation, as well as factors relating to level of sharing, security of tenure and what happens if a service user loses their housing;
3. **Service philosophy** – assessing how the team responds if a service user loses their housing, the intensity and level of ongoing support provided, what requirements (if any) are made of service users to access mental health or addictions support, how support plans are developed and the autonomy of the service user;
4. **Service array** – looking at the range of supports and opportunities available to the service users for social integration, i.e., resettlement into community, access to treatment, physical health support, employment, education and volunteering, as well as the engagement of peer activity within the service;
5. **Team structure and human resources** – considering how the team is resourced, case load levels, level of contact between staff and service users, planning and management capacity and opportunities for service users to input to the service.

The findings from the Depaul assessment report using the Fidelity scale pointed towards a Housing First service operating with a high level of fidelity, with both sites (Belfast and Derry/Londonderry) achieving an overall score of 3.2 out of 4[96]. The following scores were recorded for each of the five areas:

Housing process and structure – 2.9
How housing and services are related – 4.0
Service philosophy – 3.9
Service array – 2.4
Team structure and human resources – 3.0

This assessment also incorporated analysis of outcomes, feedback from service users and feedback from key stakeholders. In summary, analysis of this data provided a very positive picture. There were 87 successful placements into independent, permanent accommodation made over the 3-year period in the two sites; in Belfast 78% of service users had sustained their placement for two years or more, and in Derry/Londonderry the figure stood at 72% over a 12-month period. Service users were positive about individual outcomes, whilst stakeholders suggested that engagement with the Housing First service had a direct connection to positive outcomes including a reduction in criminal behaviour, increased health outcomes, a reduction in A&E hospital usage and other emergency services, a decrease in homeless presentations and increased stability for service users.

Further monitoring figures produced by Depaul in 2021 reported that they had worked with 368 cases; as some people had presented more than once this number represented 296 individual cases, of which 88.5% were accommodated under the Housing First service. There was a further expansion of the Depaul Housing First service in Belfast in April 2021.

Depaul have recently submitted a proposal to the NIHE (December 2022), having been asked to indicate how they would expand Housing First over a four-year period to meet the growing needs of those presenting with complex needs and experiencing homelessness.

[96] An overall score of 3.5 and above is considered a high-fidelity score and scores of 1 – 3 are considered low fidelity scores.

Data provided by Depaul for this feasibility study, on the Housing First client group for the period 2017 - 2023[97] is now reviewed.

Table 8: Depaul: Number of Housing First Cases Belfast and Derry 2017 to 2023

Year	Belfast	Derry/ Londonderry	Total cases	Total unique individuals
2017	72	56	**128**	**120**
2018	53	48	**101**	**98**
2019	39	35	**74**	**74**
2020	42	40	**82**	**81**
2021	49	35	**84**	**82**
2022	30	33	**63**	**63**
2023	28	25	**53**	**52**

Source: Depaul

Table 8 indicates the total number of Housing First cases by year. The total number of unique individuals per year is also noted; this varies from the total number of cases in situations where individuals have been closed and then presented again during the year.

Whilst the total number of cases per year (and unique individuals) has declined in the last 5 – 6 years (from 128 cases in 2017 to 53 cases in 2023) Depaul noted reasons for this. In the past cases were closed more quickly to allow them to work with more individuals in-year and to create a higher level of throughput in the service[98]. However, Depaul noted that over time they have learnt that the model works more effectively when the service user is provided with long-term support, and they have therefore not closed cases as quickly as in the past. In addition, Depaul noted that the current situation in terms of difficulties and long lead-in times for finding and accessing accommodation (which are outside their control) has resulted in them not being able to move service users through the service as quickly, translating into a decline in total number of cases per year[99].

[97] Calendar years.

[98] The concept of 'throughput' needs to be examined, as it does not fit with the model of high fidelity Housing First. Page 12, Depaul report states: *When a service user has been stable for over 3 months, a decision can be taken to close the Housing First case following a review of needs, providing the relevant supports are in place. There is always a reassurance to the service user and the external agencies that re-referral is possible.*
https://ie.depaulcharity.org/wp-content/uploads/sites/2/2020/07/Housing-First-Booklet-Sml.pdf
This contrasts with similarly large services in Dublin: *Housing First participants will have ready, time-unlimited access to support and treatment services, for as long as the participant requires. Even if a tenancy fails, Housing First continues to support the individual to another tenancy and the support service continues to engage with the participant.*
https://pmvtrust.ie/housing/housing-first/#hf

[99] Similar to footnote 37, the concept of 'move on' for service users will need to be examined. This concept is more akin to Critical Time Intervention (CTI) models than Housing First.

Table 9: Depaul: Annual number of referrals to Housing First, Belfast and Derry 2017 to 2023

Year	Belfast	Derry/ Londonderry	Total referrals	Total cases in year[100]
2017	49	46	95	**128**
2018	28	36	64	**101**
2019	19	19	38	**74**
2020	27	37	64	**82**
2021	29	60	89	**84**
2022	3	25	28	**63**
2023	45	26	71	**53**

Source: Depaul

Table 9 outlines the annual number of referrals. Depaul noted a significant drop in the referrals for Belfast in 2022. They note that this was due to staff shortages and a resultant reduction in the number of service users during this year, and a temporary halt in accepting referrals. The figures for 2023 indicate that referral figures have once again increased.

In looking at the service since it was launched in 2013 up to the end of 2023, Depaul's Housing First service had a total of 433 cases, representing 353 unique individuals[101]. Tables 10 – 13 indicate the following:

- In 2023 the largest proportion (38%) of Housing First service users are in the 31 – 40 years old age bracket, with the remainder spread fairly evenly across three other age brackets: 21 – 30, 41 – 50 and 51 – 60 years old. In previous years there had been more service users in the 60 plus and under 21 age brackets. Looking at the last six years, most service users were in the broad range of 21 to 50 years old (table 10);
- In each year there were more male service users than female; this was generally in a proportion of 3:1 to 2:1 (table 11);
- In each year the highest proportion of service users identified as Irish, followed by British (table 12);
- In each year the highest proportion of service users were white (table 13).

Table 10: Depaul: Number of Housing First Cases: Age profile 2017 to 2023

Year	Under 21	21 – 30	31 – 40	41 – 50	51 – 60	60+	Total cases
2017	<5	35	39	34	14	<5	**128**
2018	<5	27	27	29	16	<5	**101**
2019	-	14	26	21	11	<5	**74**
2020	<5	12	31	23	9	6	**82**
2021	-	17	36	13	13	5	**84**
2022	-	13	30	10	9	<5	**63**
2023	-	9	20	13	9	<5	**53**

Source: Depaul

[100] Note – this is higher than the number of referrals as cases continue from previous year.
[101] This number is different from the total cases per year, which include ongoing cases from previous years.

Table 11: Depaul: Number of Housing First Cases: Gender profile 2017 to 2023

Year	Belfast		Derry/ Londonderry		Totals		Total cases
	Male	Female	Male	Female	Male	Female	
2017	52	20	44	12	96	32	**128**
2018	37	16	35	13	72	29	**101**
2019	26	13	23	12	49	25	**74**
2020	29	13	29	11	58	24	**82**
2021	36	13	23	12	59	25	**84**
2022	22	8	27	6	49	14	**63**
2023	18	10	18	7	36	17	**53**

Source: Depaul

Table 12: Depaul: Number of Housing First Cases: Nationality 2017 to 2023

Year	Irish	British	Other	Undisclosed	Total cases
2017	67	34	5	22	**128**
2018	56	22	<5	21	**101**
2019	42	16	<5	15	**74**
2020	45	21	<5	14	**82**
2021	43	16	<5	22	**84**
2022	30	17	<5	13	**63**
2023	28	16	<5	7	**53**

Source: Depaul

Table 13: Depaul: Number of Housing First Cases: Ethnicity 2017 to 2023

Year	White	Black	Irish Traveller	Other	Undisclosed	Total cases
2017	105	<5	-	<5	18	128
2018	90	-	-	<5	8	101
2019	65	-	-	<5	6	74
2020	73	-	<5	<5	7	82
2021	72	<5	<5	<5	9	84
2022	53	<5	<5	<5	7	63
2023	46	-	-	-	7	53

Source: Depaul

Table 14 outlines the total number of support areas identified for service users in each year of service delivery. It should be noted that service users may have one or more support areas; identified support areas therefore do not total to the number of service users.

Table 14: Depaul: Number of Housing First Cases: Identified support areas 2017 to 2023

Year	Physical	Mental	Drug	Alcohol
2017	78	108	48	66
2018	52	75	29	64
2019	35	52	18	49
2020	42	60	23	52
2021	37	53	24	40
2022	29	36	22	32
2023	24	41	22	24

Source: Depaul

In terms of outcomes, Depaul figures indicate that 269 individuals were supported into accommodation (figures up to end of December 2023). This included 83 in NIHE accommodation, 63 in Housing Association accommodation, 47 in the private rental sector, 52 with family and 24 with friends.

Depaul also provided some information on repeat presentations to their Housing First service. They noted that since commencement (in 2013) there have been 54 individuals who have made repeat presentations to the Housing First service. The majority of these were presentations on two occasions; however for seven individuals there were three periods with Housing First, for four – four periods, for two –five periods and for one individual – six periods with Housing First. Depaul note that for three of these individuals, representing higher levels of repeat engagement with Housing First, the reason for this was that they were in and out of prison over a period of a number of years. In these situations their Housing First case was opened and closed accordingly. For many of the other service users with repeat presentation, this was largely due to very unsettled periods due to their alcohol and substance abuse and chaotic lifestyle, which impacted their willingness to engage in the Housing First service, leading to case closure and then representation at a later stage.

Simon Community NI - Housing First

The Simon Community also operates a Housing First service called Housing First for Youth (HF4Y), formerly known as the Flexible Outreach Service. It was initially commissioned by the Northern HSC Trust in 2018, and then subsequently jointly commissioned by the South Eastern HSC Trust and the Belfast HSC Trust in 2021. In late 2022, the NIHE provided additional funding so that young people can avail of continued support from the service once HSC Trust responsibility ends for them.

HF4Y is a partnership initiative between the Simon Community, the HSC Trusts and the NIHE. As such, the service separates the housing and support elements. This means that if the accommodation element breaks down, the support remains. Simon Community note: *the service is built on the concept of stickability; no matter what happens, support and relationships will remain.* An initial financial investment for the service was secured from the Transformational Fund[102].

The Simon Community have a long history of working with young people experiencing homelessness including those who are care-experienced. This has provided them with insight into difficulties for

[102] DHSSPS funding - https://www.health-ni.gov.uk/publications/allocation-transformation-funding

young people who become homeless, where temporary accommodation is the only option. Simon Community noted: *Group living is not viable for some looked-after young people, either residential or supported accommodation. This is due to their needs, risks, and inability to manage in a group setting. Often, these young people have experienced multiple placement moves and continued relationship breakdowns (as these are attached to placements). They may have spent time in secure accommodation or the youth justice system. Their care trajectory shows significant placement breakdown, exhausting all options from residential care joint commissioned projects to supported lodgings. These young people are in continual placement crisis, with last resort, unregulated accommodation options, such as bed and breakfast, hotels, and spot purchasing of ad-hoc arrangements, to prevent experiencing homelessness as a looked-after child. These are the young people from the care system who are most at risk of becoming homeless and experiencing continued episodes of homelessness throughout their adult lives.*

In addition, in reviewing service user needs the Simon Community indicated the following everyday realities for this group of young people:

- Significant substance use (drug and alcohol)
- No regard to risk posed to themselves or others
- Discharge from JJC
- Criminal involvement
- Not included in any structured daytime activity
- Not engaged in any education or training
- Poor family support, if any - isolated in the community
- Multiple placement moves
- Limited relationships have been formed
- Mental Health issues
- Drug-induced mental health issues
- Currently in unregulated placements

The HF4Y service is therefore focused on a specific service user, both in terms of age and client background. The service is now an agreed care pathway as part of the HSCT portfolio of provision to looked after children. The service criteria are as follows:

- Aged 16 – 17 years old at the point of referral
- The individual is a HSC Trust 'looked after' child[103]
- The care pathway identifies the need for the HF4Y service, with evidence that all other options have been considered
- The young person is willing to engage in support

The HF4Y service model draws on and is informed by similar models operating effectively in some local authorities in England, and informed by the Housing First for Youth: A Program Model Guide (Gaetz, 2017)[104]. The following core principles underpin the service model:

[103] 'Looked after' child – the Children (NI) Order 1995 defines a 'looked after' child as one who is in the care of the HSC Trust or who is provided with accommodation by the Trust.
[104] Gaetz, Stephen. (2017). THIS is Housing First for Youth: A Program Model Guide. Toronto: Canadian Observatory on Homelessness Press. https://www.homelesshub.ca/sites/default/files/attachments/COH-AWH-HF4Y.pdf

- A right to housing with no preconditions
- Youth choice, youth voice and self-determination
- Positive youth development and wellness orientation
- Individualized, client-driven support with no time limits
- Social inclusion and community integration

In addition, the Simon Community noted the following about the HF4Y service: *Essentially, it delivers a bespoke service that is resilient and flexible, targeted at the most complex young people and offered at times when the young people are most vulnerable and most in need of support. This is a preventative* HF4Y *service, targeting young people in care at high risk of homelessness.*

The service support staff work a 24/7 rota, providing support through day and night. Young people are supported to engage with the Housing First Team and work alongside them to identify their accommodation needs. Accommodation is sourced via the NIHE, and young people can access support 24 hours a day, seven days a week via the Housing First Team. The support offered is defined by a strength-based risk strategy informed by multiple agencies and professionals. By March 2024, the service was supporting 16 young people. No data on the profile of these young people was available[105].

An evaluation report[106] noted that the service had supported 11 young people (for the period 31st March 2018 to 31st March 2022), enabling them to seek accommodation and maintain a level of independence in the community. The evaluation findings demonstrated that there were marked improvements in health and wellbeing, mental health, community connections, together with reductions in risk taking behaviours and re-integration to supportive services. The report also noted that the young people experienced a greater sense of stability and longer periods of settled behaviour with all returning to education or employment. The evaluation concluded: *overall, HF4Y has been a successful model of practice to support the most vulnerable young people in society.*

[105] Given the age of the young people, the fact that are 'looked after' children at the point of entry, and the relatively small numbers would mean that individual young people could be identified, no further profile information is available.
[106] Housing First for Youth, Evaluation Report, Dr Olinda Santin, 2022

Section 4 Understanding the client group

This section examines the number of clients that could be suitable for and targeted by Housing First and provides a range of estimations of future need. The following areas are covered:

- Thinking about the client group – the definition and nature of chronic homelessness;
- Thinking about the numbers – looking at available quantitative data and examining qualitative feedback on client numbers and estimations.

Section 3 outlined the underlying homelessness legislation and statutory duties on the Housing Executive in relation to homeless presenters and households. This feasibility study on Housing First is focused on those experiencing chronic homelessness rather than more generic or wider homelessness. Whilst there is no specific statutory or legislative duty in relation to chronic homelessness, the duties and categorisation of priority need outlined are clearly relevant and applicable, but fall short in terms of providing clear parameters for defining and responding specifically to chronic homelessness.

At the outset of this section it is perhaps useful to sum up the client group we are focussed on as chronic homeless, and for whom Housing First may be an option. The Housing First model and service has been defined in Section 2. Analysis of all stakeholder and service user feedback is included throughout this report and is in *italics.* For context, stakeholder analysis is identified as KI - Key Informant and P – Provider.

The Housing First model is for those who find that the traditional temporary accommodation[107] response is less than adequate for their needs. It's people who have had multiple episodes of homelessness in their homeless journey. They are likely to have addictions and mental health challenges, and also here in Northern Ireland – a connection to the troubles or the past or now for young people being under paramilitary control – a toxic part of Northern Irish culture. For these individuals there are 'critical time interventions' for services – there's a need for their own front door and because of breakdowns in placements they often have no access to services. (KI)

Definition of chronic homelessness

The Homelessness strategy 2017-22 set out a definition for chronic homelessness based on the one developed in the Crisis report (2010)[108]. The situation of chronic homelessness or being chronically homeless is defined as "a group of individuals with very pronounced and complex support needs who found it difficult to exit from homelessness."[109] The discussion under the theme of chronic homelessness acknowledges that Housing First may not be relevant for every individual who is chronic homeless, and equally there may be some homeless individuals around the edges of homelessness for whom Housing First could be more of a preventative model e.g. including for care leavers and those leaving prison. Key informants pointed to the linkage; one respondent noted: *all of the international research points very clearly to this client group being those with the most complex needs, and that they are most suitable for Housing First.* (KI) Another said: *we shouldn't*

[107] The make-up of temporary accommodation in Northern Ireland is described in Section 5.
[108] Anwen Jones and Nicholas Pleace, *A Review of Single Homelessness in the UK 2000 – 2010,* Crisis 2010. www.crisis.org.uk/media/237174/a_review_of_single_homelessness_in_the_uk_2000-2010_es.pdf
[109] Op cit.

forget about prevention and early intervention. If we can work with someone from the homeless cohort to prevent them moving to the chronic homeless cohort. (KI)

A Chronic Homelessness Action Plan (CHAP) was published in January 2020, following a public consultation exercise. The CHAP focuses on the Housing Executive's commitment, set out in the current Homelessness strategy, *to develop appropriate responses to address the needs of the population in Northern Ireland experiencing chronic homelessness*[110]. The CHAP includes several objectives including the design of specific criteria for measuring chronic homelessness and the implementation of a range of support services to help people sustain their accommodation. The CHAP report also emphasised that the problem of chronic homelessness cannot fully be resolved through housing provision; that it requires collaborative working across the statutory, voluntary and community sectors.

The definition of chronic homelessness was developed through a process of consultation and detailed discussion across the homeless sector, and was finalised as part of the CHAP report. The focus of the definition was broadly on ensuring that the needs of such individuals were identified, recognised and responded to, whilst on the other hand ensuring that criteria for inclusion in the definition would enable a form of measurement or counting of those experiencing chronic homelessness.

The definition and criteria therefore outline that an individual can be said to be experiencing chronic homelessness if they meet **one** of the primary indicators listed:

1. An individual with more than one episode of homelessness in the last 12 months; OR
2. An individual with multiple (3 or more) placements/exclusions from temporary accommodation during the last 12 months.

AND two or more of the following additional indicators must also apply:

- An individual with mental health problems;
- An individual with addictions e.g. drug or alcohol addictions;
- An individual that has engaged in street activity, including rough sleeping, street drinking, begging within the last 3 months;
- An individual who has experienced or is at risk of violence/abuse (including domestic abuse) - risk to self, to others or from others;
- An individual who has left prison or youth custody within the last 12 months;
- An individual who was defined as a 'looked after' child.

[110] *Chronic Homelessness Action Plan* (CHAP), January 2020, page 1.

The parameters of the definition of chronic homelessness are important for the discussion on Housing First, if chronic homelessness is viewed as the gateway into Housing First services. The two 'gateways' into the chronic homeless definition essentially place a duration on the nature of the chronic homelessness i.e., must be within the last 12 months[111].

As such the use of duration and timing means that this is defining episodic or recurrent homelessness which may or may not be related to chronic homelessness. Other jurisdictions provide a wider definition, e.g., the HUD[112] definition is "people who are chronically homeless have experienced homelessness for at least a year – or repeatedly – while struggling with a disabling condition such as a serious mental illness, substance use disorder, or physical disability" and in Finland, where the definition is extremely broad: 'anyone who is homeless for a year or more' in some contexts. Then in other countries e.g. Canada, Denmark and France Housing First is mainly, or exclusively, directed to people with a psychiatric diagnosis and in some cases e.g., Canada and France it is funded from the mental health rather than housing budgets. Analysis of the feedback from key informants and providers (see below) suggests an understanding of chronic homelessness which is more akin to a 'life course' view rather than a very tight time period. The danger with the latter is that someone could be under the radar and making their own arrangements in the last year (the defined period of 12 months) and may not have had the level of repeat presentations or placement breakdowns (three in the last 12 months) to be defined as chronic homeless, but their experience is very much within the long-term cyclical homelessness and complexity of needs linked to trauma described in our analysis.

The list of six additional indicators, of which the individual must demonstrate two, could also be viewed as being restrictive. For example, an individual may have mental health issues but none of the other indicators and would therefore be deemed to be outside the definition of chronic homelessness. The definition of chronic homelessness in Northern Ireland is therefore a crucial part of the discussion on developing Housing First services. Footnote 111 outlines exceptional circumstances in which the primary and additional indicators do not need to be fulfilled, and the Housing Advisor can use their skills and discretion when determining if a client is experiencing chronic homelessness.

[111] It should be noted that there is scope for exceptional circumstances. LSAN (HSG) 01/23 states that chronic homelessness can also be determined by the NIHE caseworker without meeting the primary and additional indicators, in exceptional circumstances. . 6.1 of the Advice note states: *It will be necessary on occasion for Housing Advisors to use their skills and discretion when determining if a client is experiencing chronic homelessness. The client should be looked at holistically and their entire story taken into account when making this determination. Some clients may not meet all of the necessary criteria but the Housing Advisor may still determine that they are experiencing chronic homelessness.*

[112] US – Department of Housing and Urban Development (HUD) - www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/definition-of-chronic-homelessness/

Feedback from service users on definition of chronic homelessness

The definition and nature of chronic homelessness was explored with service users. In summary those who fell into this category verbalised what being chronically homeless meant to them; this included:

- **Multiple moves** over a period of time and **a varied accommodation history**, including multiple placements in hostels, multiple tenancies, and a range of shared housing, living with friends and sofa-surfing, as well as placements in hospital and psychiatric units, and sleeping rough on the streets;
- **Elongated timescales** – being homeless over significant periods of time; 5 – 10 years and 10 years plus were not uncommon;
- **Experience of substance use (drug and alcohol)** interlinked to their chronic homelessness both as a causal factor and a resultant factor;
- **Triggers into chronic homelessness** including the lack of accommodation, their substance use, and other factors such as interface with the care system, juvenile and adult criminal justice system, intimidation and neighbourhood harassment, adverse childhood experiences, trauma throughout life including references to loss of children (through adoption and death), domestic abuse and violence, sexual assault and other traumatic incidents.

Feedback from interviews with stakeholders and providers on definition of chronic homelessness

The definition and nature of chronic homelessness was also explored with key informants and providers; their feedback is outlined below:

Long periods of homelessness – respondents commented on the length of time people had been homeless, either for one continuous and long period, or in recurrent or repeated periods over a protracted time period. References were also made to sleeping rough, time periods in different temporary accommodation and having 'no fixed abode.' Several providers referred to chronic homeless clients with experiences that are 'habitualised' in that they will stay in a hostel for a while and then return to sleeping on the streets; and noting their work as providers to assist people *used to living on the streets… and for some that adjustment can be difficult*. Reasons for initial and persistent homelessness were noted, covering the broad span of reasons for homelessness recorded by the NIHE[113].

Multiple moves – respondents noted that chronic homeless service users are *in and out of tenancies in a short space of time* (KI) as well as being in a variety of temporary accommodation settings. The recurrent or cyclical nature of movement and the reasons for moving were highlighted including barring and exclusion from temporary accommodation, difficulties in tenancies such as arrears or other financial reasons, anti-social behaviour, or lack of support to sustain their current placement. Lack of life skills and limited or no normal/family support networks were also highlighted. Providers referred to the revolving door and the 'washing machine effect' of going around different services.

[113] **Reasons for homelessness include:** Accommodation not reasonable, bomb/fire damage, breakdown sharing/family dispute, child ex care, domestic violence, fire/flood/other emergency, release from institution (including hospital, prison or other), intimidation, loss of NIHE accommodation, loss of private rented sector accommodation, mortgage arrears, neighbourhood harassment, no accommodation in Northern Ireland, relationship breakdown, sexual abuse/violence or other.

Difficulties exiting homelessness – this was noted by a number of respondents; that chronic homeless service users had availed of services but for various reasons could not exit and then sustain a tenancy. Whilst this was noted in two ways: firstly, the difficulties experienced by individuals to support or sustain themselves when living independently, and secondly in terms of service and system failures, where services may not recognise the long-term nature and complexity of people's support needs. The type and nature of temporary accommodation (covered in Sections 3 and 5) was referenced; one key informant summarised this as follows: *it's those for whom the traditional staircase of temporary accommodation doesn't work or meet their needs…their needs are immediate.* (KI) Providers also noted that for many of the clients in this group, there is no 'right place' or space to work on their issues or receive services. Reference was also made to structural difficulties in exiting homelessness not least access to affordable housing, access to benefits and support services and previous attempts to settle in the community which have resulted in harassment and intimidation.

Multiple additional and complex needs – respondents talked about needs that were significant and compounded, and often undiagnosed or untreated. One provider noted: *homelessness is in itself not always the primary challenge facing the clients we work with – it is the 'additional' needs that we should not lose sight of.* (P) Reference was made to physical health needs, poor mental health, learning difficulty, forensic history, self-neglect, care history, domestic and sexual abuse and violence, history of offending, exploitation, human trafficking and safeguarding issues. Respondents put forward a higher incidence of mental health problems in Northern Ireland compared to the rest of the UK, suggesting that this is related to the legacy of the Troubles/the past and the associated trauma[114]. One respondent noted: *across the board the level of demand on mental health services has increased. It's not just the level of demand, but the acuity. And the level of mental health issues is very complex and requires a lot of bespoke treatment. The pressures on mental health in-patient beds and bed pressures is really significant at the moment.*

Respondents also highlighted that the chronic homeless population are known to multiple agencies as they come in and out of service provision; this includes the prison and wider criminal justice system, police, social services, health services, housing including the NIHE, drug and outreach teams, community and multi-disciplinary teams, the hostel sector, floating support services, day centres, voluntary groups such as foodbanks etc.

Drug and alcohol addiction – this was noted as an underlying factor for those falling into the chronic homeless definition; respondents suggested that the incidence of IV/injecting and poly-drug use was increasing, together with the level of substance use including use of synthetic opiates, and that

[114] A number of reports have highlighted the higher prevalence of mental health problems in Northern Ireland than elsewhere in the United Kingdom, indicating that the prevalence among adults is 25 per cent higher than in England. This higher prevalence in Northern Ireland is associated with both greater levels of deprivation and the legacy of the 'Troubles'. See - https://www.niauditoffice.gov.uk/files/niauditoffice/documents/2023-05/00293490%20-%20Mental%20Health%20Report_WEB.pdf
However, this figure should be treated with caution as it originates from the comparison of findings from surveys undertaken, in the 1990s, in NI and England which employed different methods and measures, and there is limited current data to verify this suggestion. In addition, using the same measures across the UK nations, NI also comes out as highest for happiness, life satisfaction etc. and lowest for anxiety.
www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/april2021tomarch2022 See Figures 4 and 5.

alcohol usage was variable amongst this cohort (some suggested it was high with others saying it was low or rarely seen without associated drug use), generally using what they referred to as cheap cider and cheap vodka. One key informant noted: *in the past people injected heroin 3 – 4 times a day. But now with cocaine injecting it's 25 or 35 times a day, and this brings additional problems. There is a massive spike in amputations because of cocaine injecting…. This change in drug usage brings us into new territory, with the uncertainty of incidents and people are very volatile.* (KI)[115]

Evidence of impact of trauma and at risk - respondents indicated that chronic homeless service users were at risk of harm and frequently demonstrated the impact of unresolved trauma in their lives, either in early childhood or throughout their adult lives, through exposure to neglect, violence and family breakdown. One provider summed up their interaction with young people who meet the chronic homeless definition. *There is a complete systemic breakdown – trace it back to when they were a kid – ACE – disruption in school, suspended, no education – not fit for purpose for them, they run about with other young people, no GP, no access to CAHMs – smoking grass – and getting involved in crime – GBH – this is the norm. Very few young people come to us saying – I had a great childhood…* (P)

Difficulties in engagement with services – respondents pointed to the mismatch between the level of need and positive engagement with services, noting a range of system barriers and failures and difficulties for individuals to access services. This included comments on the lack of diagnosis or dual-diagnosis of service users and associated combined addiction/mental health services, low levels of GP registration, moving in and out of services, difficulties in accessing specialist services because of long waiting lists and removal from lists because of non-attendance etc. Providers also highlighted the incidence of mistrust; one provider noted: *they have a distrust of the whole system – and this leads to a cycle of non-engagement.* (P)

High levels of interaction with emergency services – again respondents highlighted this as a repeated theme for those described as chronic homeless. Reference was made to frequent attendance at hospital Emergency Departments, as well as call-outs of emergency services including police, ambulance and fire services. The high financial and systemic costs associated with this pattern are examined in Section 9.

Lack of purposeful activity and lack of hope – whilst this category is of course more subjective, this was noted by several providers as feeding into the amalgamation of reasons for chronic homelessness. One provider summed it up: *The use* (of any of the above) *is mainly because they have nothing else – no opportunities, no training, no jobs, no accommodation. When you haven't got that, of course you are going to fill the void…*

[115] Caution should be noted with this viewpoint. In Belfast there is a small group of IV heroin users that have moved onto cocaine injecting since the pandemic. Cocaine injecting is more frequent than for heroin but the quote suggests a very extreme usage which may not be representative of all cases. In addition, the 'massive spike' in amputations cannot be confirmed by specific numbers and may indeed be in single figures.

Additional vulnerability of chronic homeless women[116] – this was noted by a number of respondents, particularly providers working with women, in terms of gender specific issues relating to sexual exploitation and gender-based violence. One provider noted: *additional layer of vulnerability of being a woman – if they are on the streets, then additional risks; if they are in hostels then there are mixed risks – management of communal space, management of the relationships in the physical environment.* (P)

One key informant summed up a description of chronic homelessness as follows: *it's people who are in and out of the system multiple times. They have multiple issues including addictions and mental health, and there's a question over what came first? They are in poor physical health as they get older. And there is a shift to more younger people who are chronically addicted. There are often offending behaviours and chaotic lifestyles. It's the people that society has the least time for, but they do have rights and the right to a better outcome for themselves.* (KI)

Another key informant noted: *They are a chaotic and very vulnerable set of service users*. *Their usage of substances and addiction results in vulnerability and is often the result of a number of factors including trauma related events, unique NI specific events/activities; in many cases related to paramilitary activity, high risk into and out of the criminal justice system, the need for money for substances – and links with groups and dealers, and the fact that they tend to end up homeless and in hostel accommodation.* (KI)

Overall respondents also noted that these individuals had not chosen to fall into this category; but because of initial needs or trauma that were unmet, the movement towards being defined as chronic homeless has snowballed and become embedded. One respondent said: *they have slipped through the nets and there have been missed opportunities.* (KI)

One provider provided the following list of what they understood as comprising and contributing to a situation of chronic homelessness. These provide a useful reflection for later thinking about what the Housing First model needs to address.

Multiple needs	High risk of child sexual exploitation
Engaged in negative activities	Using substances
Paramilitary involvement	Absconding from care settings
Mental health	Trauma and history of abusers and being abused
No day-time activities	Potential learning disability – undiagnosed
Limited or poor family involvement	Known to the police
No emotional regulation	Poor attachment, behavioural challenges

[116] It is worth cross-referencing the NIHE report on chronic homeless women, as follows: F. Boyle (Fiona Boyle Associates), with Professor Nicholas Pleace and Dr. Joanne Bretherton, Centre for Housing Policy, the University of York, The Impacts of chronic homelessness for women, NIHE June 2021
https://www.nihe.gov.uk/getattachment/bc4f20a3-73be-42bc-888a-b002916f7c37/Impacts-of-Chronic-Homelessness-for-Women.pdf
In addition, there is considerable newer research on this including:
https://www.feantsa.org/en/report/2021/04/01/womens-homelessness-european-evidence-review?bcParent=27
Other research makes the case for separated Housing First for Women, designed, managed and run by women:
https://homelesslink-1b54.kxcdn.com/media/documents/Jigsaw_Housing_First_for_Women_Final_Evaluation_Report_2021.pdf

A number of providers also referenced the negative connotations of the word 'chronic'. According to one provider: *chronic is, in my view, a pejorative word with negative connotations. I would typify our client group as having developed a pattern of coping/living that is outside what is the norm. It is my opinion that this needs to be recognised and not necessarily described as always being 100% negative.*

Data on chronic homelessness

This sub-section examines the range of possible available data sources, which could be utilised to estimate the number of clients who would potentially benefit from the Housing First service. These include the following:

- NIHE data on repeat presentations – see also Table 24, Section 5;
- NIHE data on multiple placements – see also Table 25, Section 5;
- Current numbers/levels of uptake (for Depaul and SCNI Housing First services) – these figures were included in Section 3;
- Current estimates of numbers of people experiencing chronic homelessness including figures from the NI Housing Executive and the Complex Lives project (this Section and Section 4);
- Numbers relating to individual criteria in the chronic homeless definition e.g., numbers of rough sleepers, numbers of care leavers, numbers leaving prison with no fixed abode etc.

In addition, the CHAP report [117]noted that based on wider research[118] it would be expected that between 5 – 10% of the homeless population could be identified as experiencing chronic homelessness. Based on a total of 10,135 households receiving FDA status in 2021/22, the assumption could be made that this would translate to 507 – 1,104 individuals or households who are experiencing chronic homelessness. However, there is recognition that the analytical basis for this estimation is relatively dated, plus it does not consider differences between individuals and households. Further estimates in some countries suggest that chronic homelessness can account for 10 – 15% of the total homeless population, e.g., USA[119].

Level of repeat homelessness[120]

This is reported in Section 5 (table 24); for the purposes of estimating numbers the important figure is the number of individuals who present more than once in a year. In 2022/23 this figure stood at 1,075, indicating that this number of individuals had, according to the definition of chronic homelessness, more than one episode of homelessness in the last 12 months. This total annual figure has increased slightly over the last five years from 6% of homeless presenters in 2018/19 to 6.73% in 2022/23.

[117] *Chronic Homelessness Action Plan* (CHAP), January 2020, page 25.
[118] *Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization Results from the Analysis of Administrative Data,* Kuhn and Culhane, 1998.
[119] Culhane, D. (2018) *Chronic Homelessness: How has our understanding of chronic homelessness evolved?* The Center for Evidence-based Solutions to Homelessness http://www.evidenceonhomelessness.com/wp-content/uploads/2018/04/evidence-page-chronic-homelessness-April-2018.pdf
[120] The NIHE defines a repeat presenter as any household that had previously presented within 365 days of their current application.

Level of multiple placements

In line with the definition an individual can be described as chronic homeless if they have had multiple (3 or more) placements/exclusions from temporary accommodation during the last 12 months. Data on multiple placements is outlined in Section 5 (table 25). This indicates a significant increase from 154 applicants in 2017/18 experiencing multiple placements to 985 and relating to 5,404 placements in 2022/23.

Current numbers/levels of uptake – Housing First data

Another starting point for assessing or estimating the number of clients that could benefit from Housing First is to look at current levels of referrals and uptake to the current Housing First services in Northern Ireland. Data from Depaul indicates an uptake level of around 60 service users per year, and Simon Community NI have indicated a total of 16 service users at any one time. However, these figures are clearly curtailed by factors including the contractual arrangements, the funding available and the geographical reach of provision.

Current estimates of numbers of chronic homeless: NI Housing Executive

There is limited official statutory data on chronic homelessness from the Housing Executive. There were plans to operationalise the chronic homelessness definition from April 2020 including ongoing counting/measurement, however these plans were put on hold because of the Covid-19 pandemic. Indicators were then developed into criteria within the Housing Solutions form so that Housing Advisors and Patch Managers can identify, assess and also record anyone that falls within the categorisation of chronic homelessness. The recording and counting of chronic homelessness commenced on 7th January 2023. To date the NIHE has not shared this data. The NIHE has acknowledged challenges in ensuring that the data recorded on chronic homelessness is representative and there is ongoing work to address challenges ahead of the provision of any data.

Current estimates of numbers of chronic homeless: Complex Lives

The current uptake of Complex Lives (December 2023) indicates a core cohort of 123 clients. Again, it should be noted that this figure relates only to Belfast.

Other relevant data relating to the six indicators

The following data and reports could provide mechanisms for estimating the number of individuals for whom Housing First would be an appropriate service; albeit that this information has been collected for different reasons, and this approach does not discount issues around over-counting and under-counting.

Indicator 1: Mental health problems

The most recent Health Survey (NI): First Results 2022/23 [121] indicated that around a fifth of respondents (20%) had a high GHQ12[122] score which could indicate a mental health problem. This self-reported score suggests an increase since 2016/17 when 17% of respondents showed signs of mental ill health; albeit that figures have usually been around 19/20% although there was a much higher figure in 2020/21 of 27% due to the COVID-19 pandemic.

[121] Health Survey (NI):Health survey Northern Ireland: first results 2022/23 | Department of Health (health-ni.gov.uk)
[122] General Health Questionnaire 12

In addition, from a Northern Ireland perspective the 2008 Northern Ireland Study of Health and Stress[123] , estimated that 39% of the Northern Ireland population had experienced a conflict-related event, and identified significantly higher prevalence of mental health disorders among men and women who had experienced this type of traumatic event compared to those who had not. This is also referenced in the Department of Health, Mental Health Strategy, 2021 – 31.[124]

A study by PHA and CHNI[125] reported that 98% of providers in the study sample felt that the mental health of those who used their services was somewhat or very different to that of the general population. The top three mental health problems reported by providers were depression/ depressive disorders (96%), anxiety/anxiety disorders (89%) and suicidal ideation (88%). Clients indicated similar levels: depression (80%), stress (78%) and sleep problems (77%). This study was published in December 2017 and its representativeness of the whole homeless population is unknown. Nevertheless, it provides useful indications of the mental health of those who are homeless. It is also worth noting that mental health, as a factor in the individual's life may arise before or 'after' homelessness has occurred, particularly in cases where there has been a sustained period of homelessness, lack of access to services and other experiences associated with trauma and being homeless, as well as co-existing with other characteristics such as substance use disorder.

Indicator 2: Addictions e.g., drug or alcohol addictions

The extent of substance use is reported by the Public Health Agency.[126] The study cited above (PHA and CHNI)[127] reported that 88% of providers in the sample felt that the substance use issues of those who used their homelessness services were somewhat or very different to that of the general population. The top substance use issues reported by providers in the sample were alcohol, tobacco smoking, prescription drug use (for purposes other than intended); and Novel Psychoactive Substances (NPS). Ninety three per cent of providers reported excessive / problematic use of alcohol anytime in the 12 months up to and including data collection; 88%, NPS; 82% prescription medication (for purposes other than prescribed); and 89% 'other substances'. 98% reported their clients missing meals anytime in the same time period and 86% engaging in risk behaviours whilst intoxicated / relating to their substance use.

The most recent census of drug and alcohol treatment services was on 30th April 2019. Overall, 6,743 individuals were in treatment which represents an increase of 13% in comparison to the previous census in 2017 (5,969)[128].

[123] An epidemiological study of mental health disorders in Northern Ireland, conducted from 2007 to 2008, forming part of the World Mental Health Survey, an initiative under the auspices of the World Health Organization which incorporated regional and national surveys in 27 countries worldwide.

[124] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mhs-strategy-2021-2031.pdf

[125] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.publichealth.hscni.net/sites/default/files/A%20Picture%20of%20Health%20Dec%202017_0.pdf

[126] Extent of substance use and misuse in Northern Ireland, Updated October 2020
Summary of key statistics for the PHA Alcohol and Drug Commissioning Direction,
D. Gossrau-Breen & L. Hamilton, Health Intelligence.
https://www.publichealth.hscni.net/sites/default/files/2020-10/Extent%20of%20substance%20misuse%20in%20NI%20update%20Oct%2020.pdf

[127] Ibid.

[128] Op cit, Extent of substance use and misuse in Northern Ireland, October 2020.

The number of drug-related deaths registered in Northern Ireland in 2022 was 154; this was down from 213 deaths registered in 2021. The same was true for drug use deaths, decreasing from 175 in 2021 to 127 in 2022. However, since 2012, NI has seen deaths due to drug related causes rise by 98% from 110 to a peak of 218 in 2020 and to 213 in 2021[129]. The number of alcohol specific deaths in 2022 was 356; six more than the previous year and an increase of 45.9% over the last decade[130].

The Northern Ireland Needle and Syringe Exchange (NSE) Quarterly Report for the period 1st January 2023 to 31st March 2023[131] reported that needle exchange activity was recorded in 27 active sites throughout this period. Within this reporting period 2,277 new clients registered to use the service, bringing the overall total of clients registered (since the online database was first phased into use on 11th July 2022) to 3,637 clients. In addition, it was recorded that there was a total of 8,797 NSES transactions carried out across Northern Ireland[132].

Similar to our comment on the occurrence of mental health problems, addiction can be a factor for the individual before, during or after homelessness, and can occur sporadically or as a constant throughout their homeless episode. Further reading on factors such as mental health or addiction which lead to or result in multiple exclusions help to inform the discussion on chronic homelessness.[133]

Indicator 3: Engagement in street activity, including rough sleeping, street drinking, begging within the last 3 months

Rough sleeping is included as one of the criteria within indicator 3 of chronic homelessness. Rough sleepers are identified by the NIHE using the following definition:

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 streets, in tents, doorways, parks, bus shelters or encampments). People in buildings or other places, not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations or 'bashes').

The NIHE carry out a physical street count in Belfast, Derry/ Londonderry and Newry on an annual basis[134], and provide an estimated count[135] of rough sleeping for other locations. Table 15 provides data on the number of rough sleepers by Local Government District (LGD) area over the last six years. This suggests that numbers have remained relatively steady in the 5-year period with a dip for the Covid-19 period and an increase over the last year, and that the main area where rough

[129] Drug-Related and Drug Misuse Deaths 2012-2022 | Northern Ireland Statistics and Research Agency (nisra.gov.uk)
[130] Alcohol-Specific deaths in Northern Ireland, 2022 | Northern Ireland Statistics and Research Agency (nisra.gov.uk)
[131] https://www.publichealth.hscni.net/publications/northern-ireland-needle-and-syringe-exchange-quarterly-report
[132] There needs to be caution around the use of this data. Firstly, the total number of clients is an overestimate of actual numbers as many keep re-registering with a new ID no. at each visit - individuals cannot be tracked with this system; secondly, the majority of NSE clients seem to be steroid users who are unlikely to be homeless; and thirdly, proportions of clients using heroin and/or cocaine should be the focus of any discussion on chronic homelessness.
[133] England, E., Thomas, I, Mackie, P., and Browne-Gott, H: A typology of multiple exclusion homelessness, June 2022. https://www.tandfonline.com/doi/full/10.1080/02673037.2022.2077917
[134] The exact dates for the counts change each year, but the guidance states that the chosen nights must be between 1st October and 30th November.
[135] this method is intelligence-led and involves working with partner agencies, including local Housing Executive offices, PSNI, local councils, health trusts and relevant community and voluntary agencies. These agencies record and report how many people are rough sleeping in their area on a chosen night.

sleeping occurs is Belfast, with numbers recorded in Derry/Londonderry declining sharply since 2018.

Table 15: Number of rough sleepers by LGD 2018 - 2023

Council area	Year					
	2018	2019	2020	2021	2022	2023
Antrim & Newtownabbey	0	0	0	0	0	0
Ards & North Down	0	0	0	0	0	0
Armagh, Banbridge & Craigavon	0	4	0	1	1	1
Belfast	16	28	10	18	26	32
Causeway Coast & Glen	4	0	0	0	0	0
Derry City & Strabane	13	1	2	0	2	3
Fermanagh & Omagh	0	1	0	0	0	0
Lisburn & Castlereagh	0	0	0	0	0	2
Mid & East Antrim	0	1	0	0	0	0
Mid Ulster	0	0	0	0	1	0
Newry, Mourne & Down	5	1	6	4	3	7
TOTAL	**38**	**36**	**18**	**23**	**33**	**45**

Source: NIHE

In addition, the NIHE carried out 'Street needs' audits[136] with support from provider organisations[137] in February and March 2023 in Belfast, Derry/Londonderry and Newry. This covers all forms of street activity including rough sleeping. Whilst the CHAP (2000) had included a commitment to conducting street needs audits across Northern Ireland, this had not been possible in the period January 2020 to March 2022 due to the Covid-19 pandemic and associated public health guidance. The previous street audit had been undertaken in Belfast in 2016. It should be noted that this is a more expanded approach than the estimates in table 15 which provides a snapshot of how many people are rough sleeping on a given night. The street audits take place over a 6-week period (Belfast and Derry) and 2-week period in Newry and cover all types of street activity[138]. Counts were made twice a day, once during daytime hours and recorded the following:

- Belfast: 226 unique individuals over 980 engagements
- Derry: 50 unique individuals over 411 engagements
- Newry: 12 unique individuals over 44 engagements

Indicator 4: Experience or is at risk of violence/abuse (including domestic abuse) – risk to self, to others or from others

Data including the level of domestic abuse/violence recorded by the PSNI and numbers presenting as homeless as a result of domestic violence, contribute to estimations of numbers who might fit this criterion under chronic homelessness[139]. The most recent PSNI statistical bulletin[140]noted that in the year 2022 – 2023 there were 32,875 domestic abuse incidents in Northern Ireland. Whilst this was a

[136] Street Needs Audit 2023, NIHE www.nihe.gov.uk/housing-help/homelessness/rough-sleeping
[137] The Welcome Organisation, Depaul and First Housing Aid & Support Service.
[138] Information is unavailable directly from usage of the Welcome Centre.
[139] It is important to note that this is overwhelmingly women and women with dependent children; however men also experience domestic abuse/violence but in smaller numbers.
[140] Domestic Abuse Incidents and Crime Recorded in Northern Ireland Monthly Update to 31st March 2023 (psni.police.uk)

decrease of 311 (-0.9%) on the previous 12 months, this is the second highest annual figure recorded since the start of the data series in 2004/05. Table 16 indicates the level of households presenting as homeless because of domestic violence.

Table 16: Homelessness relating to domestic violence: households presenting and accepted, 2018 - 2023[141]

Year	Number households presenting with reason for homelessness: domestic violence	Number households accepted as homeless: reason for homelessness: domestic violence
2018/19	1,067	1,050
2019/20	1,055	1,009
2020/21	1,222	1,101
2021/22	1,035	947
2022/23	1,128	1,061

Source: NIHE

Indicator 5: Leaving prison or youth custody within the last 12 months

The Department of Justice[142] provided information from the Prisoner Needs Profile (PNP)[143] relating to the type of accommodation the individual was moving on to, when leaving prison. For 2022, this indicated that 15% (170 individuals) were moving onto a temporary arrangement with family/ friends, 8% (95) were moving to a hostel with 3% (36) indicating that their accommodation type would be 'on the streets/night shelter' or 'no fixed abode'. Again, this figure of 170 could be taken as part of an estimation of numbers for whom Housing First might be appropriate.

Indicator 6: Defined as a 'looked after' child

Tables 17 and 18 below indicate the number of young people (aged 16 and 17) recorded by the Health & Social Care Trusts who present as homeless; firstly, by age and gender (table 17) and secondly by HSC Trust area (table 18). Data is available for the period April 2018 to March 2021; at this point data collection was stood down temporarily[144]. The collection of data on the number of young people presenting to the HSC Trusts then resumed with a more streamlined approach for the six-month period ending 31st March 2023. This data is shown on the tables.

The change in data collection approaches results in an incomplete picture in relation to young people presenting as homelessness. However, if extrapolated for a full year (48 x 2 = 96), the data is not dissimilar to the earlier years (2018 – 2021).

Table 17: Annual number of young people (aged 16 and 17) recorded by Health & Social Care Trusts, NI wide, 2018 - 2023, presenting as homeless

[141] This table does not include households where the reason for homelessness was sexual abuse/violence, which might come under this indicator of chronic homelessness.
[142] Reducing Offending Division.
[143] This information form the Prisoner Needs Profile (PNP) is not published. This information is self-reported and not all prisoners choose to complete a PNP. Responses are not verified and may not represent an individual's needs at the end of custody.
[144] A Freedom of Information (FoI) request, DOH 2024-0063, March 2024 noted that the collection of such information involved a detailed manual collation of data by social workers at a time when there were significant pressures in terms of staff absence/vacancies.

Health & Social Care Trusts – NI wide data	Number of young people presenting as homeless				
	April 2018 – March 2019	April 2019 – March 2020	April 2020 – March 2021	April 2021 – March 2022	October 2022 – March 2023
Males aged 16 years	19	15	15	NA	11
Females aged 16 years	22	12	17	NA	
Males aged 17 years	36	41	26	NA	37
Females aged 17 years	46	34	28	NA	
Total	**123**	**102**	**86**	**NA**	**48**

Source: HSC Board & HSC Trusts

Table 18: Annual number of young people (aged 16 and 17) presenting as homeless, by Health & Social Care Trust area, 2016 - 2021

Health & Social Care Trusts – NI wide data	Number of young people presenting				
	April 2018 – March 2019	April 2019 – March 2020	April 2020 – March 2021	April 2021 – March 2022	October 2022 – March 2023
Belfast HSC Trust	18	24	15	NA	15
Northern HSC Trust	32	17	11	NA	<5
Southern HSC Trust	23	23	25	NA	10
South Eastern HSC Trust	16	22	23	NA	<5
Western HSC Trust	34	16	12	NA	18
Total	**123**	**102**	**86**	**NA**	**48**

Source: HSC Board

Whilst reviewing available data and previous/current estimations, it is important to emphasise the limitations of this approach. Firstly, there is a gap in available data on chronic homelessness from the NIHE. In addition, the range of data sources above include different collection mechanisms, differing availability and robustness of data in different organisations and availability of information for different timescales, as well as question marks over the relevance or comparability of some of the data sources quoted, and the usage of any household surveys which essentially exclude people experiencing homelessness. Furthermore, the use of different terminology and definitions impacts the comparability of secondary data sources. In addition, it is important to bear in mind that the use of multiple data sets can result in over-counting; taking into account that many service users in the category of chronic homeless may be counted by multiple organisations/providers and appear on multiple data sets. At this point there is limited opportunity for cross-referencing or checking, albeit the Complex Lives project has been developing an information sharing protocol[145].

Stakeholder respondents highlighted the difficulties in measuring chronic homelessness and needs within this. One key informant noted: *They are at risk of harm and lead very chaotic lives – this is not good for maintaining stable accommodation. They often also have physical health issues and mental*

[145] This will be a key factor in terms of calculating the level of need for Housing First; that is calculating the overlap between the different support needs and homelessness. Work in England, which looked at mapping severe and multiple disadvantages using overlap factors, may be relevant for this scoping study. See: https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

ill health. You put all of this together and they are moving from pillar to post. It is very difficult to categorise and pin down the client group in terms of their numbers and needs. (KI)

One provider noted: *estimating the number of people with complex housing/additional needs, specifically those who are chronically homeless and those for whom Housing First might be the best response, involves a combination of data collection, research and collaboration between government agencies, service providers and researchers.* (P)

Feedback from interviews with stakeholders and providers

In the absence of categoric data on numbers of people experiencing chronic homelessness, and considering the wide range of possible indicators and estimations, and the challenges in respect of data provision by the Housing Executive, as referenced earlier, stakeholders and providers were asked to estimate the number of chronic homeless individuals, so as to estimate potential demand for Housing First[146].

In terms of Belfast, a number of stakeholders pointed to the numbers being 'picked up' by the Complex Lives service. One key informant suggested that Complex Lives had already worked with 20 – 25 people who would be considered the most chaotic within the homeless sector; the respondents referenced these as the 'big hitters'. The same respondent noted that the Complex Lives service had a list of 130 potential clients, known to multiple agencies, and suggested that the number of service users in Belfast who could be defined as chronic homeless is likely to be in the parameter of 150 to 200. This was endorsed by other respondents, who also suggested that whilst this was the core group, there may be additional people on the periphery who are not so complex in nature but who have multiple needs. These might include others in non-standard accommodation and specialist hostels.

The Housing Executive respondents suggested that whilst counting was still being monitored and calibrated, their best estimation was that there were around 230 – 250 individuals who could be defined as chronic homeless across Northern Ireland. The need to identify the actual people was noted, as was the need to cross-match and validate numbers so that scaling up could be done. One provider said: *the likely size and nature can be assessed through the review of figures of service users involved in the Complex Lives programme as well as those who are repeat presenters at homeless hostels and who have complex needs in terms of their physical and mental health, substance use and experience of trauma. The figures are difficult to definitively determine as there is a very significant number of hostel residents and Floating Support service users (estimated at 80 – 90%) who have the same presenting needs as those with the Complex Lives programme, but who are not part of it.* (P)

[146] In considering an estimate of the need for Housing First, it may be possible to think about developing a 'By Name List' from multi-agency sources as has been done in some English cities/local authorities, e.g., Barnsley. This would look at individuals in other services who are in crisis, top of the list, at risk of reaching the top of the list or who are off radar (in prison, making own arrangements, unknown) but who are likely to come back into services again.

Is this the final figure?

As noted by one provider: *it's important to note that estimating these numbers is an ongoing and evolving process, as the homeless population can change due to various factors, including economic conditions, housing policies and the availability of support services. Collaboration and data sharing among relevant agencies and organisations are crucial for accurate and up-to-date estimations.* (P) Another provider said: *anecdotally we are aware that the numbers requiring such support is increasing at a marked rate, the age profile of the client group is becoming younger and the issues that they present with are rarely simple.* (P)

Whilst these estimations of some 150 to 200 individuals in Belfast, with potentially another 50 individuals Northern Ireland wide, are useful, the need to have robust figures based on needs assessed at presentation of homeliness is vital. To this end, the Research team recommend that chronic homelessness becomes a mandatory element of the keying in process, rather than a choice made by Housing Advisors. It is likely that these are conservative estimations in the light of the other wider information available about repeat presenters (over 1,000 individuals per year) and the level of placement breakdowns (still to be provided) and the incidence of the other six factors.

Section 10 outlines the modelling phase of this Feasibility study. The initial population who will need support in the context of their experience of sustained systemic failure and their length of time/ embeddedness in chronic homelessness is likely to be larger than the subsequent flow into Housing First, which will be much more around prevention of chronic homelessness. Experience from Finland indicates an expectation that the complex needs/long term homeless population will drop over time if Housing First is successful, and can drop quite significantly and quite rapidly depending on the level of resource input.

Section 5 Understanding the current homeless provision

This section explores current homelessness provision in Northern Ireland, and seeks to respond to the research objective: to examine the strengths and weaknesses of the existing temporary accommodation portfolio in relation to client outcome. This section examines factors including length of placement, lack of opportunities to move-on and repeat homelessness; with analysis of and reference to previous work in the homeless sector on this topic, together with feedback from the interviews with key informants and providers.

The relative costs of temporary accommodation versus Housing First models will be explored in later sections. However, a number of factors are worth noting at this point. Firstly, there is a key difference between Northern Ireland and the rest of the UK and particularly England, where more than £1billion has been taken out of homelessness service commissioning by local authorities since 2010. In comparison to the Northern Ireland approach with high levels of units in temporary/ emergency hostels, significant proportions of GB temporary accommodation is short-lease private rented sector, apartment hostels, hotels and B&Bs. This makes the context, in terms of cost, operational situation etc. for Housing First quite different than GB. In section 7 we will explore the cost benefit arguments around expanding Housing First, based on the NI situation where the cost of temporary accommodation is significant (see table 4 in Section 1) relative to what Housing First might cost. It should be noted at this point that whilst Housing First may not be a cheaper option, it may be more cost effective in the longer-term for the public purse, as the individual is settled and not moving in and out of services. In addition, the outcomes are better for the individual; this is explored in Section 6.

Feedback from service users on this topic is covered in Section 5. The key points from analysis of service user views on the current homeless provision included poor availability of suitable temporary accommodation specifically for people experiencing chronic homelessness, and that available temporary accommodation is not supportive or geared up for those with additional needs associated with chronic homelessness. Factors under this theme included the regime and restrictions in some of the hostels, lack of privacy, limited support and the location offered for temporary accommodation which was often perceived to be unsupportive for the service user. Reference was also made to overall staffing levels and a perceived lack of trained staff in hostels in general. More in-depth comments related to limited provision of female-only hostels, a lack of hostels for young people, especially for those leaving care, low levels of wet hostels for people with alcohol addiction and limited addictions support; all with the underlying theme of the specific support needs of people experiencing chronic homelessness. Service users also pointed to the lack of support for moving on from temporary accommodation and moving into the community for those with chronic support needs. In contrast, some service users highlighted a positive experience of homeless services including the input of support staff in temporary accommodation, the support in day centres and the positive support and input of Housing Advisors in the Housing Executive.

Homeless temporary accommodation provision in Northern Ireland

Tables 19 and 20 outline temporary accommodation provision in Northern Ireland, funded through the Supporting People programme. The Supporting People programme was introduced in Northern Ireland in 2003. Its aim is *to commission housing support services aimed at improving the quality of life and independence of vulnerable* people; this is an important contextual factor when thinking about chronic homelessness. Details of the level of Supporting People expenditure on temporary accommodation was referenced in Section 3.

Temporary homeless accommodation (as of 2022) is provided by a wide range of different types of providers from the NI Housing Executive, to the Health & Social Care Trusts[147], Housing Associations[148], regional networks such as Women's Aid[149] and charitable/voluntary sector organisations[150].

Tables 19 and 20 outline the different primary client groups under the homelessness temporary accommodation provision, and indicate the number of hostels and contracted units for these groups over the last five years. Table 19 outlines the number of hostels or service provision (not Floating Support) by primary client group.

Table 19: Primary client groups: Number of hostels of SP funded temporary accommodation, 2022

Primary client group	Number of hostels
Homeless families with support needs	23
Offenders or people at risk of offending	4
People with alcohol problems	9
Single homeless crisis accommodation	2
Single homeless with support needs	33
Women at risk of domestic violence	15
Young People	22
Total	**108**

Source: NIHE

During 2022 Supporting People funded 2,206 units of temporary accommodation in hostels (voluntary sector and NIHE) for the primary client groups under the heading of homelessness, as outlined in table 20. The total number of units has increased overall since 2018 (17% increase from 1,880 to 2,206 units) with the largest increase for single homeless clients with support needs.

[147] Belfast, Northern, Southern, South Eastern and Western Health & Social Care Trusts.
[148] Apex, Ark and North Belfast Housing Associations.
[149] Antrim, Ballymena, Carrick, Larne & Newtownabbey, Armagh Down, Belfast & Lisburn, Causeway & Mid Ulster, Fermanagh, Foyle, North Down & Ards and Omagh Women's Aid.
[150] Action for Children, Barnardo's, Belfast Central Mission, Cithrah Foundation, Council for Social Witness, Cuan Mhuire (NI) Ltd, Depaul NI, East Belfast Mission, Extern NI, First Housing Aid & Support Services, HarmonI, Larne Community Care Centre, Life Housing NI, Living Rivers Trust, MACS Supporting Young People, Mind Wise New Vision, Morning Star House, North West Methodist Mission, Praxis Care, Queen's Quarter Housing Ltd, Rosemount House Ltd, Shelter (NI) Ltd, Simon Community NI, Tarasis Support Services, the Salvation Army and The Welcome Organisation.

Table 20: Primary client groups: Number of contracted units of SP funded temporary accommodation by year, 2018 – 2022

Primary client group	YEAR				
	2018	2019	2020	2021	2022
Homeless families with support needs	283	299	299	325	315
Offenders or people at risk of offending	73	73	88	68	68
People with alcohol problems	185	185	185	185	185
Single homeless crisis accommodation	26	26	31	31	31
Single homeless with support needs	911	947	921	1,391	1,208
Women at risk of domestic violence	156	157	157	156	156
Young People	246	248	243	243	243
Total number of units	**1,880**	**1,935**	**1,924**	**2,399**	**2,206**

Source: NIHE

From the earlier discussion, it is clear that much of the above accommodation is relevant to one or more of the list of needs in the definition of chronic homelessness. For example, there is specialist or targeted provision for an individual with addictions including drug or alcohol addictions, or for an individual who has left prison or youth custody, or who has experienced or is a risk of violence/abuse including domestic abuse or who is engaged in street activity. However, as noted later in this section, many people experiencing chronic homelessness are placed in generalist temporary accommodation e.g., for single people experiencing homelessness with support needs, which does not necessarily meet their additional needs. Furthermore, from the discussion below it is evident that there may be no suitable temporary accommodation for those with the most complex and chronic needs.

In addition to the above units of supported temporary accommodation, the Housing Executive also has access to further non-standard accommodation[151] for placement of those requiring temporary accommodation. This includes privately-owned single lets[152]. Table 21 provides a snapshot of temporary accommodation placements as of 31st December 2023.

[151] Non-standard accommodation includes single lets, B&B's and hotel accommodation.
[152] Single Let - Houses/flats etc. made available under licence agreement to households on a short-term basis.

Table 21: Snapshot of temporary accommodation placements – as of 31st December 2023

Type of temporary accommodation	Number of placements
Single Lets	2,792
DIME	115
Voluntary sector hostels	808
Housing Executive hostels	281
Hotel/B&B	397
Bespoke facility[153]	39
Crash: Voluntary sector[154]	18
Other[155]	21
Total	**4,471**

Source: NIHE

Floating support[156] is also funded through the Supporting People homelessness budget; floating support services are viewed as being important in the prevention of homelessness and in sustaining tenancies. Floating support is a generic name for any arrangement where support is delivered on a peripatetic basis to households in their own home or separately from the provision of housing. It is usually provided on a time-limited basis, by a range of providers including the NIHE, Health & Social Care Trusts[157], Housing Associations[158], regional networks such as Women's Aid[159] and charitable/ voluntary sector organisations.[160] Table 22 outlines the number of contracted units of Floating Support by primary client group.

[153] Counts for bespoke facilities were added during the Covid-19 pandemic and are now part of the overall count.
[154] Counts for Crash: voluntary sector were added during the Covid-19 pandemic and are now part of the overall count.
[155] Other includes Housing Association temporary accommodation and HMOs.
[156] There is a shift in England to calling these services 'housing-led' rather than floating support, i.e., mainly housing with some support as distinct from intensive support in Housing First.
[157] Western HSC Trust.
[158] Apex, Ark and Triangle Housing Associations.
[159] Antrim, Ballymena, Carrick, Larne & Newtownabbey, Armagh Down, Belfast & Lisburn, Causeway & Mid Ulster, Fermanagh, Foyle, North Down & Ards and Omagh Women's Aid.
[160] Action For Children, Belfast Central Mission, Bryson Care, Depaul NI, East Belfast Mission, Extern NI, First Housing Aid & Support Services, Life Housing NI, Link Family & Community Centre, MACS Supporting Young People, NIACRO, North Down YMCA, Simon Community NI, STEP, Tarasis Support Services and The Welcome Organisation.

Table 22: Primary client groups: Number of contracted units of SP funded Floating support by year, 2018 – 2022

Primary client group					
Homeless families with support needs	691	691	691	691	691
Offenders or people at risk of offending	229	229	229	229	229
People with alcohol & drug problems	149	149	149	149	132
Single homeless crisis accommodation	-	-	-	-	-
Single homeless with support needs	482	482	493	493	493
Women at risk of domestic violence	1,173	1,173	1,173	1,173	1,423
Young People	509	509	673	564	564

Source: NIHE

Other important factors in an analysis of current homelessness provision in Northern Ireland include the average length of time in temporary accommodation (see table 23), the level of repeat homelessness (see table 24) and the level of applicants having multiple placements within a financial year (see table 25). These factors are discussed in more detail below in terms of stakeholder feedback, and interconnect to the theme of chronic homelessness and appropriate services, acknowledging firstly that the length of time spent in temporary accommodation is difficult for the individual with 'very pronounced and complex support needs' (chronic homeless definition) and the interplay of repeat homelessness and multiple placements are also key factors in chronic homelessness (an individual with more than one episode of homelessness in the last 12 months and multiple placements – chronic homeless definition). This was examined in Section 4.

Table 23 indicates that the overall length of stay in temporary accommodation has increased slightly over the last six years, from 282 days in 2017/18 to 300 days in 2022/23; a period of around ten months. The data for single lets and Housing Executive hostels show the average longest length of stay; 749 days in a single let in 2022/23 (around two years) and 404 days in a NIHE hostel (around 13 months).

Table 23: Average length of stay (in days) in temporary accommodation by year, 2017/18 – 2022/23

Type of temporary accommodation	Average Length of Stay By YEAR					
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Single Lets	394	427	451	443	541	749
DIME	125	128	135	91	43	1
Voluntary sector hostels	245	231	233	160	169	263
Housing Executive hostels	223	208	216	219	277	404
Hotel/B&B	48	18	36	14	21	34
Bespoke facility[161]	N/A	N/A	N/A	32	76	114
Crash: Voluntary sector[162]	N/A	N/A	N/A	20	63	49
Total Average Length of Stay	**282**	**281**	**275**	**175**	**217**	**300**

Source: NIHE

Table 24 outlines the level of repeat homelessness; the NIHE defines a repeat presenter as any household that had previously presented within 365 days of their current application. Table 24 indicates that the total annual figure of repeat homelessness has remained relatively steady both in total numbers (slight increase) and as a proportion. In 2022/23 this figure stood at 1,075 (6.73% of total presenters that year), indicating that this number of individuals had, according to the definition of chronic homelessness, more than one episode of homelessness in the last 12 months.

Table 24: Level of repeat homelessness by year, 2018/19 – 2022/23

Year	Number of repeat homeless[163]	Total homeless presenters	Number of repeat homeless as %age of total presenters
2018/19	1,088	18,202	6.00%
2019/20	1,101	16,802	6.50%
2020/21	1,188	15,991	7.40%
2021/22	1,745	15,758	11.10%
2022/23	1,075	15,965	6.73%

Source: NIHE

Table 25 indicates the level of applicants who have experienced multiple placements (three or more) within one financial year. This was the experience of 154 applicants in 2017/18 and had more than quadrupled by 2022/23, affecting nearly 1,000 applicants. In addition, this was relevant for 5,404 placements (2022/23), indicating a high level of multiple placements.

[161] Counts for bespoke facilities were added during the Covid-19 pandemic and are now part of the overall count.
[162] Counts for Crash: voluntary sector were added during the Covid-19 pandemic and are now part of the overall count.
[163] This figure is unavailable by household type.

Table 25: Multiple placements (3 or more) by type of temporary accommodation, 2017/18 – 2022/23

Type of temporary accommodation	YEAR					
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
External accommodation – Hotels, B&Bs	350	457	787	3,824	2,680	2,145
Single Lets	98	90	165	446	290	312
Voluntary sector hostels	74	146	173	706	726	592
Housing Executive hostels	30	45	53	114	88	86
Leased property[164]	31	67	71	406	1,093	2,060
Bespoke facility	N/A	N/A	N/A	69	85	107
Crash: Voluntary sector	N/A	N/A	N/A	94	39	102
Total placements	**583**	**805**	**1,249**	**5,659**	**5,001**	**5,404**
Total applicants	**154**	**220**	**319**	**1,102**	**945**	**985**

Source: NIHE

It is important to stress that repeat homelessness and multiple placements do not automatically mean an individual should be defined as experiencing chronic homelessness. However, if combined with the other criteria listed in the definition of chronic homelessness, individuals could then be described as experiencing chronic homelessness. In addition, the NIHE have noted that counting and measuring repeat homelessness is not without its difficulties[165]. This was examined in Section 4.

A further factor which impacts on the homeless individual/household is the waiting time for social housing and the lack of affordable and accessible other housing options. This compounds with the length of time in temporary accommodation and relates directly to a limited supply of social housing in Northern Ireland, when compared to the levels presenting/accepted as homeless (as noted in tables 2 - 4) and those on the social housing waiting list. Table 26 indicates the number of homeless accepted cases (FDA) who are then rehoused in the social housing sector by year since 2019. It should be noted that their presentation as homeless may have been in a previous year to their rehousing.

[164] Leased properties are defined as those properties which have been leased on a block booking basis by the NIHE.
[165] The Housing Executive noted the following - Some of the repeat presentations – particularly those with a very short number of days between can on occasion be down to errors in case processing. For example, if we lose contact with someone the case can be closed, however they may appear again some days or weeks later. If this happens, staff should reopen the existing case, but on occasion a new case will be opened if perhaps they present to a different office. It is the nature of the chaotic lifestyles of some clients experiencing chronic homelessness which can cause this to occur. Strictly speaking a new case should only be taken where the client is in a different bout of homelessness, however, it can sometimes be difficult for staff to determine this.

Table 26: Homeless accepted cases (FDA) rehoused in the social sector by year, 2019 - 2023

Year	Nr households accepted as statutorily homeless - FDA[166]	Allocated Housing Association tenancy	Allocated Housing Executive tenancy	Total social housing allocations	%age of those awarded FDA
2019	**12,512**	2,156	2,687	**4,843**	**39%**
2020	**11,323**	2,106	2,597	**4,703**	**41%**
2021	**9,889**	2,362	3,002	**5,364**	**54%**
2022	**10,135**	3,281	3,282	**6,563**	**65%**
2023	**10,349**	2,220	2,531	**4,751**	**46%**

Source: NIHE

Strengths and weaknesses of the existing temporary accommodation portfolio: a review of literature

This sub-section highlights research previously undertaken on the existing homeless and temporary accommodation provision in Northern Ireland. As this is already well-documented in academic, voluntary sector and government research reports, a summary is provided.

The Strategic Review of Temporary Accommodation[167] commented on factors such as the standards of temporary accommodation, the ability of hostels to respond to those with significant support needs and the average length of stay in temporary accommodation. The following paragraphs illustrate:

- Stakeholders in Northern Ireland reported that standards vary across the different types of temporary accommodation types. For example, facilities can be poor in older hostels, whereas purpose-built accommodation is generally of a high standard. Likewise, some single lets are of a poor standard and repairs can be lengthy, while others are in new build developments and are of a very high standard. It was noted that high standard temporary accommodation can act as a barrier to residents moving into settled accommodation if the standard of the settled accommodation is lower or the location is not as good; (para 1.22)
- The Housing Executive relies significantly on emergency/crisis/crash accommodation and to a lesser extent on B&B accommodation to meet the needs of households with significant support needs and those at high levels of risk. These forms of accommodation provide very short-term solutions and can be unsuitable for vulnerable people. Yet a significant proportion of people identified as vulnerable appear from the data to be returning there repeatedly; (para 1.39)
- The data indicates that households stay in temporary accommodation longer in Northern Ireland than in the other UK jurisdictions. The average length of a stay in temporary accommodation in Northern Ireland for those who left the accommodation in 2018/2019 was 220 days[168]; (para 1.53).

[166] This data is for financial years i.e. 2018 – 2019.

[167] https://www.nihe.gov.uk/getattachment/48f61a4a-780b-47f8-bb0a-f94417c93555/Strategic-Review-of-Temporary-Accommodation.pdf

[168] Data provided by the NIHE indicates an average length of stay of 281 days in 2018/19 and 228 days in 2022/23.

Lynne McMordie's report on Chronic Homelessness and temporary accommodation placement in Belfast[169] provided a detailed examination of negative effects relating to hostel living. These included internal factors for the service users such as a diminishing of self-worth as a result of having to live in a hostel, and keeping within the rules and boundaries of the hostel, for example, managing trauma and substance abuse, and the consequences of breaking rules and resultant exclusion. McMordie noted that the stress of potential exclusion from a hostel often led to three coping strategies: firstly, covert behaviours (often to manage substance dependency), muting behaviours (using substances to ease stress levels) and avoidance behaviours (refusing or abandoning placements if there was a threat to remaining in a placement). McMordie also examined the current temporary accommodation provision from a planning perspective, noting that the current portfolio has remained relatively static whilst the service user need has evolved and changed over time, *giving rise to widely acknowledged gaps and misalignment in service provision.*

Work undertaken by Ruth Flood Associates for the Public Health Agency[170] highlighted a range of key themes from wider literature, drawing on research undertaken during the period 2018 – 2021 by a number of research consultants. In terms of particular reference to the current homeless temporary accommodation provision the following points are relevant:

- There is evidence of a lack of availability of accommodation for people who have been chronically homeless that would meet a variety of needs;
- There are concerns about the effect of staying in temporary accommodation on some service users including feelings of being at risk of harm from violence, intimidation, theft and exploitation;
- There was some evidence from service users that hostels were where their substance abuse worsened;
- There was feedback from services users about the strictness of approach in hostels;
- There was evidence that women in mixed hostels are vulnerable; this is interconnected to short stays and multiple moves leading to an increased chaotic lifestyle and reducing the chance of moving out of homelessness.

Feedback from interviews with stakeholders and providers

This sub-section now looks at what key informants, including stakeholders and providers, said about current homelessness provision in Northern Ireland, and its applicability and suitability to the needs of the chronic homeless population. Respondents, particularly providers, noted positive comments about many aspects of temporary accommodation as it currently stands. Their feedback included comments on the vital service provided by emergency night shelters, the support services provided in hostels including meals, access to hygiene facilities, counselling and assistance to find permanent housing, the positive partnerships and collaboration between hostels and other organisations to coordinate services, the development of a number of specialised services for specific populations such as women and young people, and the development of harm reduction strategies and hostels to support people with substance abuse issues. However, setting these positive aspects to one side, there was broad agreement and consensus that the homeless provision, as it is currently formatted,

[169] chronic-homelessness-and-temporary-accommodation.pdf (hw.ac.uk)

[170] Complex Lives Project: Review of recent literature on chronic homelessness in Northern Ireland, prepared by Ruth Flood Associates for the Public Health Agency, March 2022.

does not suit or meet the needs of those defined as experiencing chronic homelessness for the following reasons:

The high usage of temporary accommodation – respondents noted that the response to homelessness, through the provision of temporary accommodation, effectively results in a barrier for those who are chronically homeless, i.e., that access to affordable, settled housing is not available and services cannot therefore operate as intended, and clients get stuck in temporary accommodation and cannot move on. In addition, the term 'temporary' accommodation is a misnomer, as lengths of stay in temporary accommodation are frequently lengthy. One key informant noted: *there is a danger that hostels are just large warehouses of people who don't get moved on…* One provider said: *historically homeless provision was for people at the start of their journey. But these are now chaotic service users with multiple and complex needs. The goal is to get a tenancy but when that doesn't happen, people get pissed off and then even though work is done there is no output…behaviours start. How do you help them to maintain when they are in temporary accommodation for so long?*

With a history of multiple moves and placements, often stretching back to childhood experiences, those with the highest needs find it difficult to remain in the one place. As well as traditional hostel models, reference was also made to crash facilities, where service users present at 8/9pm and then have to leave the next morning (referenced by one provider as: *late in and early* out), with accommodation available on a night-by-night basis, and how this may not provide the crucial stability needed for the client, including in some cases the lack of somewhere to go during the day.

The location and availability of temporary accommodation was also cited as a frequent issue for this client group. One key informant noted: *the challenges of moving away from support networks, at a time when they really need their support networks – compounded with their other difficulties.* (KI) Another respondent highlighted difficulties resulting from having to move to temporary accommodation in a different HSC Trust area. *If people are moving or being moved around, they may then be moving Trust area or key worker. It is very difficult for them to build up the relationship with them. Also, when this happens, they are having to retell their stories, and this can retraumatise or be a barrier. And if they are moving out of the area but have appointments in their original area, there is more likelihood they will drop out of treatment.* (KI)

The type, structure and format of temporary accommodation – again there was consensus that the communal and mixed needs nature of temporary accommodation is not the best environment for someone experiencing multiple and chronic needs. One provider noted: *the mix of issues in the hostel, where there are so many different backgrounds coming together. With the mix of needs and issues there is a very high risk of relapse. So many factors under one roof; it's like a melting pot in one hostel.* (P) This is further exacerbated when their specific chronic needs cannot be supported in particular environments e.g., those who have experienced domestic abuse/violence where the only provision is in a mixed gender hostel, those who have alcohol or drug addictions where the only provision is in a dry hostel or environment where there is no tolerance in terms of drug taking or drinking etc. One key informant noted: *hostels are not equipped to deal with the explosion of injecting drug users* (KI), with providers concerned: *you are introducing them to a drug and alcohol problem* (P). Another provider said: *they come in with less issues but become entrenched in this life*

very quickly…they are speaking to people who are already addicts and, on the streets, and they get sucked in very quickly. A further key informant commented that chronically homeless service users do not feel safe in hostels and often indicate that they feel safer sleeping rough.

Another factor examined under this heading was the size of many hostels, originally developed to meet the needs of single homeless men, and how this was not a helpful model for those who have additional needs. *One main drawback of the traditional hostel model is the high density of people in a small congregated space. There could be 40 to 60 individuals, and in some hostels it's as much as 80. This is a breeding ground for vulnerable people to succumb to negative consequences.* (KI) There was acknowledgement that larger temporary homeless provision does meet the needs of many service users, but this is not the best fit for those experiencing chronic homelessness. *For the homeless client group the current services are good for some people. But for those who have chronic issues and young people, an 80-bed hostel is not the right place.* (KI)

The age and building standards of a proportion of temporary accommodation hostels was also noted as a factor, both affecting those living in them and for future planning consideration within the homeless sector. One key informant noted: *in terms of physical maintenance and standards some are reaching the point of not fit for habitation.* (KI)

The type of service available – whilst respondents were positive in many cases about the levels of skills and expertise in the homeless sector, and providers noted the commitment of staff, reference was also made to the lack of staff/poor staffing to service user ratios and in some cases difficulties in attracting and retaining well qualified and experienced staff members, as well as reliance on bank staff. One key informant noted: *the better providers are better at preparing people to move on…but there are some clients they are not able to engage. The staff don't have the experience to engage with them. So, there's no move-on and any work – it gets lost.* (KI)

Staff skills and experience was in part due to the level at which job roles were pitched, linked directly to available resources and salary/remuneration levels. Key informants and providers emphasised the lack of trauma-informed practice and psychologically informed environments in the current temporary accommodation provision. *The culture of provision is a factor. There is not as much evidence as we would want to see in terms of trauma informed practice, user led models of delivery, tolerance levels which are appropriate and the power dynamic between hostel staff and user/customer.* (KI) Another respondent noted: *some of the facilities are not geared up to support individuals who are needing intensive support. The staff don't have the skills and training.* (KI)

Providers also commented that since the Covid-19 pandemic there has been a reduction in tolerance levels in some hostels, mainly due to lack of staff and lower levels of experienced staff. One provider noted: *in the past there were service users that hostels would have given a go, but staffing pressures has forced services to reduce.* (P)

The system of allocating temporary accommodation – feedback from key informants also highlighted a concern that because of the nature of presenting as homeless, the system for assessing this and offering temporary accommodation often results in the individual not receiving much advance notice of where they are to be placed. This was reported for all chronically homeless individuals, but

in particular for those leaving prison. One key informant noted: *I think the issue is not having the bed available until the last minute. This causes issues. They end up in an area they are not familiar with, and it may cause issues in terms of support – it's not always 24-hour support. They end up lacking in confidence and self-esteem and don't know how to access local services. So, the planning of where a person is to be placed, that is really important, but I understand there is a lack of spaces in temporary accommodation.* (KI)

The usage of single lets and accommodation in B&Bs – this was highlighted as unsuitable for those who have chronic homeless needs; the lack of 24/7 support and isolation in the community were noted as key factors. *Single lets here and there are not stable, and it doesn't allow them to build up relationships with service providers. They need a secure pocket.* (KI) Them *going into a hostel isn't suitable, and it's a B&B if they don't get a hostel. This is dangerous never mind not suitable.* (P)

The interconnection to poor mental health – stakeholders noted that the chaotic nature of temporary accommodation hostels, with services users coming and going with a wide range of needs and often undiagnosed conditions, leads to a situation which negatively impacts the chronically homeless service user in terms of their mental health. One key informant noted: *it is unsuitable because it creates uncertainty and with that anxiety, and the person ends up back on the streets.* (KI) Another said: *their behaviour is so chaotic that they are getting barred around every hostel.* (KI)

Difficulties in engagement – this factor was highlighted by the majority of respondents. Factors included the way in which services are set up (high threshold/low tolerance), the barriers and hurdles which create challenges for service users to both enter and remain in temporary accommodation, and wider difficulties for those with multiple needs to navigate the accommodation and support available. It was noted that the way in which services are set up effectively means that it is difficult for someone who is experiencing chronic homelessness to engage with the service, and if they do engage, the service profile means that they are often asked to leave or barred. One key informant summed this up: *Because of their behaviour they are being repeatedly excluded across temporary accommodation provision…this in turn leads to a situation where there is a reduction in the availability and suitability of accommodation for these chaotic individuals…as a result people move and move and move…* (KI) In addition, providers also viewed the discussion on tolerance levels from the perspective of service delivery, where they noted the difficulties they encountered where some service users were posing a risk to other service users and lone workers as a result of violence and aggression, and how to manage this in a controlled way to ensure the health and safety of all. One provider said: *it's seen as the negative impact of one person (the chronic homeless person), onto the rest of the group. They then unsettle the whole house, so they are asked to leave for the greater good.* (P)

The lack of move-on – throughput linked to a lack of move-on provision was cited as a further issue, compounding difficulties experienced as a result of being in temporary accommodation for an extended period of time. Respondents noted that because of the low levels of affordable and available housing stock and the associated lack of opportunities for move-on, service users end up having to stay in group living for longer periods than is helpful for their chronic needs and additional issues. Capacity issues were noted as leading to overcrowding in hostels and in some cases, people being turned away; this was particularly noted in relation to the emergency shelters where demand

often exceeded available bedspaces. They also pointed to what they considered to be a lack of associated support and intensive Floating support for when chronically homeless clients did move on. One provider noted: *there is a lack of intensive support, the type of support which enables the service user to navigate different systems such as the GP, community Mental Health services, Benefits, whatever they need…*

Many of the factors outlined above are interconnected; with respondents concluding that the current temporary accommodation hostel setting is not the appropriate service for people experiencing chronic homelessness. This was summarised by one respondent:
Stability is needed and that's not what you get from temporary accommodation. It provides the complete opposite. It provides temptation and easy access to the things they don't need. And people are at different stages of using, so there is a significant chance of relapse if they have not been using. (KI)

Key informants also highlighted wider concerns about the level of use of temporary accommodation, not specifically linked to the needs of the chronically homeless client group. These comments were more around the cost of providing temporary accommodation, and the impact this was having on other homelessness work. This was summed up by one key informant:
Temporary homeless provision was supposed to be brief, non-recurrent, but it's the opposite of what it's supposed to be. Also, it's hugely expensive and the outworking of it curtails the prevention work and work that needs to happen upstream because the whole or most of the homeless budget is spent on temporary accommodation. When you look at the trends the numbers of presenters and acceptances hasn't moved a lot, but the need for temporary accommodation has soared, almost quadrupled and there are much more complex people coming into the system. The system is fire-fighting the whole time. (KI)

In addition, there were comments that Housing First as a model will not fix the range of difficulties within the temporary accommodation system. One provider noted: *we need to move away from warehousing…but that's not for Housing First to fix. There are things in temporary accommodation that need fixed.* (P) Another provider said: *the current temporary hostels weren't set up to deal with this level of need presenting. In particular the staff and infrastructure set up of the hostels. So, then it's difficult for the hostel to deal with someone who is chronic homeless. The person themselves fails to engage. There is a critical need to look at other solutions.* (P)

Section 6 The component parts of a Housing First model

This section examines feedback from the qualitative interviews with key informants and providers in terms of what they thought were the key building blocks necessary to move towards developing and embedding a Housing First model in Northern Ireland. Qualitative quotes are provided in *italics,* and reference is made to whether the comment was from a key informant (KI) or a provider (P). Appendix 5 lists respondent organisations. Nine organisations (key informants) with 19 respondents, and 12 provider organisations with 30 respondents, participated in the fieldwork through interviews, focus groups and in a small number of cases through email returns. Appendix 6 outlines the interview/discussion themes and questions.

Respondents were asked what they thought were the component parts of a Housing First model, and what would be essential in terms of the development and further rolling out of this model in Northern Ireland. The key questions addressed in this part of the interview were:

- What do you think are the component parts that are essential for Housing First?
- To which existing resources, assets, services, initiatives and structures should the proposed Housing First model link and how?
- What else needs to be developed in order to provide Housing First?

As well as exploring the critical component parts of Housing First, a number of respondents talked about the need to have a clear and agreed understanding of what the model is (as outlined in Section 2). This was summed up by some as the 'integrity of the model.' One key informant noted the following:

This needs to be at the centre. This is vital if it is going to be done properly. There needs to be a number of checklists along the way – tick boxes. It is not a Housing First model if there is a low tolerance level, or if the user is not supported to make full decisions in the service, and if it is not led by trauma-informed practice by skilled key workers – with very clear Job Descriptions to ensure elements of Housing First in case management, a team of key workers who will support a user to engage in this – who are clued in – to bridge gaps for people to health and other services. Also the client needs to be front and centre. (KI)

One provider said:
It's about a journey. A Housing First service should have their accommodation and support as two separate entities. And the service should be there for as long as they want it – not a 2-year lifespan. There needs to be stickability – to come back – and that the service is not stopped. There are a range of challenges. (P)

Respondents also highlighted that before the building blocks of Housing First can be explored, this needs to be integrated into the development of a common understanding and definition of what the model is. One provider said: *People don't understand what Housing First is; that needs to be done first. There needs to be commitment around the table, they have to get it in order to drive it forward. (*P) Another provider said: *The concept is a good one – we need a solution and an agreed definition of what it is. There needs to be continuity of funding – to make it sustainable in the longer term – and so that there can be the right staffing and skills and recruitment and retention of staff.* (P) These

themes of cross-departmental working and staffing are explored in more detail in Section 10: A Housing First model for Northern Ireland?

Funding was another recurring theme throughout this part of the interviews, with all respondents noting that ongoing and committed funding at a sufficient level would be essential for current Housing First provision and any proposed expansion. Respondents also referenced the potential for cost savings and efficiencies. This will be explored in more detail in later sections of this report. The need for funding and financial investment was summed up by one key informant:

It's going to cost us. You have to invest to save the cost and it will give long-term savings. They won't come straight away, because of the scale of what needs to be delivered and the length of support that is needed. (KI)

Concern was expressed that in order to produce the desired outputs and outcomes from Housing First there will need to be adequate funding. One key informant noted: *it sub-optimises the service if we can't guarantee that it provides a substantial period in order to recruit and retain staff of the calibre we need. They need to have professional knowledge and we have to pay for that.*

Respondents were clear that funding needs to be provided for a number of key elements including the housing supply, the provider case management role and the relevant services needed for individual clients. Respondents noted:

Investment is required in a number of areas to increase the chances of real and positive change for the client group. (P)

There needs to be funding and capacity for the services – funding that goes along with this – a good clear path of providers. (P)

It is worth highlighting at the outset of this analysis that a small number of respondents held the opinion that Housing First is not a model for all, noting that supported accommodation would be a better option[171], and that Housing First could be delivered in stages, initially through temporary accommodation and a 'staircase' type model rather than in a permanent home. Some respondents suggested this was necessary in order to get the relevant support in place – like a series of holding spaces or stepping stones – *to enable the individual to be sustained whilst they are waiting for the relevant services.* However, it was recognised that that this 'waiting' period may not be beneficial for those in significant need. There was reference to - *a window of tolerance* in terms of when someone may indicate they want to detox – *if you lose that opportunity they may continue or overdose.* (KI)

[171] Whilst outside the scope of this study, the debate on shared supported housing, and wider housing led services should be referenced. Work in Scotland may be of interest in this discussion: https://homelessnetwork.scot/shared-spaces/ In addition, work by Imogen Blood – see pages 3 and 4: https://www.crisis.org.uk/media/243746/crisis_oxfordshire_report_summary.pdf

Table 27 outlines the range of component parts that were deemed as being essential for Housing First, and how frequently these were mentioned by respondents in response to an open question. These are ordered in terms of the frequency of mentions, and are explored in more detail below.

Table 27: Key component parts of Housing First

Key component parts of Housing First	Number of respondents
1: Housing	30
2: Wraparound support and access to tailored or bespoke health & social services (referred to by some as: intensive case management)[172]	14
3: Cross- or inter-departmental working and involvement of all parties/Departments	12
4: Specialist Housing First staff and team	9
5: Identification/Assessment of needs and referral system	7
6: Ongoing support to manage housing (floating, tenancy sustainment[173] etc.)	6
7: Political or ministerial endorsement or Champion	3
8: Involvement of service users/co-production	3

Source: Housing First Feasibility Study

Key component part 1: Housing

The top and by far the most frequently mentioned component part was housing (mentioned by 30 respondents). Respondents noted that without access to a steady and affordable stream of social housing, Housing First as a model will not be able to function. There was considerable strength of feeling that if Housing First could not offer an individual accommodation, and they had to remain in temporary hostels or other provision, then in effect this was not Housing First. *Housing First relies on how quickly you get them into the properties…and with no properties sitting waiting for you, and with no special access to the Housing Executive or Housing Association stock, this can then be a minimum of three months and often very much longer.* (KI) One respondent put it starkly: *It's not Housing First if people are still in hostels.*

Respondents were sympathetic to the position of current Housing First providers in Northern Ireland, with respect to housing supply. One key informant noted that a lack of available accommodation for Housing First was detrimental to the delivery of the service, and that in effect

[172] There was considerable variation in language from respondents in relation to what was often referred to as 'wraparound services' for Housing First clients. For consistency purposes we have used the terms intensive case management. This may involve service provision through a dedicated multi-disciplinary team (as in Complex Lives) or via the Housing First personnel arranging services/access to services through the mainstream service provision. An understanding of what intensive case management will mean for Housing First in Northern Ireland is an important part of the discussion. For the purposes of this report, we have used the term intensive case management, except when the term wraparound services is used in a quote from a respondent.

[173] The NIHE sustainment rate for tenancies of less than one year's duration in 2023/24 is 91%. A wide range of tenancy support activities are provided by NIHE Patch teams and Financial Inclusion teams.

Housing First was being provided but without one of the key ingredients or building blocks, namely housing. There was recognition that this element was outside of the provider's control.

Providers expressed similar frustration around the supply of available and affordable housing.
If the Housing Executive wants to deliver Housing First to scale it can't be done without access to the accommodation…there needs to be a housing supply strategy alongside Housing First – which links to the Housing Executive, Housing Associations and the private rented sector. (P)
This is not a blanket condemnation of the current model but the lack of adequate social housing and the service poverty in terms of ongoing, sustained, consistent, meaningful and sufficient support is a major factor that cannot be ignored. (P)

Housing should not be the problem of the end user or the provider…if there is Ministerial agreement to this – then this should be sorted operationally – and housing should be in place. (KI)

Other respondents commented on the impact of the lack of available housing, and the fact that in some cases Housing First clients are currently living in hostels and other forms of temporary accommodation, querying if there is a danger that these clients have a Housing First Key worker and a hostel Key Worker leading to duplication. Respondents referenced a person's fundamental or human right to a home, and the opportunity to live independently.

In addition to the need to ensure housing supply, respondents made a range of comments about the suitability of any housing acquired for Housing First, noting a number of elements which they considered critical. These included factors such as location, type, affordability, condition, access to services and amenities, scattered and dispersed rather than congregated, adaptations etc; the following quotes illustrate these points.

Housing has to be in the right location. If it was in estates then it's too insular – the person moving in would be seen as a threat – and that would lead to a rocky start…their area of choice needs to be close to their support network (if they have one). (P)

This needs to be looked at by the Housing Executive – if they want Housing First to work and for someone to resettle – then they need to provide the suitable house or home from the start….
All the work done in prison – they can be set up to fail…if they are then moved into a hostel.
…this needs to be looked at by the HE – if they want Housing First to work and for someone to resettle successfully… the answer is not putting them all together in blocks – ex prisoners can become stigmatised – and part of the resettlement pathway is to integrate them into communities. (KI)

Another factor is where they are put. If they are removed from their communities and stigmatised – it's important to think about how these people will be viewed and how you think where to put them. There needs to be thought given to co-location. On the one hand – there are benefits for service delivery if a number of people are in Housing First nearby. On the other hand it can be negative if there are too many vulnerable people put in one area. We need to also think about how accessible the accommodation is to services – for example mental health services, substitute services, opiate substitution therapy and needle exchange and to transport – they are unlikely to have access to a car. Infrastructure is an important factor. (KI)

Reference was made to clients who may have a physical disability or an amputation, linked in some cases to their complex needs, and that getting the right type of housing and service would be important. One respondent noted: *There is an increase in the number of amputees because of poor injecting practice. And we can't get accommodation adapted – something like a simple handle needs a full assessment and we are told it will be six months.* (KI)

Linkages between housing and acceptance within communities was also referenced, with providers noting that there will need to be community acceptance for Housing First if it is to expand in Northern Ireland. *This is a massive thing – the community accepting Housing First as a service….we don't have this in Northern Ireland with the drug use, alcohol use and mental health. People are all tarred with the same brush – the community would have to be welcoming if this was to work…*(P) Another provider noted: *Large estates which are paramilitary controlled…there is a question mark over the local community accepting our service users?* (P)

Provider respondents also emphasised the need for housing to be well furnished and equipped, to contribute to the potential success of the Housing First model. One provider noted: *You need to think about all of the practicalities – have they all of the mundane things they need, like furniture, bed clothing, kitchen items, toilet rolls – the basics for the first 72 hours, food in the cupboard, and heating. Who is doing that? There needs to be housing management and support.* (P) Another referenced examples where people have moved in without any electricity or gas – *things break down before they have even started…. there needs to be a pot of money for house furnishings.* (P)

The theme of housing, and where it should be supplied from is explored in more detail at the end of this Section.

Key component part 2: Intensive case management and access to tailored or bespoke health & social services

This essential building block was mentioned by 14 respondents. Some key informants, whilst acknowledging the need for intensive case management ongoing for Housing First clients, questioned what exactly the term meant and how it could or would be provided. There was concern that without an agreed definition, and which agency is providing what elements, this could create a significant barrier to the delivery of Housing First.

It is supposed to be available from the minute a person is in the home, but we have never really got an answer on what this would look like… (KI)

Wraparound support would be useful – but in the absence of an agreed definition of it, it then allows the relevant stakeholder (Health) to ignore it. It is too easy not to provide the input. (KI)

Following the depth of discussion on housing, this scheme attracted the most in-depth discussion. This included factors such as acknowledging that whilst a bespoke health and social services provision will not be financially possible, there needs to be a model which firstly overcomes current barriers for the client group in getting services e.g. 'three strikes and you are off the list' approach and secondly, provides a level of ongoing access to services that essentially wrap around the client,

thus enabling them to maintain their well-being and to sustain their tenancy. The need to ensure that the services are tailored to each individual's needs was also emphasised.

We can't commission a bespoke service just for homeless. So we need to understand how the Housing First cohort are going to be treated within the health services given the current waiting lists. (KI)

Existing services won't cut it…there needs to be a way in at least for lower-level supports. For people to be assessed and receive support and be referred for treatment. There needs to be joint commissioning of services, with some funds put together collectively. Not just referring people into a queue. But this will need to be done with the existing pots of money. (KI)

There was also an understanding that the services already exist but that in some cases they are not trauma informed *in order to support people to engage…rather than removing services because of how people engage…. we have all of the services already there for Housing First but it's about (a) getting access to them and (b) keeping people in those services…there's an education needs to happen in terms of the power dynamics between the end users and the services.* (KI)

There were references to soft hand-overs, so that as Housing First clients move to a new area, they need to get ID and they need to get registered with a GP in order to ensure access to health services: *for Housing First to continue with those service users and to not back out or to retraumatise them…there needs to be access to health services. The support needs to be set up with the tenancy…otherwise they come to a service cliff edge.* (P)

On the whole respondents did not think Housing First clients should 'leap frog' over other clients in the community, noting that their needs may be equally or more immediate, but that some form of 'fast-tracking' or priority should be put in place, if the model is going to work effectively.
How is it fair to have someone in custody going into Housing First – catapulting to the front of the queues? Other people with needs are being missed… (KI)

They need to have access to a GP and face-to-face engagement for their mental health and physical health. They would need to have immediate access to assigned individuals in local provision and community services and access to MH services. The negative here is that *we won't get a stand-alone team – these people can't advocate for themselves. They have addictions and are not well – they can't access services on the phone.* (P)

The silting up of the current system was mentioned. Respondents were clear that that this element of Housing First needs to be delivered at critical intervention points, with particular reference to early input of an intensive case management approach.

Access to statutory services is silted up – if people can't engage then there is a crisis at critical intervention points…present to A&E as a result. *When service users are excluded from a service they are at the bottom of the pile. The system and funding is flawed. It has never been challenged or changed to prioritise the needs of the client group.* (P)

In an ideal world there would be a bespoke team in each HSC Trust area…. or key workers to fast track where possible. It's about the timing of the interventions – the timing is critical in their pathway. If going with the waiting list timescales – it's not going to work. It will lead to tenancy breakdown. The health professionals need to come up with ideas. (KI)

It's all about timing – if the person is ready to engage – if there is that readiness – but then they don't get the support when they need it – they get deeper and deeper in… there's a moment – but it's being missed – and it's hard to get the moment back. (P)

Providers recognised the need to ensure that following identification and assessment of needs, there was a clear plan developed to respond to and meet those needs, and that services should be based on high tolerance, low threshold approaches. One respondent noted: *the success of a Housing First model depends on effective linkages with existing resources, assets, services, initiatives, and structures within a community…. Effective coordination and communication with these resources and partners are essential for the success of Housing First initiatives, as they can provide the wraparound support necessary to help individuals transition from homelessness to stable housing and self-sufficiency.* (P)

Key component part 3: Cross- or inter-departmental working and involvement of all parties/Departments

Twelve respondents mentioned the need for working across all the parties or agencies who need to be involved in the delivery of Housing First. In terms of integration with existing resources, services and structures, respondents noted concerns that the model will fall down in terms of operational delivery if one or more of the partners, needed to deliver the full scope of services, is not fully on board in terms of policy, practice and associated funding for the intensive case management model including essential elements such as a multi-disciplinary team.

Different respondents, representing different Departments and interests had divergent views on this; the allocation of perceived blame as to who is not sufficiently on board at present varied across the key informants. There was cognisance of conflicting Departmental priorities and budgets, and suggestions on how this area can be side-stepped by some. There was agreement that more can be done together, and that this had been evidenced during the Covid-19 pandemic period. *Health, housing and justice can do a lot more when they work together and they are working with the same people – the same cohort.* (KI)

Respondents also agreed on the need to have the Housing First model formalised at cross-departmental level, with some suggestions on how this could be done via an overall Housing First unit or designated person; this was different to the discussion on a champion noted below.

There needs to be buy-in from all other Departments – we have housing but it needs to have health and justice. To make it cohesive and holistic for the customer. If they are not at the table – then you sub-optimise the potential results we could be getting. With health we look at their physical and mental health issues and provide the support. With Justice we work with the client from prior to release from custody – so that we are not starting on the back foot. (KI)

This discussion was inter-connected to discussions on funding and also how the model would be delivered at an operational level as demonstrated by the following quotes:

Better coordinated interagency support structures need to be developed…need to have one 'ringmaster' to coordinate the service support for one particular client – should any or all of the agencies be involved in a client's support. (P)

There needs to be more resource expended on both dealing with the deeper issues impacting on their lives and the scaffolding of support that needs to be in place to ensure that even a 'successful' move on to their own tenancies does not quickly breakdown.

There needs to be shared governance and shared risk and shared ownership…if something goes wrong. There needs to be stickability in the approach – to Housing First principles – for all and no banning. Complex Lives and Housing First are very similar models – involving the same operational and strategic group of the key players. (P)

Key component part 4: Specialist Housing First staff and team

The theme of staffing for Housing First was mentioned by nine respondents, almost exclusively from the provider interviews. Providers talked a lot about the staffing model and the staff skills base required for Housing First, referencing the need for clear job descriptions, salary levels, staffing ratios and cover, and the need for an intensive case management model including essential elements such as a multi-disciplinary team.

There were wider concerns about staff recruitment and retention in the homelessness sector, together with comments on the need for a model and training that was both trauma-informed and focused on psychologically informed environments, and broader training which enables the development of specialist teams. In addition, the case management function and role of the key worker were seen as crucial to the success of Housing First for the client, with reference to protected caseload numbers. The discussion on staffing was also predicated on the agreed understanding that this group of service uses have high and complex needs, with frequent crisis points, and staff need to be available to respond to this in an appropriate and timely way.

The following quotes illustrate these points:
Staffing needs to be/have trauma informed practice – everyone needs to be trained in this – it changes how you understand behaviours. Also psychologically informed environments (PIE). (P)

This is of critical importance; we are at the mercy of the market place. It comes back to funding and long-term contracts. It's really difficult to get staff in post. Housing First needs consistency in the staff team and committed staff who have really active local knowledge of everything a client needs … There is a need for a lot more support for these service users. (P)

Role of the case management worker – help the person to sustain their tenancy, support to attend appointments, support to access health needs, which are really critical. (P)

There is a need for specialist staff. A mini team with more skills, higher levels and multi-agency. There is a need for the coordination of this, with good capacity and the focus on building partnerships. There needs to be an ecosystem of support, in-house and then continuity and embedded in the community. (P)

Key component part 5: Identification/Assessment of needs and referral system

The need for a clear identification of potential clients for Housing First and then an assessment of their needs and a referral or pathway into the model, was mentioned by seven respondents. A number of respondents talked about the need for a clear pathway into this provision which covers a bio-social-psycho assessment of the individual's needs including physical and mental health, sexual health, addictions etc. They noted: *The bio-social-psycho assessment needs to be at the front door* (when the person first presents). *There needs to be a clearly defined pathway for this model.* (KI) Respondents also talked about how the client group is defined, how this interconnects to the definition of chronic homelessness and what information is and can be shared between the relevant agencies working across the presenting needs.

A number of respondents suggested that the Complex Lives project could serve as the pathway, although there was acknowledgement that this is Belfast focused and would not necessarily work outside of a city setting. *It lends itself to this – it's a case management approach – it's positive and doing the right thing, but it's not the only model – we need to take learning from it.* (KI)

Complex Lives - we have got it up and running. It would be a good place to start. There is a lot of goodwill in the project, good cooperation across the agencies and departments involved – use this as the starting point. (KI)

Providers emphasised the need to identify and assess needs; one noted:
What are we doing about the most critical presenting need? What is the biggest concern? We have solved the housing situation – at least for the start but what about the longer term – they could bring in a pile of friends in the first 48 hours…Is it physical health or mental health right now? If they are drinking, how do they do that safely? Is harm reduction services for addictions involved – make it as safe as humanly possible in their tenancy. (P)

Key component part 6: Ongoing housing support (floating, tenancy sustainment etc.)

Six respondents talked about the need for ongoing housing support, described in different ways including tenancy support and floating support, as a critical element of the Housing First model. One key informant noted: *housing support should be bespoke and unique to every individual – one size doesn't fit all…there's a lot of us trying to help one person – and this needs to connect. At the outset of a person's Housing First experience – should cover basic things like – ID, bank accounts, payment of bills – they have to know how to budget, cook and set up bills if they are going to be able to live there. Period of intensive support for basic living requirements. – How to establish as a settled person.* (KI)

In talking about housing support, respondents noted that this needs to go hand-in-hand with the necessary intensive case management approach: *Housing First needs to be in what the name says, so there should be no barriers and services need to be wrapped around individuals – wraparound*

services. This is what will produce and aid stability. There is evidence from elsewhere which suggests that even if their substance use continues, if they have stability via their accommodation it leads to better outcomes and less chaotic lifestyles. (KI)

The ability for housing support to be sustained. The presenting and return issues are linked. There needs to be consistency of support and relationships built up to provide continuity – this is alien in their lives. (KI)

Key component part 7 Political or ministerial endorsement or Champion

There was some discussion on the need for political or ministerial endorsement with most respondents suggesting that this was already in place (see Section 3). A small number (3) suggested having a Champion for Housing First at a political or strategic level. *We need to have a champion. Someone to champion and advocate this cause – bring the actors to the table. Someone with the gravitas, respect and trust in the wider sector.* (KI) However, the majority of respondents felt there was no need for a Champion - *no need for a champion per se. There is progress. And if you did this – who would it be and where would they sit.* (KI)

Key component part 8: Involvement of service users/co-production

There was limited mention, except by three providers, of the need to Involve service users in the development and co-production of services. One provider said: *Go at the pace of the client and their needs, their values – not based on societal norms and what are society's priorities.* (P)

Possible housing supply for Housing First in Northern Ireland

As noted earlier the biggest deal breaker identified for Housing First was deemed to be housing itself. The interview phase enabled more in-depth discussion on where housing might come from, how housing could move between sectors (from private rented sector into management by providers and social landlords) and how additional housing could be built and funded. Respondents were very clear that new, additional housing supply was needed; not just for Housing First but in the light of long social housing waiting lists and demand in terms of housing stress levels. One respondent summed it up: *we need houses built rather than 'freeing' up current houses*[174]*.*

This sub-section now examines a number of possible housing sources or funding options, a number of which are already in operation, and may offer further options for any expansion of Housing First.

Private rented sector

In the discussion there was considerable reference to the early days of Housing First in Northern Ireland – in the period around 2013 - 2015. At that point it was noted there were some sympathetic landlords and Depaul worked alongside them to enable clients to obtain tenancies in the private rented sector. Feedback indicated that this source has completely dried up, with virtually no Housing First clients now in the private rented sector, mainly because the tenure is already oversubscribed, landlords do not want the client group and there are other issues around security of tenure, client behaviour etc. Some respondents suggested that there may be some merit in trying to

[174] This is the strategy in some other countries including Finland and the Republic of Ireland (dedicated supply of one-bed units) – see https://www.gov.ie/en/publication/c49d0-housing-first-national-implementation-plan-2022-2026/

revitalise links with the private rented sector; however, a number of respondents were less supportive of this, referencing security of tenure, especially if the client has complex needs and concerns about the sustainability. This was summed up by one provider: *the private rented sector is a dead duck. There are interviews for each letting, waiting lists – they take a look at you and then say 'no' – and they are priced out money wise.* (P) Another commented: *there is a hesitancy in taking on vulnerable or complex clients. And there is an affordability question as Housing Benefit doesn't cover the cost of private rental – the solution is not there.* (P)

The option of Housing Associations or voluntary/community organisations letting from a private landlord and then sub-letting to potential Housing First clients was seen as a safer and more sustainable option[175]. Respondents suggested that the private landlord would be more confident about the agreement and getting their rent covered, and the managing agent (Housing Association or community organisation) would manage the tenants including ensuring the tenancy agreement was kept.

Direct provision from new social housing

A number of key informants suggested that a proportion/percentage of newbuild social housing could (and should) be earmarked for Housing First. The Housing Supply Strategy[176] notes that lessons should be learnt from other jurisdictions on approaches to increase stability and security of people in poverty, with the Housing First model referenced as an example. The Strategy cross-references the Homelessness Strategy for 2022 - 2027[177], and comments on the need to prevent homelessness, support those exiting homelessness into settled accommodation and to extend the Housing First provision.

Whilst respondents noted that targeting new social house building as one element of housing supply for Housing Support, would be helpful as building could be directed to where clients need housing, there were concerns that such an approach could result in negative community responses together with opportunities for Judicial Review. As one key informant put it: *Why would you fast track someone? There would be uproar.* (KI) There was also concern that such a strategy would only have a negative knock-on effect on other people in the general housing list, many of whom also have significant housing and other complex needs, thus only moving the problem on. Respondents noted that the level/targets for new build social housing would need to be increased significantly with some suggesting up to 10,000 new houses per year are required to meet the wider social housing need; whilst acknowledging that only a fraction of this would be needed for Housing First tenancies.

Direct provision from current social housing

Some key informants suggested that there would be merit in allocating directly for Housing First clients from the Housing Selection scheme, through the use of Rule 84 for this individual group,

[175] This is in line with the original Housing First model's arrangement of holding the actual tenancy itself to minimise private rented sector landlord worry/concern, and to then issue licences or sub-leases.

[176] Housing Supply Strategy 2022-2037 (communities-ni.gov.uk)

[177] NIHE, Homelessness Strategy - Ending Homelessness Together 2022 – 2027, Ending Homelessness Together Homelessness Strategy 2022-27 (nihe.gov.uk)

given that there is precedent in this approach. The NIHE are currently looking at this option and are considering a pilot with the intention of using Housing Association stock[178] in addition to NIHE stock.

Rule 84[179] reads as follows:

Authority of the Department/Board

1. The authority of the Department / Board of the Housing Executive is defined as follows:
a) The Board of the Housing Executive may, after consultation with the Department of the Environment, make allocations otherwise than in accordance with this Scheme. [The Landlord may, with the prior approval of the Department, make allocations otherwise than in accordance with this Scheme].
b) In particular the Board may, after consultation with the Department, authorise the making of allocations in specific designated 'difficult to let estates', to Applicants who have not applied for housing in that estate; [In particular the Landlord may, with the prior approval of the Department, authorise the making of allocations in specific designated 'difficult to let estates' to Applicants who have not applied for housing in that estate]

Other suggestions in terms of the use of current social housing included the use of empty properties over shops and void Housing Association properties. Respondents noted that there would need to be consideration of and a willingness to engage in this type of approach across the HA movement.

Financial Transactions Capital

Another methodology to develop specific housing supply for the Housing First client group was in terms of the use of the Financial Transactions Capital (FTC) scheme. Introduced by the UK Government in 2012 – 13, Northern Ireland has benefitted in recent years from an allocation of funding for this purpose, as outlined in table 28, although it is acknowledged that this funding is unlikely to make a significant impact to housing build or supply numbers for Housing First.

Table 28: Financial Transactions Capital – allocations to DfC, 2012 to 2023

Year	Amount to DfC for housing purposes £000s
2012 – 13	11,839
2013 – 14	15,900
2014 – 15	13,000
2015 – 16	94,498
2016 – 17	5,502
2017 – 18	0
2018 – 19	0
2019 – 20	0
2020 – 21	39,250
2021 – 22	45,750
2022 - 23	36,250

Source: DfC

[178] A pilot of this approach is under consideration between DfC and Radius Housing, with the view to allocating 25 units in this way over a 2-year period.
[179] Housing Selection Scheme Rules (nihe.gov.uk)

The NI Assembly Briefing Paper (102/14)[180] provided an overview of the scheme, providing the following definition of FTC: *FT capital or policy lending is: transactions in financial assets, such as loans and shares, which are required to further the policies of a department…* Whilst FTC has been used for a range of projects[181] to date, our focus here is on housing. The DFP Overview Paper[182] (2013) notes that the funding can be utilised for housing schemes which help to stimulate the local housing market and housing supply. Examples were provided of the Empty Homes scheme, the Affordable home loans scheme and the Get Britain Building scheme. Funding from 2012 onwards has included elements for each of these schemes.

The Financial Transactions Capital scheme is attractive given the low interest rate, and has been utilised by a number of voluntary providers to purchase properties, which they then lease or use for move-on accommodation purposes, building in rents which are subsidised in relation to the Local Housing Allowance (LHA). For example, a FTC loan of £1.5 million was provided to the Simon Community in March 2022, to support their *Creating Homes project*. Other providers such as the East Belfast Mission are in the process of negotiating a FTC loan for similar projects.

Funding from banking institutions

Reference was also made to initiatives whereby voluntary providers had put in place arrangements for them to have access to a supply of affordable housing, through loans from other sources, which they then let to vulnerable clients. One example of this is Extern Homes[183], who have provided the following summary, although they note that their client group for this provision would not be as complex as chronic homelessness.

[180] FTC briefing paper (3).pdf
[181] DETI Agri-food loan scheme, University of Ulster Greater Belfast Development scheme and DHSSPS Loan scheme to GPs and dentists.
[182] Financial Transactions Capital - Overview Paper (3).pdf
[183] Housing First: Extern Homes

The Extern Homes project was established in 2016. With the help of a loan from Charity Bank, Extern NI purchased 10 properties, scattered across North and West Belfast, to offer tenancies to individuals and families who are homeless or at risk of homelessness. This 'scattered model' aligns with the ethos of Housing First in that it integrates participants in a community as opposed to assembling multiple or all participants in one project or location.

The **unique selling points** of Extern Homes is that it offers people who are homeless:

Affordability - Quality, affordable housing options with rent based on entitlement rates – rents are equal to the Local Housing Allowance rates as opposed to inflated market rates.

No requirement for a deposit or guarantor – Offers individuals a chance to get into the private rented sector without the burden of a deposit – this ensures no financial burden for the transition process and ensures no barriers to entry.

Tenancy support – provision of floating support and signposting to help tenants maintain their tenancy.

A **partially furnished property** to support tenants in purchasing additional furnishings for their move on.

In order to develop the Extern Homes project, Extern developed partnerships with a reputable property management agency, Rea Estates. To date there have been 21 tenancies using the 10 Extern Homes developed to date, supporting a total of 31 individuals in these households. The service is aimed mainly at singles, but has also supported couples and families.

In 2019, Extern won the **'More than Bricks and Mortar'** award at the Chartered Institute of Housing (CIH) Awards. Extern Homes was also referenced in the Housing Rights (2020) research paper 'Preventing Homelessness & Sustaining Tenancies in the Private Rented Sector – Scoping Project'. Extern Homes has achieved positive outcomes, with a throughput of tenants onto other housing. Of the 11 tenancies which have ended since Extern Homes was set up, four have moved to the private rented sector, three to a housing association tenancy, two to a NIHE tenancy, and one each back to a family home and a hostel.

Remodelling or reconfiguring current hostel provision

A further option suggested by some respondents which could be explored in terms of creating housing for Housing First, was remodelling or reconfiguring accommodation in current hostels; including those which are under-utilised or in low demand. Whilst this would have a cost, and would take some units out of temporary accommodation, respondents felt it is worth exploration. However, a number of respondents did not favour this option as being part of the housing supply for Housing First, noting that it would end up congregating and clustering people rather than integrating them into normal community life[184].

Conclusion

In conclusion, the provision of housing for Housing First must be viewed as the responsibility of the DfC, with the Regional housing authority – the NIHE. As part of discussions about the best way forward to ensure a dedicated consistent and reliable housing supply for Housing First, the NIHE provided the following statement:

"Establishing a supply of accommodation that is both suitable and accessible is central to the challenge of developing the Housing First model, and it is envisaged that a range of mechanisms for sourcing properties will be utilised. To this end NIHE have been exploring several potential routes to secure a sufficient and sustainable supply of accommodation to meet demand and varying need and will involve both private rented sector and social sector properties. NIHE is in the process of seeking Departmental approval for a 3-year programme of private rented sector acquisitions by NIHE's Landlord body. Many of these properties are likely to be former NIHE properties that are now available in the private market. These properties could be used to meet a range of supply pressures, where there will be a focus on increasing the temporary accommodation portfolio, and also the opportunity to directly contribute to the Housing First supply. This initiative could also indirectly contribute to Housing First by reducing the overall pressure within the competing priorities across the Homeless sector though the introduction of more choice and more cost-effective options, potentially allowing more flexibility in budget management.

Within the social hosing sector, NIHE have been reviewing the existing stock and are seeking to identify void properties that may be in suitable locations and of suitable size for Housing First clients. NIHE are also exploring how these properties may be allocated specifically to Housing First clients, and are in consultation with DfC in relation to establishing a policy variation that would permit, in a limited number of cases, deviation from the normal allocations process for those identified as chronic homeless and eligible for Housing First. This approach could also be utilised in relation to Housing Association stock, and in a broader sense, NIHE will seek to engage with Housing Associations to identify opportunities to utilise vacant Housing Association stock with a view to maximising the overall supply that exists which will directly or indirectly contribute to the development of the Housing First supply."

[184] It is worth noting that this has been used in Finland and Italy; this option is favoured by some people who may struggle to integrate into the community and may be at risk of isolation.

Section 7 Service User voice

This section examines the service user voice. Two types of service user participated in the fieldwork; firstly, those who are currently receiving or had previously received Housing First services (5 service users), and secondly those who were deemed to fall into the category of chronic homeless (in line with the definition) by the service provider(s) involved in their accommodation or support, but had not received Housing First services (14 service users). Direct quotes from service users are included in *italics.*

Tables 29 and 30 provide an overview of the current situation of the 19 service users who participated in the research study. Table 29 highlights the nature of their service use and table 30 outlines where they were staying at the time of the interview. Interviews took place face-to-face in a number of settings e.g. day centres, hostels and provider's offices, as well as online and by phone. Themes and questions in the interview schedule for service users are provided in Appendix 7.

Table 29: Current service use – all service users

Current/previous status, including type and name of services	Number of respondents
Housing First service user – current and previous	5
Temporary accommodation service user – including Queen's Quarter, MACS, Catherine House, Extern Women's Project and SCNI – Belfast, and Damian House - Derry	9
Service user – other services including Foyle Haven – Derry, Ramona House – Omagh and The Welcome Organisation - Belfast	5
Total respondents	**19**

Table 30: Where staying at time of interview – all service users

Staying/living	Number of respondents
Housing Association tenancy	3
Private rented tenancy	1
In a hostel	6
In emergency accommodation	1
In crash accommodation	3
Single let	-
Non-standard accommodation, including B&B	2
On the streets	-
Rehabilitation centre/programme	1
Supported accommodation	2
Asylum seeker accommodation	-
Staying with friends/family	-
Did not answer/blank	-
Total	**19**

Table 31 outlines the profile of service users under a number of criteria including gender, age distribution, ethnicity etc. While the sample achieved good gender and age representation, in terms of ethnicity/nationality it was almost exclusively of White (not including Irish Travellers) and of Irish/British/NI background.

Table 31: Profile of all service users

Profile	Provider organisation/service	Number of respondents
Gender	Male	9
	Female	10
Age	18 - 24	<5
	25 – 34	6
	35 – 44	5
	45 – 54	<5
	55 – 64	<5
	Over 65	0
Ethnicity	White	17
	Other ethnic group	<5
	No response	<5
Nationality	British	5
	Irish	9
	Northern Irish	<5
	Anglo-Irish	<5
	Other	<5
Religion	Protestant	<5
	Catholic	7
	Mixed religion – Protestant/Catholic	<5
	Other	<5
	None	5
Sexuality	Bisexual	<5
	Heterosexual/straight	15
	Prefer not to say	<5
	No answer	<5
Disability – do you have a health condition or disability?	Yes	19
	No	0

Profile	Provider organisation/service	Number of respondents
Description of health conditions and disability[185]	Mentions of: mental health, depression, anxiety, PTSD, self-harm including Schizo-effective disorder, bipolar, OCD, learning difficulties	22
	Addiction or drug and alcohol related	13
	Mentions of physical health: arthritis, back problems, MS, epilepsy, liver disease, kidney disease, hearing difficulties	10
	No answer	1
Length of time homeless (as calculated by respondent)	Less than a month	0
	More than a month but less than a year	3
	1 – 2 years	4
	2 – 5 years	2
	5 – 10 years	4
	More than 10 years	5
	No answer	1
Length of time in current accommodation/living situation (as calculated by respondent)	Less than a week	2[186]
	More than a week but less than a month	1
	1 – 3 months	6
	3 – 6 months	1
	6 – 12 months	4
	1 – 2 years	2
	More than 2 years	3
	No answer	-
Total respondents		**19**

[185] Health conditions and disability do not add to 19 as respondents may have two or more health conditions and/or disabilities.

[186] This was the Crash accommodation/beds – this is day by day accommodation.

Exploring the homeless story

The research study included enabling the service users to provide insight into their 'homeless story', with particular focus on why they had become homeless in the first instance and then why their situation had moved towards or into chronic homelessness. Analysis of individual homelessness, and in particular chronic homeless stories and lived experience, highlighted the following themes.

Multiple moves – respondents pointed to multiple moves over the course of their homelessness. This included moves from one hostel to another, within their town or city, regionally within Northern Ireland, and between countries.

There was evidence of people moving back to Northern Ireland. One respondent said he had got involved with drugs and had then moved back home, hoping to become drug-free. He said: *I ended up on heroin, smoking and then injecting…I wanted to come back home to get off the drugs. I came back here – I was born and bred here and had family here.*
Another commented: *I have been homeless most of my life in England… I came here when I was screwed over by the landlord. I had paid £400 deposit but then was kicked out.*

Elongated timescales – whilst some respondents had only recently moved into a situation of chronic homelessness, as illustrated by table 31, significant numbers had been homeless for a considerable period of time. Five respondents said it was more than 10 years, with another four saying 5 – 10 years. This was highlighted in their comments:
It doesn't make up for the fact that I had 18 years of being homeless (now with Depaul Housing First). *No-one should have to wait 18 plus years for a house – no-one should be homeless full stop.*

Experience of substance use (drug and alcohol) – respondents interlinked their chronic homelessness with their substance use. This varied across the sample, with references to alcohol dependency as well as varied levels and types of drug use. There were examples where substance use had caused their homelessness, whilst for others it emerged as a result of their homeless situation. One respondent said: *I was in an abusive relationship at the time, I didn't cope, and I turned to alcohol…I have been an alcoholic for a long time.* She described the impact this had on her ability to keep a tenancy, movement between placements and eventually feeling that it was safer to sleep on the streets. Another respondent stated that he had become a heroin addict in his early 20s, and that previous tenancies had broken down because of alcohol and drug addiction.

Triggers into homelessness – there was very clear evidence of what each service user thought had resulted in their chronic homelessness. For some this was linked to the lack of accommodation, their substance use, and other factors such as interface with the care system, juvenile and adult criminal justice system, domestic abuse etc.

Respondents talked about their entry point or stage into homelessness. This included adverse childhood experiences. One respondent noted: *I had a very hard time when I was a child and then a teenager. A lot of things happened to me. I've had to be resilient.* Another respondent described how he had been in foster care from birth to age 16, at that point being placed in a children's home in England; he then came to Northern Ireland knowing no-one. A further respondent described a disrupted childhood, where he was living on and off with his mother, who had poor mental health.

He noted that she introduced him to drinking and then opiates, and that when his mother was in prison or in psychiatric units, his grandmother was unable to cope with the situation. This led to a downward spiral where the service user was moving from placement to placement, with a significant substance use problem. References were also made to having been homeless as a child, and relationship breakdown within the home. Feedback from service users pointed to multiple complex and traumatic trajectories into homelessness; underlying poverty was clear in many of their homeless journeys.

As well as childhood trauma, respondents highlighted trauma in adult life, with gender-specific references to loss of children (through adoption and death), domestic abuse and violence, sexual assault, and other traumatic incidents. This focus on trauma and the disabling impact it has on someone's life was a key point in the analysis of respondents' homeless journeys. One respondent highlighted these factors. *I fell into drugs – heroin to be specific – through a friend. Everything took on a desperate tone and it went to another level. I had two children and I lost them – this was a big trigger. I fell into that pit. I was homeless and on the streets for two years in Belfast. My partner was very controlling at that stage, it was a very manipulative relationship.* The loss of a child/children was highlighted by four of the 19 respondents[187].

A number of respondents also referenced intimidation as their initial or ongoing reason for homelessness, including paramilitary/sectarian intimidation and wider factors around neighbourhood harassment[188]. In some cases, this led to a perpetuation of their homeless status as they had to keep moving on. *I was homeless due to a threat against me…I was told not to go back to the flat on my own….I was only there for six months but it nose-dived after that threat.* A number of respondents indicated that despite getting a tenancy, because of the type of area and the levels of intimidation and neighbourhood problems this always very rapidly ended up in them having to leave. One respondent outlined his experience: *I was given a flat but every time I went out they broke into it. It was a terrible place to live – I felt dumped there. I was put in unsafe places – in the end I had to leave.*

Varied accommodation history – for respondents that were aged 35/40 years old and under there was evidence of considerable moving around during their teens and 20s. In most cases these service users had no long-term tenancies. Respondents described multiple placements in hostels, multiple tenancies, and a range of shared housing, living with friends and sofa-surfing, as well as placements in hospital and psychiatric units, and sleeping rough on the streets. This was highlighted by one respondent: *I have never had my own flat or my own kitchen.* When tenancies were secured these

[187] Similar points about chronic homelessness for women were made earlier. It is worth noting that wider literature and research points to past and current experience of abuse, the risk of ongoing abuse and the loss of children to child protection systems is more common among women; again, highlighting that their needs are often higher than those of men. The need for Housing First as a separate service for women will be explored as part of the modelling exercise for this research. A gender specific/informed approach to Housing First for women would enable support and a service which can help the woman navigate specific topics and services such as child protection and domestic abuse, as well as providing the accompanying emotional support and gender dynamics that surround this.

[188] The Research team noted that this is one of the unique challenges of delivering services such as Housing First in Northern Ireland. The need to build in factors such as choice of neighbourhoods, risk assessments for people with a history of intimidation or harassment and managed moves or sanctuary-like measures if this reoccurred will be considered at the modelling stage.

frequently broke down very rapidly due to lack of resettlement support and in some cases inappropriate placements.

One respondent said she had been homeless for six years, ending up living on the streets. She said: *I have been homeless for a long time. I have been left like a dog…worse than a dog. I can recall one night in particular; I was in a sleeping bag outside M&S and I thought – where's my family? I ended up on heroin. It all spiralled out of control after this, because you're vulnerable and meeting these people – they are the kind of people that would steal the eye out of your head – they would take everything. And I had nowhere to live…I have had to rebuild myself so many times.*

The interconnection between all of these factors is highlighted by the following case studies (referred to as Service users 1 and 2)

Service user 1 is 24 years of age. He has been homeless on and off since his teens, and meets the chronic homelessness definition with addiction, poor mental health, criminal justice involvement and care experience. These factors were inter-linked throughout his early 20s, thinking that partying and using substances was normal, but at a point recognising that these were impacting his mental health. He noted that *I took myself to rehab because things had spiralled out of control.*

Service user 1 highlighted difficulties he had encountered in hostels including keeping the rules and regulations, being asked to leave, finding it hard to share accommodation, having rows and disagreements with other residents and finding that hostels provided him with access to and a steady supply of substances. He said: *there is a lot of drug use in places. These had a big part to play in my addictions. If anyone is struggling with a drug or drink problem, the hostels would run you into the ground.* This young man now has his own accommodation. He said: *the journey started when I got my own tenancy. Having somewhere safe at night so I can lock my door.* Service user 1 received support from a voluntary sector agency on an ongoing basis and still appreciates contact from this agency and the fact they are available by phone for help and support.

Service user 2 is a man in his early forties. He self-referred to a Floating Support service provided by Triangle Housing Association. At that point he was living in a HMO property that was badly in need of repair. There was a broken window in the front door, a strong smell of urine when entering the property and very limited furniture. Service user 2 had been considered homeless for about 12 years and had been moving around properties that were unsuitable for him. At this point he was the sole tenant in a property for 5 people, with financial penalties due on the electric, a notification that the gas was going to be cut off and the landlord wanting him to leave.

Service user 2 had a forensic history which had a long list of offences attached, mainly related to alcohol/drug use. However there had been no convicted offences in the last ten years. He had a history of intimidation and harassment. This had resulted in a number of assaults which had left him with life changing injuries. This was still a current threat. There had been polydrug use in the past, this was not as much of an issue now, but he was alcohol dependent and drank daily. This had also impacted on his mobility. He also had mental health issues. At the point of engagement from Floating Support this service user had no input from any statutory or voluntary services. He said that he couldn't keep appointments and he had no current wish to make changes to his alcohol use.

It was clear to the service provider that rehousing was a priority, but the individual was refusing to take temporary hostel accommodation due to concerns around his vulnerability, his drinking, and the current threat against him. The Floating support service worked with the service user on a plan over a number of months, achieving extra housing points, an offer of social housing, support through the process of sign up and all start up tenancy tasks, support to make a grant application, connection with necessary services including physical health and disability services, occupational therapy, adaptations, community services etc. Throughout this process reassurance, encouragement and support were provided. This service user has now been able to sustain his tenancy, with no movement back into homelessness.

Views on temporary accommodation services

Service users were asked to reflect on their lived experience of homeless services; in particular to reference their own experiences, to discuss their views on homeless services and to think about what has been helpful and unhelpful. All of the respondents had a view based on their own experience of temporary accommodation services in Northern Ireland[189]. The following views were expressed.

Availability and suitability of temporary accommodation

Feedback from those with lived experience indicated both a lack of availability of suitable temporary accommodation specifically for people with chronic homelessness, and that the available temporary accommodation is not supportive or geared up for those with chronic homeless needs.

Respondents also commented on the regime and restrictions they felt were imposed on them during their stay in some of the hostels, in particular night shelters. Reference was made to having to leave early in the morning and doors not opening until the evening, lack of privacy and lack of support.

[189] It is worth noting, in the context of a discussion on Housing First, that usage of temporary accommodation hostels is much higher in Northern Ireland than in England and Wales, where the use of hotels and B&B accommodation is more common.

One respondent said: *you can't even make a cup of tea. It's supposed to be a drinking hostel with a wet and dry side but you are not allowed drink in. And you have to be in by 9.30pm. I'm 40 years old – feel like a child. But if you're not in by then you are locked out and the shutters are down.* Another respondent commented: *you are sleeping with one eye open in certain services*, because they were concerned about their belongings and lack of private space.

Throughout the interviews concern was raised about the overall staffing levels and a perceived lack of trained staff in hostels in general. One respondent noted: *Properly trained staff would make a big difference. Someone who actually cares could make a big difference in someone's life.*

Lack of support connected to specific needs of people experiencing chronic homelessness

Respondents also highlighted what they felt was a lack of hostels/support for specific needs including:

- Lack of female only hostels rather than mixed gender hostels; raising adult safeguarding issues. One respondent said: *a lot stems from mixed hostels. In women only hostels it is more controlled and controllable. In mixed gender it is chaos and a lot more can happen – there is promiscuity, drug use and drug dealers;*
- Lack of hostels for young people, in particular for those leaving care, raising young people's safeguarding issues. *There's no hostels for young people. Once you are in – and in with older ones – then it's onto hard drugs straight away;*
- Lack of wet hostels for people with alcohol addiction, in particular outside of Belfast and Derry. *They end up going onto the streets. It's not a safe environment – this ends up with drinking and fighting and you get injured.* Another respondent talked about his addiction, and the difficulties of managing this in a dry hostel. He said: *they didn't allow you to drink...I got into trouble when I had drink in me.*
- Lack of specialist addictions support. One respondent said: *hostels need addiction support for adults and for young people. If it's not provided, then there is a vicious circle for the rest of their lives. Addiction takes everything. It takes your home, your family, your savings – it's a constant circle and people need the right networks put in place.*

Service users felt there was insufficient support or direction in terms of their additional needs, specifically relating to their chronic homelessness. They commented on specific hostels where, in their words, drug use is rife. One respondent noted: *If you're a drug addict it's not good. If you're a recovering addict it can put you back on it was well. It's the people that's in the hostels too…*

Lack of support for moving on/into the community

Service users also pointed to additional factors which they felt prevented them from moving on and out of chronic homelessness. One respondent talked about the fact that you cannot work whilst staying in temporary accommodation and this does not enable people to get back into society. Others noted that the location offered for temporary accommodation was often not beneficial or supportive to the service user. One commented: *sending people away from their family networks and from their doctors. Why send them 70 miles away from everything they know – it doesn't make a lot of sense to me – you are sending the problem round in circles.* The lack of support in the community was also noted, and respondents felt that the cycle of moving from one temporary accommodation project to another was not helpful. One noted: *first I was put into a hotel at the*

airport. Then I was in a B&B in Crumlin for a couple of months. Then I was in the Ormeau Centre. I broke there because of being on my own…. Other respondents talked about the lack of support mechanisms when they had previously tried to sustain a tenancy in the community, and that with no or limited support this had broken down again.

Overall comments about the availability and suitability of temporary accommodation included:
I have very limited trust in the housing and homelessness system. It's got worse in the last three years – there's the lack of beds – and they try to get you off the streets – just to cover their own arse. The mixture of people who are alcoholics, drug addicts, convicted of something. You are just thrown in with the animals. And they're dirty places. You are far away from family and having to travel to see kids. It's unsafe – full of men, terrible state – not in a good place.

Positive experience of homeless services

In addition, service users did highlight some positive experiences and positive practice. A number of respondents noted the positive input of support staff in temporary accommodation. One respondent said: *I am still a bit anxious* (about the threat) *but the staff in here are brilliant. Anything at all – if you need a wee chat – you can talk to your Key Worker.* Respondents also referenced the positive nature of support in day centres (Foyle Haven in Derry and the Welcome Organisation in Belfast). One commented: *They have been very helpful. They have given help with appointments, paid for a taxi for me to go for my injection. And the use of the phone if I need to contact the GP.* This respondent also commented on the opening hours in day centres, plus the provision of hot food and beverages. In some cases respondents also made reference to the positive support and input of Housing Advisors in the Housing Executive. *I had a very good housing officer. He was brilliant – he helped me get more points for my needs. It was good to have the same person – that made a big difference.*

Other services/support that they currently have – what they would need if they were in their own accommodation

Service users firstly noted their need for additional services and support, and secondly, in the majority of cases referenced the lack of available or suitable services/support for their needs. There was a clear need for floating or tenancy sustainment support, for the periods some of the service users had a tenancy. Their ability to live independently was often short-lived and ending in circumstances which caused further detriment to their situation. One respondent noted: *I had a couple of tenancies – in one it broke down in a couple of months. My mental health deteriorated because I was not taking medication properly. I had a nervous breakdown and ended up in a mental health unit for 10 days…* This feedback points to the service users' needs for support for managed moves and tenancy sustainment, rather than periods in and out of different tenancies with limited support. A key factor highlighted was the need for support that specifically met their needs; that is whilst floating support may be helpful the service user needs clear and sustained support from mental health services.

Movement between temporary accommodation and different locations was cited as a problem, with respondents talking about how they were 'removed' from their GP list and then had difficulties establishing themselves on healthcare lists (GP, dentist etc.) in a new location. Service users

highlighted specific lack of support in relation to trauma and the availability of trauma-informed practice and services.

A lack of wider support in the community, and the absence of support networks through friends and family were also viewed as a difficulty; with service users talking about how they had no-one to turn to, no-one to advise them or help them when things got difficult.

Service users made reference to positive services they had received from temporary accommodation providers, day centres (in Belfast and in Derry), community addiction teams, homeless healthcare provision, and a vast range of community and voluntary sector organisations including foodbanks, advice agencies and support for specific circumstances e.g., leaving prison.

Views on Housing First – for those with Housing First experience

Five of the respondents (referred to as service users 3 – 7) had direct experience of Housing First; three of them were currently supported by Depaul's Housing First project (two in Belfast and one in Derry), one was supported by the Simon Community Housing First for Youth service and a further individual was now living independently in the community, having been supported by Depaul's Housing First provision in Belfast. This latter respondent continued to receive some weekly support from the service.

Service user 3 had been supported by Depaul's Housing First project for 4 – 5 years, living in his own tenancy in Belfast. He said: *with my housing situation at the moment (Housing First) I feel like I am the lucky one – others didn't survive, the ones on the streets.* The respondent reflected that the tenancy had not been without its difficulties and at one point he had to sign a 'good behaviour order', but that things were now going well. He said: *I have all my support in place*, referencing his Key Worker, input from Homecare and Floating support, and support from Extern in relation to alcohol and drug issues. Overall, this service user said that Housing First had been brilliant for him, and felt that the type of service provided him with ongoing support, which enabled him to believe in himself and his ability to retain the tenancy. He summed up by saying: *I would have been on the streets or in jail if I hadn't got me flat.*

Service user 4 had moved around for 18 years, becoming homeless as a teenager. He has been supported by Depaul's Housing First project and has been in his tenancy in Belfast for four years. He made comparisons between his life now and his life in hostels, and highlighted all of the positive factors about having his own place and doing his own shopping, budgeting and cooking. He noted the support he receives from his Key Worker, and also that every day of the week he has some type of support with Homecare on Mondays, Wednesdays and Fridays, and Depaul on Tuesdays and Thursdays. He said: *it gives me a structure in my life. I've always had a problem with no structure.*

Service user 5 was receiving support from Depaul's Housing First service in Derry. At the time of the interview he did not have his own tenancy and was living in temporary accommodation in a B&B. However, he was very involved in the planning process with Depaul, and was looking forward to having his own tenancy and his own kitchen.

Service user 6 had been part of Depaul's Housing First project in Belfast; she and her partner had then decided to move outside of Belfast, and as a result had to move into their own independent tenancy. This was going well, and she mentioned that the Housing First team were continuing to provide them with 'light touch' support. One of her main comments was that Housing First should not just be confined to Belfast and Derry. She said: *there should be other Housing First out there regionally – it's so much better to be in your own house rather than a hostel.* She also highlighted that Housing First provision should be located in the places that will best support the individual, suggesting that this should not be in large housing estates, and that Housing First should be ongoing as many of the service users can relapse and need support. She was very positive about the input of Housing First in her life, talking about the staff: *they were there to listen to me. When I went to their office they always opened the door to me – they kept going with me and helped in every eventuality. With Housing First my periods of stability and sobriety were longer and longer. At the start it was the hostel and then the street – back again. But once I got the accommodation with Housing First, through time there were longer periods of sobriety and longer periods of time in the accommodation.*

Service user 7 was a young person with the Simon Community NI Housing First for Youth service. Whilst it was the early stage of her involvement with the service, she was positive about having her own tenancy and felt she was managing it well, with support. This service had come at a point where the young person was leaving care, and as a result she did not have to go into temporary accommodation hostels.

Views on Housing First – for those with no Housing First experience

This section represents the views of 14 respondents who had no Housing First experience. An outline and explanation of the model was provided during the interview (see Appendix 7); respondents were asked to respond to this. All of the respondents were extremely positive about the concept of Housing First and how it works on the ground. Responses included: *It would get people off the streets and give them a home so that they can feel safe again.*

Some respondents commented specifically on how Housing First, if available, could help them: *Yes, it would work for me, 100%. Part of my housing points are for complex needs. For my addictions and the support I need, I need this wraparound support. And having that extra bit of support would keep me sober.*

To know that I would have a safe place and security, so that I could come in and close the door at night and feel safe – that is my number one thing.

A number of respondents, who had no prior knowledge of Housing First, were visibly shocked that such as service exists. One respondent said: *Get away, you're joking. If I had my own place it would be the making of me…I feel I wouldn't need much other support.*

Respondents also put forward suggestions on how Housing First should be delivered in terms of locations, type of accommodation and type of support. Comments included: *it depends where you are going to place them. If they are doing drugs, then there could be community backlash. People would need support for moving into the community.* And: *don't congregate them into big blocks of flats – all of the homeless in one place – that will lead to issues…*

Service users also noted that they would need a sustainable income in order to maintain the tenancy, input in terms of furniture and equipment and support for budgeting. One respondent noted: *I would need help to rebuild a home. I would be starting from scratch. I would need information on other places to help me and someone calling in and checking on me.*

Based on past experiences of tenancies failing or being terminated, some respondents said they preferred the level of support they had in temporary accommodation, and were worried about, based on past experience, boredom and going back to drinking, and the tenancy not working out. This was summed up by one respondent: *it might be more complicated, as people have a lot more in-depth issues…they need to be willing to accept that support.* Another respondent, who was positive about the Housing First model said it would not be for him at present, noting: *I am not ready to consider this, I have too much going on. I would be afraid. I'm so fragile in terms of staying off the alcohol. I would be concerned about a relapse in six months.* However, this comment further highlights a common misconception about the Housing First model, which aims to enable people to live independently with support tailored to their individual needs.

Conclusion

This section highlights the importance of the service user voice; firstly, in terms of their experiences in temporary accommodation and Housing First and secondly, in relation to how they would frame Housing First services.

Service user feedback reflected their homeless stories, focusing on reasons for or triggers into homelessness, recurrent and repeat homelessness and the impact on their own lives, in relation to chronic homelessness. Respondents highlighted multiple moves, long periods of time in homelessness or housing instability, experience of substance use. Of particular relevance was their varied accommodation history and comments on the suitability or otherwise of different types of accommodation, placements and resettlement and Floating support.

Those with lived experience pointed to the availability and suitability of temporary accommodation, the lack of support connected to the specific needs of people experiencing chronic homelessness and the lack of support for moving on and into the community. Service users also highlighted positive practice and experiences, and what support they would need if they were in their own tenancy, and if they were able to access Housing First. All those with lived experience were positive about the possibility of availing of Housing First including the level and nature of support, and how they felt this would enable them to live independently.

Section 8 Fidelity to the Housing First model

This section of the report was prepared by Imogen Blood (Imogen Blood & Associates).

What is model fidelity and why does it matter? Potential risks or pitfalls

Experience of and evidence from evaluations of Housing First indicate that it can be effective in achieving a sustainable exit from long-term homelessness for people for whom other standard service offers have failed. It can also have preventative functions for high-risk groups such as care leavers with multiple and complex needs. There is a strong body of UK and international evidence demonstrating that, with close fidelity to the Housing First principles, between 80% and 90% of those receiving Housing First remain housed within 2 years, with reduced criminal justice involvement and health inequalities[190].

In terms of the fidelity of the Housing First model it is important to highlight that it is a defined, strengths-based model which enables people to take control of their lives, by removing the barriers that prevent them from doing that. The key features of the model which enable it to engage people with long term histories of trauma and reduce the health inequalities they face are[191]:

- The **longevity** of the housing and support, which provides stability.
- The **flexibility and stickability** of the support which help build trust.
- The focus on **choice and control**, through co-productive and strength-based approaches for people who have marginalised.
- The focus on enabling an **ordinary life** – removing barriers to accessing mainstream services to promote citizenship and inclusion.

These key aspects of the model can be particularly challenging to deliver in the current UK landscape, due to a lack of resources as well as the way in which these resources are typically allocated. This is particularly acute in England but also challenging in other parts of the UK. Housing First services have had to adapt and innovate as access to affordable housing has become more challenging, local authority/ council commissioning budgets have reduced, and health, social care and criminal justice services have become increasingly over-stretched. This typically creates systemic constraints on achieving fidelity.

Housing First is a philosophy as well as a service model. To deliver the above features, it is essential that services are based on the values and spirit of Housing First:

ngoing reflective practice and advocacy at both individual and system levels are needed to drive and sustain the necessary changes in culture, policy, and practice.

[190] Chapter 9, The role of Housing First in Ending Homelessness, Crisis (2018) The Plan to End Homelessness: https://www.crisis.org.uk/ending-homelessness/the-plan-to-end-homelessness-full-version/solutions/chapter-9-the-role-of-housing-first-in-ending-homelessness/

[191] p.9 Homeless Network Scotland: A National Framework to START-UP and SCALE-UP Housing First in Scotland, 2021-2031: https://homelessnetwork.scot/wp-content/uploads/2020/11/National-Framework-For-Housing-First-CONSULTATION-NOV-DEC-2020.pdf

The contexts in which the model has been used – both internationally and within the UK - are so diverse, it is not possible to be prescriptive about all aspects of implementation. However, there is a point at which adaptation to circumstances may cross the line into model drift. In the UK, deviations from fidelity have tended to include:

- Large caseload size (e.g. more than around ten 'live' cases);
- Tenure – e.g., use of license agreements rather than tenancies;
- Length of support which is overtly time-limited;
- Commissioners focusing on 'throughput', outputs, and traditional procurement/ performance management-led relationships with HF services[192].

Housing First is ultimately dependent on effective joint working with partner services which include social care, mental health, addiction support, social landlords and the criminal justice system. When this is not in place, Housing First, even if a service is well run, can face an uphill struggle to deliver effective and 'high fidelity' support.

If fundamental aspects of the model are diluted, there is a risk that:

- Quality and effectiveness decrease, leading to poorer outcomes, and poorer return on investment for funders;
- Individuals are further excluded (leading to widening health inequalities, and rough sleeping):
    - If tenancies fail in lower fidelity contexts, services and individuals may find it even harder to persuade landlords to offer properties in future.
    - If the support offer is not sufficiently flexible or 'stickable', individuals may find it even more difficult to trust services in future.
- If 'Housing First' did not work for an individual, it is difficult to know what to try next if it is not clear that the original intervention was accurately delivered.

What have other countries done to promote or quality assure fidelity?

When assessing the opportunities for expanding Housing First in Northern Ireland, and with a view to promoting and ensuring fidelity to the model, it is therefore important to look at the other UK jurisdictions, in terms of their various approaches to promoting fidelity, ranging from the more self-reflective (Scotland and England) to the more rigorous (Wales). These different approaches are summarised below.

Scotland: 'Check-up' for Housing First

Homeless Network Scotland and the Scottish Government consulted widely on a process to support local authorities to deliver Housing First in line with the principles. They developed a collaborative and self-reflective process called the Check-Up[193], piloted initially with 13 local authorities, and delivered annually, consisting of:

- Self-reflections
- Insights from local partners

[192] This list is based on verbal feedback from Housing First England

[193] The process is described in more detail on p.7 of this annual overview: https://homelessnetwork.scot/wp-content/uploads/2022/12/Housing-First-Scotland-2022_web1-2.pdf or on this webpage: https://homelessnetwork.scot/housing-first/checkup/

- Participatory audits with Housing First tenants.
- Review of local evidence and policy.

Wales: Housing First accreditation

Having hosted the national Housing First network since 2018, Cymorth Cymru (the representative body for providers of homelessness, housing, and support services in Wales) and the Housing First Policy and Practice Coordinator (funded by Welsh Government) worked with the sector to develop a rigorous fidelity accreditation process[194].

The coordinator carries out interviews with a range of local stakeholders, including people with lived experience, to assess a service's practice against each of the model's principles and reviews documentation against an accreditation framework. Recommendations and a best practice action plan are developed and shared with the project, and a final report produced. An external panel reviews the final report and makes the decision regarding accreditation. Only a relatively small proportion of services have been successfully accredited to date.

England

Housing First England (hosted by the homelessness sector membership organisation Homeless Link with 5-year funding from Nationwide) has produced a number of tools to promote fidelity over the years, including Fidelity Guidance[195] for those delivering services and the 'non-negotiables'[196] for those planning and commissioning services.

In 2022, Homeless Link and Crisis convened a roundtable to develop a toolkit to improve fidelity in the sector. Two 'self-reflection frameworks' have been developed but not yet publicly launched, to promote fidelity by design (for commissioners) and by delivery (for services). Homeless Link and Crisis are currently in discussion with Department of Levelling Up, Housing and Communities to make the case for additional implementation support to promote take-up of the tools.

Housing First Europe

Housing First Europe, which has been supported by the Finnish Y Foundation and FEANTSA has created an online hub that brings together good practice guidance, lived experience of implementing and delivering Housing First and policy-focused research. Several UK organisations, including Crisis and Homeless Link are members of Housing First Europe. The Housing First Guide Europe[197] can be found on the Housing First Europe website[198].

[194] See Housing First Network/ HFW Accreditation for published accreditation reports and action plans for those services which have been accredited: https://www.cymorthcymru.org.uk/networks/
[195] Fidelity Guidance
[196] 'non-negotiables'
[197] Housing First Guide Europe.
[198] Housing First Europe website.

Section 9 Cost effectiveness and cost efficiencies in implementing Housing First

This section of the report was prepared by Professor Nicholas Pleace (University of York, European Observatory on Homelessness).

Cost effectiveness and Housing First in context

Housing First emerged in the United States as an effective form of service model for addressing the human and financial costs of repeated and sustained homelessness associated with multiple, complex unmet treatment and support needs.[199] Evidence had been increasing that existing US systems, which included linear residential treatment (LRT) or 'staircase' services that were modelled on stepped, institution-based resettlement from long stay psychiatric hospitals[200], were both relatively ineffective and, importantly, extremely expensive.[201] A story in the *New Yorker* 'Million Dollar Murray' drew attention to what research, particularly the work of Dennis Culhane had started to say about US homelessness in the 1990s, that there was a small high cost, high risk population who were caught in a revolving door of expensive homelessness service use that was not providing a sustainable exit from homelessness.[202] 'Murray', whose life had been a sustained interaction with homelessness services, emergency rooms (A&E), ambulances, detoxification and the US criminal justice system had never exited homelessness, had cost various publicly funded systems something close to $1m, and had eventually died on the street.[203]

The narrative that Sam Tsemberis, the creator of Housing First, introduced into US policy debates during the 2000s was that Housing First was the most cost-effective response to the experience of recurrent and sustained homelessness among people with multiple and complex needs. At the core of Tsemberis's arguments were comparative costs drawn from research in New York that (at the time of writing), drew attention to a day of Housing First costing $34, compared to $51 for a (basic) emergency shelter and $350 for a psychiatric bed.[204] Costs in LRT/Staircase services varied, but they were much higher – per day – than was the case for Housing First.[205] Tsemberis's argument also drew attention to one key aspect of relative effectiveness, which study after study during the 1990s, 2000s and 2010s reinforced, across the US, Canada and many European countries, including England, Scotland and Wales. Every study reported that Housing First provided sustained exits from homelessness for at *least* 80% of service users (i.e. people were kept out of further homelessness for at least one year). This evidence base included full blown experimental trials (randomised control trials) in Canada and France which were funded at very considerable expense, alongside much

[199] Tsemberis, S. (2010) *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction* Hazelden: Minnesota.
[200] Ridgway, P. and Zipple, A.M. (1990) The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches, *Psychosocial Rehabilitation Journal* 13 pp.11-31.
[201] Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an international review* Edinburgh: Scottish Government
[202] Culhane, D.P. (2008) The Costs of Homelessness: A Perspective from the United States, *European Journal of Homelessness* (2) pp.97-114.
[203] https://www.newyorker.com/magazine/2006/02/13/million-dollar-murray
[204] Tsemberis, S. and Eisenberg, R.F. (2000) Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric services* 51(4), pp.487-493.
[205] Pleace, N. (2008) as above.

smaller scale research in Europe and across the UK.[206] Federal government in the US was convinced of the merits of Housing First both on the basis that it had lower costs, but also, crucially that it was outperforming LRT/Staircase models at a substantial margin in ending homelessness. Compared to the 80% plus housing retention offered by Housing First at one year, the figures for LRT/Staircase services were as low as 40%.[207]

During the initial stages of the introduction of Housing First in the UK and in Europe, this narrative around cost efficiency was imported directly from the US. Housing First was portrayed as much more cost efficient than existing homelessness services based on *North American* evidence. This was problematic and produced some pushback from the homelessness sector on the basis, as for example in England, that most homelessness services bore little resemblance to the LRT/Staircase models that Housing First was being compared to in North America. LRT/Staircase services were abstinence-based and often very strict in terms of how they operated, they had run into operational difficulties partially because people became 'stuck' between the steps to independent housing they were supposed to fulfil, but often because they were routinely evicting people for breaking rules and because people were often running away.

Existing British homelessness services were, by contrast, much more co-productive, tended to use harm reduction and offered very different environments than many North American services, albeit that the effectiveness of UK and European practice in fixed site services in ending recurrent and sustained homelessness was also becoming subject to some criticism.[208] Crucially, it was also the case that these North American LRT/Staircase services typically had *much* higher operating costs than most UK or European homelessness services. [209]

Realism in approaching cost effectiveness and Housing First

During the 2010s in the UK and Europe, a narrative that Housing First was highly cost effective, to the point where it would always outperform existing homelessness services, was relatively commonplace. Voices that were hesitant about the transferability and effectiveness of Housing First were in the minority[210], especially when Housing First was (incorrectly) associated with the hugely effective Finnish national homelessness strategy which was reducing long-term and recurrent homelessness with striking efficiency.[211] A somewhat inaccurate narrative around the cost effectiveness of Housing First emerged around this time, which was that 1) it was always more cost effective than existing services and 2) there was a European demonstration project in Finland that showed a Housing First strategy could effectively end homelessness.

This narrative began to be undermined for three main reasons. The first was evidence and argument from North America and later from Europe, which challenged Tsemberis's narratives around cost

[206] Pleace, N. and Bretherton, J. (2019) *The cost effectiveness of Housing First in England* London: Homeless Link.
[207] Pleace, N. (2008) as above.
[208] Busch-Geertsema, V. and Sahlin, I. (2007) The role of hostels and temporary accommodation. *European Journal of Homelessness*, 1(1), pp. 67-93.
[209] Pleace, N. (2008) as above.
[210] Pleace, N. (2011) The Ambiguities, Limits and Risks of Housing First from a European Perspective *European Journal of Homelessness* 5(2), pp. 113-127.
[211] Allen, M.; Benjaminsen, L.; O'Sullivan, E. and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* Bristol: Policy Press

effectiveness on several levels. The limitations with the cost effectiveness of Housing First in North America that were highlighted were that while rates of ending homelessness were very good, outcomes in terms of social integration, health and well-being (while still broadly positive) were more mixed.[212] By contrast, LRT/Staircase services were less effective on one measure, ending homelessness, but it was argued that, when they did work, someone was resettled into housing with stable social support, community integration and receiving the treatment and support they needed, i.e. they were 'housing ready' in multiple dimensions.[213]

The essence of the argument here was that 'cost effectiveness' was being defined in a more limited way for Housing First than for the LRT/Staircase services it was being compared to, because the latter were delivering a more 'housing ready' individual. Time was also important here, as the LRT/Staircase model – expensive as it was – was designed to eventually stop. By contrast, Housing First was a long-term intervention, it was expected that service users would remain engaged for years and, indeed, that continued engagement with Housing First was used as an indicator of service effectiveness in North America. LRT/Staircase services might be more expensive for two or three years, but if Housing First was engaging for five, six, seven years or more, then the cost comparison might start to look rather different.[214]

The second criticism was that Housing First had a clear case for cost effectiveness *if* it was working with someone with a 'million-dollar Murray' pattern of repeated, unsuccessful homelessness service use and a very high rate of contact with emergency health, mental health, addiction and criminal justice systems. The stability and support offered by Housing First could, at least potentially (and from some evidence in practice) bring these sorts of costs right down over time. However, if Housing First was engaging with people experiencing homelessness who had multiple and complex needs and who had *not* been using many, or perhaps any, services, then the effect would be the opposite. Housing First would connect people with multiple needs to an array of health, social care, housing and other services that they needed, and costs would instead spike. There was also North American evidence that as soon as someone using Housing First was not within a 'million dollar' category of service use, the relative cost effectiveness fell away very fast, i.e. there were only specific circumstances in which Housing First was actually *cheaper* to run. [215]

The final criticism was from a more European perspective and this centred on the idea that Housing First was a cost-effective solution to all 'homelessness'. It had been pointed out that much North American homelessness was associated primarily with poverty and the same pattern was being reported in the UK and Europe.[216] For people, including families, whose homelessness was driven primarily by poverty, Housing First was, in essence, an excessive response for many people whose

[212] Aubry, T. (2020) Analysis of housing first as a practical and policy relevant intervention: the current state of knowledge and future directions for research. European Journal of Homelessness, 14(1), pp. 13-26.; Quilgars, D. and Pleace, N. (2016) Housing First and Social Integration: A Realistic Aim? So*cial Inclusion* 4.4, DOI: 10.17645/si.v4i4.672
[213] Stanhope, V. and Dunn, K. (2011) The curious case of Housing First: The limits of evidence based policy. *International Journal of Law and Psychiatry,* 34(4), pp.275-282.
[214] Pleace, N. and Bretherton, J. (2019) as above.
[215] Pleace, N. and Bretherton, J. (2019) as above; Pleace, N. and Culhane, D.P. (2016) *Better than cure? Testing the case for enhancing prevention of single homelessness in England* London: Crisis.
[216] Bramley, G. and Fitzpatrick, S. (2018) Homelessness in the UK: who is most at risk?. Housing Studies, 33(1), pp.96-116.

primary need was adequate, affordable, settled housing. Housing First was not a cost-effective solution to all homelessness.

In a wider context, the Finnish 'Housing First' strategy was very different from what had happened in North America. The similar, but distinctive, intensive case-management services using mobile multidisciplinary teams and ordinary housing were being used in combination with fixed site, large scale, supported housing and an array of other support within an integrated and preventative national strategy. Finnish Housing First actually meant using a housing-led response to all aspects of homelessness, which often centred on just providing social housing and, where needed, the kinds of intensive, flexible and service-led support like that offered by North American Housing First, but which had been developed in Finland. The other point here was the Finnish strategy was many things, including comprehensive, sustained, and systematically implemented, but it was not a low-cost solution, instead it represented a more cost-effective use of relatively high public expenditure on homelessness.[217] The Finns were not saving money through Housing First.

Drawing a distinction between cost saving and cost-effective

The current evidence base indicates that Housing First is often a relatively cost-effective solution to homelessness among people with high and complex needs. Research in England has suggested that Housing First often tends to represent better *value* in terms of public expenditure than situations in which someone becomes caught in a revolving door of service use that does not end homelessness. Much of the better use of resources stems from creating a stable situation, in which contact with criminal justice systems, emergency health and mental health services is much reduced (and sometimes ceases altogether) and use of mainstream services, e.g. being registered with a GP rather than using A&E is supported.[218]

Improvements to health and wellbeing will sometimes occur, but there is evidence that UK referrals to Housing First are often happening at a point at which someone is very ill and may continue to deteriorate, despite improvements in the services they are receiving, a pattern that has also been observed in Canada.[219] This broader pattern, where Housing First and housing-led models tend to have better outcomes than fixed-site supported housing services at a similar cost has also been reported in the USA. Again, there is distinction between this data showing greater cost effectiveness and Housing First actually costing less than other responses to homelessness.[220]

Many variables come into play when determining the relative cost effectiveness of Housing First. Salary levels, housing costs and access to other services through strong collaboration with health, social care (social services) and social landlords all make a significant difference to how effective Housing First services are. A service in London will cost more to run than an equivalent service in Manchester, both in the sense that salaries are higher and because housing costs will often be higher too.

[217] Allen, M. et al (2020) as above.
[218] Pleace, N. and Bretherton, J. (2019) as above.
[219] Blood, I.; Birchill, A. and Pleace, N. (2021) *Reducing, changing, or ending Housing First support* London: Homeless Link/Housing First England.
[220] Culhane, D. (2008) as above.

Over time, contact with Housing First workers tends to reduce, so that most people are making less use of Housing First support when they have been with services for a year than they are for the first few months. However, removing Housing First support within a fixed time frame (a model called critical time intervention or CTI) can have adverse consequences as stable housing situations may remain inherently more precarious for often highly vulnerable people using Housing First, even after some time, particularly if the support offered by Housing First is withdrawn in an unplanned way.

There are challenges, both in the sense of Housing First being able to refer up when support and treatment needs exceed levels that can be safely managed in ordinary housing in the community or when support and treatment needs drop to levels where Housing First is no longer needed. In Scotland, Wales and particularly in England, there will often be a shortage of both services to refer up to and to refer down to, reflecting sustained reductions in spending on homelessness services since 2010. This can impair the cost effectiveness as it means services can be taking on higher support needs than they are designed for and, equally, may sometimes be offering more support than someone continues to need.[221]

Key findings from English research[222] (uprated for inflation using the Bank of England inflation calculator)[223] from 2019 suggested that (in January 2024 prices):

- Housing First costs an average of £5,033 in support costs per year, during the first year of use, with support costs falling over time. There is, however, significant variation based on how Housing First is staffed, where it is located and its relationships with other services, reflected in a median cost of £4,569.
- Wages vary between the equivalent of £10 and £20 an hour at January 2024 prices, with an average across 15 Housing First services equivalent to £14 an hour (actual levels may be less, as some Housing First services pay minimum wage of £11.44 in England). There are also marked differences in caseload, ranging from three people per worker to ten people per worker[224].
- Total costs including housing are significantly higher, in England equivalent to £11,575 on average for someone claiming Universal Credit (housing element) in the private rented sector (PRS) and £11,245 for someone in social housing. Important to note here is that Local Housing Allowance rates, nominally designed to make the lower third of the private rented sector more accessible, had not been adjusted for some time in England (until very recently), so only the cheapest PRS housing was being used. Costs were typically higher in overheated housing markets like London.
- Housing First was typically cheaper than both hostel provision for people experiencing homelessness and high intensity supported housing for people experiencing homelessness. Housing First support costs were an average equivalent to £418 a month, compared to £1,200 for hostels and £1,800 for intensive supported housing.[225] When rents were included,

[221] Blood, I.; Birchill, A. and Pleace, N. (2021) as above.
[222] Pleace, N. and Bretherton, J. (2019) as above.
[223] https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator
[224] An upper caseload of 7 is generally viewed as necessary for a high-fidelity service. See: http://cdn-homelesslink-production.s3-website-eu-west-1.amazonaws.com/media/documents/Housing_First_non-negotiables_1TXdU57.pdf
[225] Twenty-four hour staffing, dedicated case management/keyworkers for every resident, specialist support e.g. around addiction.

the costs for hostels and intensive supported housing tended to average at around double the support costs, e.g. £3,600 a month for intensive supported housing compared to £958 for Housing First using private rented sector housing.

The key difference here, as highlighted in some of the criticism of the initial arguments made about the cost effectiveness of Housing First is that hostels and supported housing are designed to be time-limited, or at least not to operate as a permanent solution. By contrast, Housing First is open ended and this is where differences in overall cost might start to fall away quite quickly, i.e. several years of Housing First might start to have similar costs to a shorter time spent in supported housing. When time-limited supported housing has successfully ended homelessness, it is debatable whether it, or Housing First, is most cost effective overall. It is also important to bear in mind that Housing First is not 100% effective, so there will be at least some expenditure that does not deliver a sustained reduction in homelessness.

Cost offsets

Calculating cost offsets for Housing First can be quite challenging. In essence, this is because while some of the individual people experiencing homelessness using Housing First are individually highly expensive in the 'million-dollar Murray' sense, they are not very numerous. This is different from the criticism that Housing First is only cost effective when it stabilises someone who is a high cost, high risk individual through effective case management and reduces very high rates of emergency service use and causes costs to rise when someone has been disengaged from services. The point here is around absolute numbers. For example, if 30 or 40 high cost, high risk individuals are making use of an A&E department an average of thirty times each over the course of a year and Housing First support enables all or most of them to stop doing so, there is a clearly a 'saving' for public health systems, which can have benefits around staff morale and wellbeing as well as creating some additional capacity.

Initiatives like the *Pathway* model which began in London, using a navigator model, are designed to reduce and where possible end repeated (medically unnecessary, if in contact with mainstream GP and other community health services) use of A&E for these reasons of improving morale, lessening pressure and freeing up resources. Pathway with its holistic, housing-led, approach to reducing repeated visits to A&E and emergency admissions among people with multiple and complex needs experiencing homelessness, has some marked similarities to Housing First.[226] The rationale for reducing unplanned use of A&E use (for example) is clear, but calculating exact benefits, in terms of cash savings, can be difficult, because an A&E is so busy anyway, even without repeated visits from some people experiencing homelessness with multiple and complex needs, and there won't be 'spare' time in an easy to see and measurable sense. In other words, if people experiencing homelessness are not frequently in the queue, the queue is still more than enough to keep everyone in A&E very, very busy, even though - objectively – some capacity is being created by using an intervention like Housing First to reduce use of frequent emergency medical services by people experiencing homelessness.

[226] https://www.pathway.org.uk

Another way to look at this is again *lifetime* costs, here the difference that someone using Housing First experiences compared to when they were not using Housing First can at least be estimated. For example, if someone had been using an A&E in Belfast an average of 40 times a year for five years but following their working with Housing First that usage plummets or perhaps stops altogether, a before and after difference and an estimated lifetime cost can be estimated. The logic here is that, for example, if someone who was homeless and using an A&E in Belfast 40 times a year for five years (i.e. 200 times in five years) stopped doing so in association with using Housing First, which connected them up to primary health care, and they lived say another six years, that might have meant that something like 240 visits to A&E had been prevented. This *million dollar Murray* logic was highly influential in the US in relation to the introduction of Housing First, where it could be seen that longstanding costs from repeated contacts with emergency health, mental health, addiction, social care/work and criminal justice systems could be reduced and in some instances cease altogether, bringing the established and potential lifetime financial costs of someone with complex needs experiencing homelessness down markedly.

The area in which Housing First can generate realisable savings is in recurrent and sustained use of fixed site homelessness services, like hostels and supported housing, that are not intended for long term or repeated use. Here there is strong evidence that high numbers of bed nights in services are absorbed by relatively few individuals who are either caught in a revolving door of service use or becoming stuck in services. In the London borough of Camden, one of the most successful uses of Housing First centred on people in this situation, enabling people who were caught in a cycle of repeated use or stuck within the hostel and supported housing system (or at risk of becoming so), to often exit homelessness through use of Housing First. This in turn, did create greater capacity and improve outcomes for the hostel and supported housing system.[227]

The costs of developing and running Housing First

Housing First services do not use a single model for costing because there is variation in how they operate and in wage levels and other costs. Evidence to date indicates that Housing First services in London, as might be expected, tend to have higher wage levels and higher operational costs than those operating elsewhere in England. Equally, there is some evidence that costs can be higher in very rural areas than in suburban and urban areas of England, Scotland and Wales. When Housing First is operating across a rural area, where suitable housing might be quite widely scattered and transport infrastructure will typically be less well developed, Housing First staff will tend to spend more time travelling between service users.[228]

Another point of variation centres on development costs. Most UK examples of Housing First are floating support services, using an intensive case management team and ordinary social and/or private rented sector housing. Development costs for this form of Housing First, beyond staffing, are relatively low for a mobile team that will essentially just require office space to operate from.
In North America and mainland Europe, there are some examples of congregate Housing First services that are based in buildings that have been adapted from shelters and hostels into blocks of

[227] Pleace, N. and Bretherton, J. (2013) *Camden Housing First: A 'Housing First' Experiment in London* York: University of York.
[228] Bretherton, J. et al (forthcoming, 2024) *The Henry Smith Charity Housing First Strategic Grant: Research into the Effectiveness of Housing First Services* London: The Henry Smith Charity.

(dedicated) flats/apartments for Housing First service users and some new build of congregate Housing First.[229] Conversion and new build costs for congregate Housing First services will obviously mean that the capital outlay for establishing a new Housing First service is much higher than if a mobile Housing First team is being assembled that only requires access to a shared office.
These sorts of calculations can however become quite complicated, in the sense that developing Housing First using a congregate model centred on converting supported housing and hostels can help address (more expensive) shortfalls in social/affordable housing supply. This was the logic behind the Finnish congregate versions of 'Housing First' where housing supply shortfalls meant that quickly addressing long-term homelessness, without converting some existing shelters and communal supported housing services into blocks of congregate Housing First apartments, would have been much more difficult.[230] Equally, however, congregate models of 'Housing First' have been criticised as not really representing the route to an ordinary life, in an ordinary home in an ordinary community that the Housing First model was originally designed to provide and as undermining the fidelity of Housing First which centres around the idea of (ordinary) housing as a human right.[231] It is also important to note that the Finnish terminology around 'Housing First' refers to a self-development, integrated, preventative and housing-led homelessness strategy in which an array of services (some close to the American version of Housing First) are used. In addition, having developed large congregate 'Housing First' services, the Finns have since been moving towards smaller and more scattered models.[232]

The development costs of Housing First therefore depend on a wide range of variables, from wage levels through to whether the service is using a congregate model. Generally speaking, however, UK Housing First services which tend to be smaller in scale, tend to use a version of intensive case management that centres on workloads of between 3-10 people per worker and have a small level of managerial and administrative support, are often not very expensive to develop. A common model is a team covering 15-20 people that might have two FTE workers (perhaps 2.5) and a supervisory role that also has a small caseload. Larger services exist in the UK, but they tend to replicate this minimalist structure.[233] This is in marked contrast to ACT/ICM Housing First somewhere like Canada or France that can have dedicated psychiatric expertise, addiction specialists, nurses, trained social workers as staff and separate staffing to secure and manage housing.

[229] Pleace, N.; Baptista, I. and Knutagård, M. (2019) *Housing First in Europe: An Overview of Implementation, Strategy and Fidelity* Brussels: Housing First Hub Europe.
[230] Pleace, N.; Culhane, D.P.; Granfelt, R. and Knutagård, M. (2015) *The Finnish Homelessness Strategy: An International Review* Helsinki: Ministry of the Environment.
[231] Busch-Geertsema, V. (2010) *The Finnish National Programme to reduce long-term homelessness: Discussion Paper* European Commission.
[232] Allen, M.; Benjaminsen, L.; O'Sullivan, E. and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* Bristol: Policy Press.
[233] Pleace, N. and Bretherton, J. (2019) *The Cost Effectiveness of Housing First in England* London: Homeless Link.

Table 32 Average comparative costs of Housing First in the UK @ 2023 prices

Housing First scheme(s)	Model(s)	Number of service users	Support Costs per service user	Total operating budget
Average costs based on 2019 England research*[234]	Intensive case management	20	£4,128 (per year) £12,384 (three years)	£82,560 (per year) £247,680 (three years)
Average costs Greater Manchester Housing First (Government pilot)[235]	Intensive case management additional mental health services.	373 (budgeted) 443 (actual)	£25,417 (budgeted) £21,332*** (actual)	£9,480,000 (over three years)
Average costs Liverpool City Region Housing First (Government pilot)	Intensive case management	216 (budgeted) 237 (actual)	£42,246 (budgeted) £38,503*** (actual)	£9,125,000 (over three years)
Average costs West Midlands Housing First	Intensive case management	500 (budgeted) 600 (actual)	£22,754 (budgeted) £18,961*** (actual)	£11,377,000 (over three years)
Scotland Housing First Pathfinder Project**[236]	Intensive case management	578	£13,800	£7,900,000 (over three years)

Prices at 2019, 2021 and 2022 levels adjusted to 2023 levels using the Bank of England Inflation Calculator. * Based on 15 Housing First services being supported by local authority commissioning in England, including services in the North, Midlands and London ** Five Housing First pilots operating in Aberdeen(shire), Dundee, Edinburgh, Glasgow and Stirling. *** These costs are based on all service users worked with over three years, not the cost of supporting a service user over three years (see below for discussion of tenancy length in these pilot programmes).

Table 32 illustrates the very considerable range of Housing First costs from elsewhere in the UK, focusing specifically on the largest use of Housing First in England. The three pilot Housing First services supported by central government in Manchester, Liverpool and the West Midlands had far greater budgets, in overall and comparative terms than services funded primarily by local government. There was also a considerable range in the cost levels of local authority commissioned Housing First, so for example the median cost per service user per year reported in 2019 (adjusted to 2023 prices) was £3,747 (again based on a 20-person service) which reflected Housing First services operating with different caseloads per worker and regional variations in costs. This would be the equivalent median cost of £11,241 per person over three years. The median is lower than the average costs because costs were pulled up by London Housing First services commissioned by local authorities, which tended to be more expensive in overall and relative terms.[237]

Costs for the Scottish, five site Housing First 'Pathfinder' programme were met primarily by the Scottish Government, but with significant support from a social enterprise called Social Bite and some other philanthropic funding. The scale and overall costs of the Pathfinder programme were broadly equivalent to one of the English governments funded pilots, but rather than being concentrated on one city region, five smaller Housing First services were supported across Scotland. Costs were again significantly higher than those reported for Housing First commissioned by English local authorities but were notably less than those for the three English government funded pilots.

[234] As above.
[235] DLUHC (2022) *Evaluation of the Housing First Pilots: Third Process Report* London: DLUHC.
[236] Johnsen, S, Blenkinsopp, J and Rayment, M (2022) *Scotland's Housing First Pathfinder Evaluation: Final Report* Heriot-Watt University.
[237] Pleace, N. and Bretherton, J. (2019) *The Cost Effectiveness of Housing First in England* London: Homeless Link.

The three-year programme which ended in September 2021, was reported as having an average cost per person housed of £11,645 (£13,800 in 2023 prices), but the evaluation also noted that when the costs of the programme administration were added, this rose to £13,349 (£15,701 in 2023 prices). Table 32 is not a direct comparison in the sense that the data for the three government funded English pilots and the Scottish Pathway programme are an average cost-per-user and the people using these Housing First services had done so for different periods of time across a three-year programme (the English government funded pilots were extended after the first three years). At the final report on the three government funded pilots 27% of those housed had been with a service for one year and just under one half (49%) for up to three years. Table 32 shows broadly comparable costs for local authority commissioned Housing First services at one and three years, based on the 2019 research, but this is not an 'average cost per user' figure calculated on the same basis as the other figures in the table.

If the average, local authority commissioned, Housing First service operating in England were scaled up to the same size as, for example, the (central government funded) Greater Manchester Housing First Pilot and operated for three years, working with 443 people (147 people a year), it would cost £606,081 a year and £1.81m over three years. While this is a slightly heroic estimate, the stark differences between these services are further illustrated by this calculation, i.e. the government funded Greater Manchester pilot was operating at something like five times the budget level available to a typical local authority funded service.
During the course of 2020-2022, some research in England began to highlight a situation in which local authority commissioned Housing First services, alongside other homelessness were facing the consequences of prolonged underfunding in a context in which local authority budgets were continuously falling and contracts for homelessness had become increasingly insecure.[238] A wider crisis in the funding of homelessness services, including Housing First, was reported as inflation spiralled upwards in the wake of the Ukrainian war, as budgets were not adjusted to take into account huge increases in energy, food and other costs. Risks to homelessness services were reported across the sector.[239] In essence the evidence base suggests that Housing First, in the sense of services commissioned by local authorities in England, was thinly funded and as the cost-of-living crisis hit alongside the 27% cut in English local authority budgets since 2010[240], began to look underfunded.

In practical terms this may mean that the estimates based on the 2019 research in England in Table 32 are higher than the actual budgets for at least some local authority commissioned Housing First services, i.e. the increases in their costs since 2019 have not been matched by increases in local authority commissioning budgets. It is difficult to be precise here, as the actual costs of these Housing First services are commercially confidential, reflecting the commissioned nature of these services, but it is known that there are Housing First support workers in England being paid at, or

[238] Blood, I. and Pleace, N. (2021) *A Traumatised System: A critical crossroads for the commissioning of homelessness services* Leicester: Riverside.
[239] Homeless Link. (2022). Keep Our Doors Open: The homelessness sector and the rising cost of living London: Homeless Link; Changing Lives (2022) *PRICED OUT: The impact of the rising cost of living on people with multiple unmet needs* Changing Lives: Gateshead; Crisis (2022) *A Tale of Two Crises: Housing and the cost of living* London: Crisis.
[240] https://www.local.gov.uk/about/news/funding-gap-growing-councils-firmly-eye-inflationary-storm

only just above, the statutory minimum wage and reports that these staff have sometimes been struggling to make ends meet.[241]

Arguments that budgets available to local authority commissioned Housing First services were insufficient are supported by the levels of funding allocated by government to the three funded pilots shown in Table 32. These services were sufficiently resourced to enable them to operate well above their designed limits, in terms of the number of people they were able to support into settled housing, with effective budgets per person that still far exceeded the typical range of financial support that local authorities were able to provide to Housing First. Budgets for Housing First in Scotland and Wales, based on (limited) available evidence, also seem to be relatively low compared to the English government pilots and the level of financial support given to Housing First in some other countries, particularly for high fidelity ACT/ICM models.

The evidence base for Housing First services in the UK suggests a relatively high degree of effectiveness in working with people experiencing (or at risk of experiencing) long-term or recurrent homelessness associated with multiple and complex treatment and support needs. The key indicator is housing sustainment, which is in the 80%+ range at one year of service use across of the bulk of reports on Housing First in the UK. Alongside this, while the results can be more mixed, improvements in addiction, mental and physical health and social connection can and do result from using Housing First services.[242] Nevertheless, a situation of general funding constraint which the homelessness sector has reported is tipping into a crisis, has meant that Housing First services funded by local authority commissioning are often in a precarious situation and can struggle to maintain effective operation. The comparative costs of Housing First from elsewhere in the UK need to be seen in this light.

Table 33 summarises some of the costs of other types of homelessness service in Northern Ireland compared to the range of Housing First costs reported elsewhere in the UK. Given commercial sensitivity, and the fact that the majority of Housing First in Northern Ireland is currently provided by one provider, Supporting People did not share costs for current Housing First providers. Table 33 looks at the typical costs of Housing First elsewhere in the UK compared to other homelessness service costs in Northern Ireland. The available data shared by NIHE is based on unit costs (2023/4) per hour and the average hours provided to users of each service. Some direct comparison with Housing First costs is possible, drawing on the 2019 research conducted in England. However, it is important to note three key differences between Housing First and some other homelessness service models. The first difference is that Housing First is designed to be agile and flexible, which means the hours of support someone receives can vary considerably from week to week and the second difference is that support will tend to fall over time, i.e. as someone stabilises in their settled housing and has access to better, case managed, support and treatment. Research in England and Scotland has suggested that support hours can drop by at least two-thirds and sometimes more over the course of using a Housing First service.[243] The final difference is that Housing First is an open-

[241] Snell, C.; Pleace, N.; Browning, A. and Anderson, S. (2023*) Fuel Poverty and Homelessness: Exploring the Extremes of the Cost of Living Crisis* York: The York Policy Engine.
[242] Aziz, S.K. and Boobis, S. (2024) *More Than a Roof: Exploring the holistic outcomes of Housing First* London: Homeless Link.
[243] Pleace, N. and Bretherton, J. (2019) *The Cost Effectiveness of Housing First in England* London: Homeless Link; Johnsen, S, Blenkinsopp, J and Rayment, M (2022) *Scotland's Housing First Pathfinder Evaluation: Final*

ended service model, whereas many other homelessness services are (at least nominally) designed to work within a timeframe of several months or, at most, a couple of years.

Table 33 Comparing Housing First costs with other homelessness services in Northern Ireland

Service model	Cost per hour*	Average total hours support provided	Total average cost	Average costs per hour for Housing First*	Equivalent cost of average total hours support**
Floating support for people at risk of offending	£23.65	283	£6,692	£18	£5,094
Floating support for people with alcohol problems	£20.90	222	£4,639	£18	£3,996
Floating support for lone people experiencing homelessness with support needs	£16.33	142	£2,318	£18	£2,556

* Based on reported weekly unit cost divided by average hours provided per week **Based on Pleace, N. and Bretherton, J. (2019) *The Cost Effectiveness of Housing First in England* London: Homeless Link which reported an average total cost per hour of support of £15.37 at 2019 prices across 15 local authority commissioned services (adjusted for inflation to 2023 levels through the Bank of England inflation calculator).

Again, Table 33 shows local authority commissioned Housing First services in England have lower operational costs than other floating support service models in Northern Ireland, with the exception of a Floating support model for people experiencing homelessness. While the costs are similar, the likelihood is that this service is operating with significantly higher caseloads than is typical for Housing First services commissioned by local authorities, with most services having loads of six or less people per worker[244] and is a lower intensity service model.

However, these data must be seen in the light of both policy and academic research reporting a situation in which local authority commissioned Housing First services *lack secure and sufficient funding* across much of England. Hourly costs for the more expensive English Housing First government funded pilots and the Scottish Pathfinder Housing First programme are not available and – again – there is the limitation that these Housing First services were also providing varying levels of support, rather than a fixed number of hours being allocated to someone using them. However, it can be estimated that (see Table 32):

- The Greater Manchester Housing First pilot funded by central government had average total costs per user that were approximately 5.2 times those of local authority commissioned Housing First services in England, which would mean an equivalent hourly total support cost of £93.60.
- The Scottish Pathway pilot programme had average total costs per user that were approximately 3.3 times those of local authority commissioned Housing First services in England, which would mean an equivalent hourly total support cost of £59.40.

Report Heriot-Watt University.

[244] Homeless Link (2020) *The Picture of Housing First in England (2020)* London: Homeless Link.

Housing First is not necessarily a cheaper option than running a building-based service for people experiencing homelessness. However, much depends on how that building is designed, operates and the level of support it provides. An intensive supported housing scheme will probably usually cost more, because it is also delivering higher levels of support, with a lower caseload per worker, than other services and having to meet the running costs of its building (leaving aside the capital costs of constructing or refurbishing a dedicated building). A low intensity building based service, e.g. a hostel offering low levels of support and high caseload per worker may have equivalent operating costs per hour (or be cheaper) but will be offering much less intensive support than Housing First. Based on supporting people data shared by NIHE, fixed site services for people experiencing homelessness had costs of between £30 an hour for higher intensity and £15 an hour for lower intensity supported housing/hostel services.

Outcomes

The main argument in favour of Housing First has always been its success in ending long-term and recurrent homelessness associated with high, multiple and complex needs. All UK and European research from the 2010s and into the 2020s has reported the same thing, which was that around 80-90% of the people experiencing long-term or repeated homelessness associated with multiple and complex needs were still housed after one year with Housing First. This research has been criticised for not including direct comparisons with other services[245], but two experimental trials (randomised control trials) conducted at national level in Canada and France have also demonstrated high levels of comparative effectiveness in ending recurrent and sustained homelessness among people with high and complex treatment and support needs. The Canadian *At Home/Chez Soi*[246] and the French *Un chez-soi d'abord*[247], alongside quasi-experimental work in Denmark[248], all showed Housing First achieving better results in ending homelessness among people with high and complex needs than existing supported housing, hostel, shelter and staircase or linear residential treatment (LRT) models (which uses stages of supported accommodation, each more housing-like than the last).

The evidence around relative rates of tenancy sustainment (ending homelessness) for Housing First is less clear cut in the UK than in some other countries. In part, this is because systematic comparative analysis of outcomes has not yet been undertaken, but it is also the case that several elements of the distinctiveness of Housing First (i.e. harm reduction, coproduction/service user choice, trauma informed care) are mainstream in UK homelessness service provision and have been for 30 years. A typical UK supported housing unit or hostel for people experiencing homelessness, is very different from a US emergency shelter, because it is often congregate (people have their own rooms), rather than communal (shared sleeping areas) and the level and nature of support offered is quite different. Equally, while UK supported housing services are less intensive than LRT, they are also unlikely to be abstinence based or require behavioural change from the people using them,

[245] Pleace, N. (2018) *Using Housing First in Integrated Homelessness Strategies* London: St Mungo's.
[246] Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D., and Aubry, T. (2014) National at Home/Chez Soi Final Report (Calgary, AB: Mental Health Commission of Canada).
[247] DIHAL (2016) *The Experimental Programme Un chez-soi d'abord Housing First Main Results – 2011 / 2015* (English summary) (Paris: Délégation interministérielle à l'hébergement et à l'accès au logement). http://housingfirst.wp.tri.haus/assets/ files/2016/04/un- chez-soi-dabord-EN.pdf
[248] Allen, M., Benjaminsen, L., O'Sullivan, E., and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland* Bristol: Policy Press.

both of which were associated with lower levels of success with LRT than with Housing First in the US.[249]

Based on data supplied by NIHE, the rates of positive housing outcomes achieved by other service models are relatively high:

- Few fixed site supported housing services were reported as achieving less than a 50% rate of resettlement into secure housing at the point of service exit (this was not a measure of tenancy sustainment, as these services ended at the point someone was rehoused) and many reported much higher rates of exit into supported housing. An average of 81% of service users exiting to settled housing was reported across 32 supported housing projects for lone adults experiencing homelessness in the first quarter of 2022/23.[250]
- A measure reporting on the number of service users maintaining their tenancy as a result of floating support reported very high levels, an average of 95% across 17 floating support services.

One point to note here is how tenancy sustainment tends to be measured in Northern Ireland and in Great Britain, i.e. the amount of time a tenancy is held by a service user, with the broad measure of success being holding a tenancy for at least one year. By contrast, some of the international evidence, such as the Canadian randomised control trial, compared Housing First with other services in terms of nights *in housing* i.e. the measure was how often a tenant was in their housing, rather than whether a tenancy agreement had not broken down.

Outcomes outside tenancy sustainment have been more variable. The picture across Housing First as a whole has been that there are gains in mental and physical health, around addiction and in social support and connection. However, these gains are less uniform than the high performance around tenancy sustainment, i.e. sustained, housed exits from homelessness.[251] The limitations of Housing First, based on UK and national evidence can be summarised as follows:

- Between 5-10% of service users do not achieve a sustained exit from homelessness based on the evidence around Housing First, (UK and international evidence).
- Mortality rates can be high, i.e. exits from Housing First because the service user has died are commonplace, though this may reflect the bar/criteria for admission to Housing First services being set too high, with people experiencing homelessness only being referred at the point where they are very ill, and/or an undersupply of Housing First.
- Outcomes around addiction, mental health, social integration and physical health are broadly positive, but the results are less consistent than those around creating a sustained exit from homelessness.[252]

There are some difficulties in ascribing outcomes other than tenancy sustainment to Housing First. One issue here is that Housing First is a case management model, something that applies more to the Northern Ireland and other UK versions of Housing First, which centre on intensive case management (ICM), rather than the in-house mental health, addiction, nursing, peer support and

[249] Padgett, D., Henwood, B.F. and Tsemberis, S.J. (2016) *Housing First: Ending homelessness, transforming systems, and changing lives* Oxford: Oxford University Press.
[250] Source: NIHE.
[251] Aubry, T. (2020) Analysis of housing first as a practical and policy relevant intervention: the current state of knowledge and future directions for research. *European Journal of Homelessness* 14(1) pp.13-26.
[252] Aziz, S.K. and Boobis, S. (2024) *More Than a Roof: Exploring the holistic outcomes of Housing First* London: Homeless Link.

housing management staff found in a very high fidelity ACT/ICM service.[253] The case management matters in determining effectiveness because it means that Housing First is ultimately reliant on the other services it has to work with, including mental health, addiction, social care, health services and, in the Northern Ireland and wider UK context, social landlords. If a Housing First service is operating in a 'service desert', meaning that for example a referral to community mental health services may take months to come through, this will likely undermine performance in relation to improvements in mental health, not because of what a Housing First service is doing or not doing, but because it is a model reliant on partnership and collaboration.

In summary, based on current evidence and with some caveats, Housing First outcomes can be summarised as follows:

- Housing First has very strong evidence of sustained exits from homelessness for around 8-9 out of every 10 service users. Outcomes in other areas are positive, but more mixed, although this is related to the degree of support available from other services to support the case management model at the core of Housing First.
- Housing First services, operating under local authority commissioning in England, have very low operating costs compared to some other homelessness services and the major Housing First programmes supported by government in England and Scotland. However, there is also evidence that these English local authority commissioned Housing First services are often precariously funded at very low levels, to the point at which they may be regarded as *underfunded*.
- Housing First may outperform other service models in relation to ending homelessness among people with high, multiple and complex treatment and support needs, but the outcomes for other service models may not be very dissimilar. On this basis, properly funded Housing First (at the levels seen in the English and Scottish pilots supported by national governments) may offer better *value for money* than other service models in ending homelessness among people with high, multiple and complex needs. However, Housing First will not necessarily be cheaper than those other service models, nor will it necessarily achieve much better outcomes in terms of health, mental health, addiction and social integration than those services.

[253] Padgett, D., Henwood, B.F. and Tsemberis, S.J. (2016) *Housing First: Ending homelessness, transforming systems, and changing lives* Oxford: Oxford University Press.

Section 10 A Housing First model for Northern Ireland?

This section outlines our proposed Housing First model for Northern Ireland.

This Feasibility study acknowledges that Housing First has existed in Northern Ireland since 2014 through services delivered by Depaul and SCNI. Whilst evaluations show the outcomes this provision has had, they also reference the restrictions placed on Housing First in a Northern Ireland context by the lack of a dedicated housing supply and lack of access to other relevant services in the health and social care sector. It is important to note that Housing First is fundamentally an intensive case management model, which requires strategic integration with public health, mental health, addiction, social housing and other homelessness services, alongside wider links with welfare and criminal justice systems, if it is to function well.

This model has been developed through a number of streams. Firstly, in examining the current Housing First provision in Northern Ireland delivered by Depaul and Simon Community NI (see Section 3) and also looking at the current situation and suitability of temporary homeless provision (see Section 5) and the level and nature of chronic homelessness (see Section 4). Secondly, the proposed model takes into account the more recent development of Complex Lives, and its delivery model across Belfast (see Section 3). Thirdly, this proposed model takes into account the experience and learning internationally of Housing First (see Section 2). Fourthly, the proposed model is informed by stakeholder feedback from across the statutory and community/voluntary sector, with particular reference to what interested parties believe should be the building blocks of Housing First (see Section 6). Finally, and most importantly, the proposed Housing First model for Northern Ireland is based on the views of those with lived experience of chronic homelessness and/or of the current Housing First services (see Section 7).

Throughout this report, and with sharp focus in this section, we recognise the need for political decision-making if any development or expansion of Housing First is to be supported and if it is to be successful. This is noted later in this section, with reference to policy frameworks, funding and cross-departmental support and working. In addition, this Section acknowledges that considerable work on the development and expansion of Housing First has already been done by the Departmental Task and Finish Group in the DfC, which has put in place a four-year high-level plan for the period October 2022 to March 2026. The timescales for delivery are subject to change.

Table 34 below suggests a 4-year expansion of Housing First, recognising that the model needs to be scaled up in a timely way, and that over-expansion at any one point could be detrimental to delivery.

Definition

As part of the research process the following definition of Housing First for NI was agreed, based on the definition outlined in the Liverpool study[254]:

"Housing First is a system of support for homeless people with high and complex needs which is designed to deliver a sustainable exit from homelessness, improve health and well-being and enable

[254] It is acknowledged that this definition used the term 'homeless people'. For any further usage of this definition in a Northern Ireland context, the phrase 'people experiencing homelessness' would be used.

social integration. Housing First uses ordinary housing, such as private rented or social rented flats and is designed to house formerly homeless people with high needs in their own, settled homes *as quickly as possible* and to provide the support they will need to sustain an exit from homelessness *in their own home."*

The NI Housing First model will be based on the following principles[255] (see in full at Appendix 3):
Principle 1: People have a right to a home
Principle 2: Flexible support is provided for as long as it is needed
Principle 3: Housing and support are separated
Principle 4: Individuals have choice and control
Principle 5: An active engagement approach is used
Principle 6: The service is based on people's strengths, goals and aspirations
Principle 7: A harm reduction approach is used

The Housing First model for Northern Ireland will be focussed on reducing and preventing recurring and chronic homelessness associated with multiple and complex treatment and support needs, with the aim of supporting service users into and in sustaining a tenancy. Tenancy sustainment, for the target group who have historically bounced around and between different housing and wider services, is the key goal.

As noted later in the discussion on the target group for Housing First, discussions with key stakeholders concluded that the agreed definition of Housing First in Northern Ireland should not exclude certain groups e.g. young people, who may not fully meet the criteria outlined below or individuals who have not yet moved into chronic homelessness, but where risk factors are recognised, should also not be excluded, with a more preventative approach incorporated within Housing First delivery. The possibility of Housing First for women is referenced later in this section.

In addition, the link between this broad definition of Housing First, the definition of chronic homelessness and the assessment of potential service users under the chronic homeless criteria is expanded later in this section. The operationalisation of the assessment process (who by? At what stage? How broadly interpreted) and assessment decisions will be key to ensuring that the right people are placed in a Housing First service.

Policy context and integration
Analysis of the current Housing First provision in Northern Ireland (see Sections 3 and 6) highlights that the two main stumbling blocks to delivery and development are firstly lack of an integrated Housing First strategy across all the relevant Government Departments and secondly lack of the necessary social housing supply to make Housing First a reality. The former has been a barrier in terms of developing an integrated model, meeting the needs of service users in a holistic way, and the latter has negatively impacted the fidelity of the model as currently delivered in Northern Ireland.

[255] The Principles of Housing First | Homeless Link

Housing First, as a delivery model in Northern Ireland, is referenced in the current Homelessness Strategy[256] with a policy desire for a significant shift towards rapid rehousing[257] including Housing First. Beyond this policy assertion there is limited reference to Housing First in wider Government policy.

Many examples exist of how policy and practice in Northern Ireland do not follow their counterparts in the rest of the UK. For example, social prescribing as an alternative to medical prescriptions relating to social, emotional or practical needs, is well developed and integrated into practice in England and Wales, with Government support, initiatives and funding. As a result, it is accepted practice, although issues with resources can limit this approach. In contrast in Northern Ireland social prescribing has had limited traction, either in development or delivery; and this can be traced to a lack of policy direction and limited funding.

The same can be said for Housing First. There is considerably more policy references and funding support for Housing First in England, Scotland and Wales. Even with this the model faces frustrations[258]. In Northern Ireland, despite being around for the last 10 years Housing First could be said to be still in its infancy and is not accepted practice or an aspiration across Government. The current funding support is limited and tokenistic, giving a nod to the model but not fully embracing it. This is in a wider European context in which some comparable countries have highly integrated, housing-led/Housing First strategies and national level Housing First programmes, with clearly demarcated budgets.[259]

To move forward in Northern Ireland we suggest that the following is needed, as highlighted in Section 6:

- Political and ministerial endorsement
- Cross- or inter-departmental working and collective involvement of all political parties and Departments to ensure integration with existing resources, services and structures, and to enable the model to develop with full support and the required funding.

The need for leadership and buy-in across ministers and departments is a key plank of the Departmental Task and Finish Group on Housing First, pointing to the need to ensure this in concept and in practice with the latter providing input for commissioning and funding of services. The research team suggest that the most important aspect of this is around securing stable and sustained arrangements for the financing of current and any additional Housing First provision, through joint financing and commissioning. This approach will need a breakdown of overall costs and indicative costs per Department.

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[256] *Ending Homelessness Together,* Homelessness Strategy 2022 – 2027, NIHE.
Ending Homelessness Together Homelessness Strategy 2022-27 (nihe.gov.uk)

[257] The term rapid rehousing is used in the Homelessness Strategy. It is described as *making sure the needs of an individual are assessed and they reach a settled housing option as quickly as possible rather than staying too long in temporary accommodation.* Not to be confused with rapid rehousing as used in North America - time limited housing benefit system (using vouchers).

[258] In England there's support in principle, guidance: mobilising-housing-first-toolkit-from-planning-to-early-implementation and there were the three pilot programmes, but the bulk of Housing First is funded by local authority budgets that have been cut drastically. There remains no national Housing First strategy in England. Consideration indicates that there is more funding and strategy in Scotland and Wales, in comparison to England.

[259] https://housingfirsteurope.eu/

In addition, as noted earlier in this report Housing First is not suitable, or indeed needed, for many individuals who are homeless. This highlights the need to have an effective system providing speedy access to housing (either temporary or permanent) and lower levels of support for those who do not need the intensity and levels of input of Housing First. Unfortunately, as outlined in Section 5 the type and nature of temporary accommodation and the length of time that people are waiting for an offer of permanent housing, often means that their needs and wider factors surrounding their homelessness move them from the category of 'ordinary' homelessness into chronic homelessness (associated with multiple and complex needs, instability, moving between services etc.)

Target group for Housing First service

Based on analysis of the current Housing First provision in Northern Ireland and feedback from stakeholders, we recommend that the chronic homelessness definition is used as the main target group suitable for the uptake of Housing First. This definition describes chronic homelessness as "a group of individuals with very pronounced and complex support needs who found it difficult to exit from homelessness."[260]

Housing First in Northern Ireland should therefore be targeted at individuals who meet the following criteria, as outlined in the definition:

An individual can be said to be experiencing chronic homelessness if they meet **one** of the primary indicators listed:

3. An individual with more than one episode of homelessness in the last 12 months; OR
4. An individual with multiple (3 or more) placements/exclusions from temporary accommodation during the last 12 months.

AND two or more of the following additional indicators must also apply:

- An individual with mental health problems;
- An individual with addictions e.g. drug or alcohol addictions;
- An individual that has engaged in street activity, including rough sleeping, street drinking, begging within the last 3 months;
- An individual who has experienced or is at risk of violence/abuse (including domestic abuse) - risk to self, to others or from others;
- An individual who has left prison or youth custody within the last 12 months;
- An individual who was defined as a 'looked after' child[261].

In this report we have estimated (based on the data available) that the current known population of chronic homeless people across Northern Ireland is in the order of 250, with estimations of some 150 to 200 individuals in Belfast, with potentially another 50 individuals Northern Ireland wide. While only 35% of all homeless presenters are based in Belfast, there is a known concentration of chronic homelessness in Belfast which the estimations in this model reflect. We would suggest that Housing First delivery should therefore seek to respond to this level of current need (based on the data available) in Belfast and that regionally an additional 50 clients could be supported. The Housing Executive is aware that there is chronic homelessness outside Belfast that may yet be

[260] www.crisis.org.uk/media/237173/a_review_of_single_homelessness_in_the_uk_2000-2010.pdf
[261] As per the Children (Northern Ireland) Order 1995
https://www.legislation.gov.uk/nisi/1995/755/contents/made

hidden/unrecorded. As data capture on chronic homelessness improves, HF services will be adjusted and evolve to reflect the need across Northern Ireland as accurately as possible.

These numbers, as an estimation of current unmet need, are included in table 34 below, taking into account that as Housing First is already being delivered to a set number of people (via Depaul and SCNI) that these numbers are in addition to current provision.

It is anticipated that once these spaces are filled this will make a significant difference to the number of chronic homeless people either living on the streets and/or moving between temporary accommodation hostels. As such once this target number of current need is settled in Housing First, further work will be needed to estimate the level/numbers of those who can be defined as 'newly arising need'. Once calculated this additional number will need to be added to service provision and spaces, and recognised within a wider calculation of cumulative need. There is also the possibility that if wider strategy is more effective in terms of homelessness prevention and integration of services, that requirements/need for Housing First would eventually fall off over time.

In an (unpublished) review of housing and support for people with multiple and complex needs in 2021 for Barnsley Council in England, Imogen Blood & Associates conducted a 'By Name List' exercise in which different agencies were asked to provide information about individuals with multiple and complex needs who were not having their needs adequately met by existing services and pathways. Having eliminated duplicates (and noting that no single agency saw the full picture), 122 individuals were identified. 30% of these people were identified by professionals as being the 'current priority cohort': many were rough sleeping or otherwise roofless, a smaller number were in tenancies that were at risk of ending. The remaining 70% of the 122 was split evenly between those felt to be at risk of becoming the next priority cohort, e.g. because they were at high risk of eviction from their current accommodation, and those had been frequent users of services in the past but who were currently 'off the radar' (perhaps because they were in institutions, making their own arrangements or their whereabouts was not known). The conclusion was that not everyone from the cohort of 122 would need – or be available to engage with – a Housing First service at any given time, but that those 'at risk' and 'off the radar' could easily (re-)present and some might, over time, need such a service.

The implications from this for Northern Ireland is that, if there are approximately 250 people forming the 'current priority cohort' (the equivalent of Barnsley's 30%) there may be another 580 people who might be 'at risk' of joining the priority cohort, or currently off-radar. This is only a very rough estimate and the actual number which present as the priority cohort will be influenced by the wider policy and economic context, as well as by the success of interventions aimed to prevent them joining the priority cohort. In the Northern Ireland context, these individuals might form part of the 985 who have already been recorded by NIHE as having re-presented (see below). The NIHE may wish to develop a 'watch list' of individuals further 'upstream' who are stepping in and out of services, and where Housing First could be used in a preventative way.

In addition, the level at which service users leave Housing First services will impact the estimated level of provision for current and newly arising need. This study notes that service users may leave Housing First for a number of reasons including what can be defined as success (they are able to

sustain their tenancy without Housing First levels and type of support) and for reasons which may be less successful (they move back into some form of chronic homelessness as the tenancy/ arrangement with Housing First fails or ends, or their health deteriorates and they need to move into residential/nursing care or they pass away). In addition, the element of choice in the Housing First principles means that service users may choose to no longer receive the Housing First service.

Additional Target groups for Housing First service

During this Feasibility study the drawbacks of this definition and categorisation were acknowledged, and the need for a broader and more flexible inclusion of people in the area of chronic homelessness was noted. We therefore recommend a degree of latitude in assessing the needs of individuals who may be suitable for and benefit from Housing First. Taking this on board, and looking more specifically at repeat homelessness (1,075 individuals in 2022/23) and multiple placements (985 individuals in 2022/23), it is clear that Housing First could be a solution to repeat and multiple/ complex homelessness for a much bigger number of people.

Feedback from stakeholders, and the review of international evidence pointed towards the need for dedicated Housing First services for specific groups of people. Simon Community NI already provide Housing First for Youth (HF4Y) for young people in the age bracket 16 and 17 years old, who are care experienced. Evidence would suggest there would be benefit in rolling this out across Northern Ireland.

Housing First for women, and particularly those who have experienced domestic abuse/violence is another specific group which the NIHE should consider. Women's Aid Causeway and Mid Ulster have recently commissioned a specific research project to examine this option. Housing First for those outside the two main cities (Belfast and Derry) including those in rural settings is a further key consideration, as noted below.

Location of Housing First in Northern Ireland

Current provision in Northern Ireland is limited to Belfast and Derry. Whilst there is recognition and data confirms that these are the two main cities where people experiencing chronic homelessness are located, wider analysis of quantitative (number of rough sleepers by LGD, number of homeless by Council area – see Appendix 4) and qualitative data point to a need for Housing First as a model in more locations across Northern Ireland. More detailed analysis would be required to identify (a) geographical areas which have the highest levels of chronic homelessness (using the NIHE's count/ recording of chronic homelessness which commenced in January 2023) and (b) locations most suitable for delivery of Housing First from a regional hub across a specified area, and where the other required services are available and can be brought into the service delivery model. This combination of demand and need for Housing First, alongside the operational realities including a housing supply would enable the NIHE to target specific delivery hubs, alongside covering wider geographical areas.

Our research also pointed to situations where service users in Belfast and Derry who wished to avail of and were suitable for Housing First, but who wanted to move outside of these two cities, could not be supported under the current service delivery models. We recommend the following expansion of Housing First, beyond Belfast and Derry, over the 4-year period, which would produce

an overall figure of 220 additional units of Housing First delivery across Northern Ireland, in an initial scaling up of Housing First.

Table 34: Four-year expansion of Housing First – Northern Ireland

Year	Location(s)	Current Numbers	Proposed Numbers	Rationale
1, and ongoing over all years	Extend provision for Belfast/Derry service users – who wish to have a tenancy outside of these two locations. **For Belfast** – extend to the Belfast Metropolitan area or Greater Belfast area – covering in addition to Belfast – Lisburn, Newtownabbey, North Down, Castlereagh and Carrickfergus **For Derry** – extend to include Strabane and Limavady	Belfast - 28 Derry - 25	Belfast – 100 Belfast Met area – 50 Derry – 35 Derry area - 6	Focus on ensuring people can live where they want to live. Availability of housing supply in these wider areas. Can be delivered from the hubs within Belfast and Derry.
2	Set-up small-scale Housing First provision in two regional areas as hubs covering: **Ballymena** – Antrim, Ballymoney, Coleraine **Dungannon** – Portadown, Lurgan, Armagh, Banbridge and Craigavon	-	Ballymena Hub – 8 Dungannon Hub - 8	Based on rough sleeper numbers, street audits, current homeless provision in areas. Also linking in with current homeless services in these areas
3	Set-up small-scale Housing First provision in two further regional areas as hubs covering: **Newry** – Downpatrick, Banbridge **Enniskillen** – County Fermanagh, Omagh	-	Newry Hub – 8 Enniskillen Hub - 4	
4	Pilot Housing First for different groups: Young people (under the age of 25) Women (including those who have experienced domestic abuse/violence).	No SP current provision	SP funded HF for young people and women – numbers to be agreed	Provision needs to be specific to the needs of the group
Total		**53**	**219**	**Grand total - 272**

The above estimation of numbers is similar to the estimations put in place by the Departmental Task and Finish Group which have indicated 252 additional Housing First places by 31st August 2025[262]. Whilst these ambitions to scale up Housing First are laudable, the Research team suggest a slower and more gradual build-up of spaces will be needed, based on recent experience of securing accommodation to support new places[263]. In addition, the expansion of Housing First needs to consider securing commitment at cross-Departmental level, legal and other requirements around acquisition of properties, procurement timescales and availability of/accessibility to skilled staff. This longer lead-in timing is also placed in the light of recent developments in Dublin where the Housing First service was underspecified and the provider encountered funding difficulties, highlighting the need for a gradual and robust development of services.

Outline of Housing First service

Discussions with NIHE and wider stakeholders during this Feasibility study point to two clear potential options for the further development and expansion of Housing First in Northern Ireland. The first option is to retain the current model of commissioning Housing First services from homeless providers through the Supporting People budget; with the opportunity for further funding streams for some specific projects e.g. the SCNI example of HF4Y which is funded through HSC Trust budgets.

The second option is to envelope the Housing First delivery options within the wider Complex Lives model, expanding this model within and potentially beyond Belfast, and working with homeless providers to facilitate the housing support element of Housing First. Complex Lives would provide the referral route, the assessment and triage service and potentially ongoing multi-disciplinary support mechanisms. Decisions would need to be made around whether to roll-out a format of Complex Lives regionally, providing multi-disciplinary teams in all suggested locations/hubs, or in contrast to operate through coordinating existing services in regional areas. The latter would take into account 'trusted partners, local context and local service provision'. The option of integrating with Complex Lives appears to have considerable promise. It would provide reliable and ongoing funding, a housing supply could be arranged and clear requirements could be put in place around the integration of Housing First services into Complex Lives itself and wider systems and strategies.

Whichever approach is chosen, and it could be an amalgamation of both in different regional areas, the research points to a number of factors which need to be in place if Housing First is to be effective, both in terms of best outcomes for service users and in relation to the cost-effectiveness of the model. These are as follows:

- **Staff -** Having access to a pool of suitable staff, with backgrounds in homelessness and housing provision, health-care provision, offending and justice provision and multi-disciplinary working, and the clear engagement skills necessary for working within a Housing First model. In addition, sufficient salary levels to recruit and retain experienced staff teams;

[262] The Task and Finish Group proposed:
Total additional places 42 by 31 August 2023 in Belfast
Total additional HF places 84 by 31 December 2023 – including 2 new locations
Total additional HF places 126 by 31 August 2024. With possible Belfast additions, 189. (105 Belfast, 84 across 4 locations outside Belfast)
Total additional HF places 252 by 31 August 2025

[263] Learning from Republic of Ireland (one-bed unit strategy) and Finnish strategy.

- **Caseload -** Having a protected caseload of 3 – 8 service users per full-time support worker, with numbers varying by the type and nature of homelessness;
- **Services -** Having access to the relevant services (housing, health, justice) and networks which are the lynch pins of delivering Housing First. The Departmental Task and Finish group points to the need to secure consensus and buy-in across all partners;
- **Referral and assessment -** Having a clear referral route for assessment for Housing First. This could be exclusively through identification by the NIHE via Housing Advisors in Housing Solutions interviews and or via services such as Complex Lives (who then refer into Housing First) or homeless providers (in particular those working with the most chronically homeless).

Based on learning from the current provision in Northern Ireland, and experience internationally, and from qualitative feedback from stakeholders and those with lived experience, we suggest that the range of support which could be provided under the heading of Housing First should include the following:

- Emotional and psychological support, including the use of PIE[264] and trauma informed practice
- Practical support to set up and maintain home and finances
- Help and advocacy to access benefits and services
- Support in building social networks and meaningful activity

In addition, having looked at the current provision in Northern Ireland, and through experience more widely, it is important to reflect on the need to have commitment and adherence to the principles of Housing First, and to translate this for any current or prospective Housing First service user. In effect this should mean the following:

- If someone refuses or fails to engage with the support, they are not 'struck off', or their tenancy threatened or ended;
- That service users of Housing First have tenants' rights and responsibilities;
- That services users have choice and control in decision-making, and that this enables the rebuilding of trust and self-efficacy around their own journey;
- That the ethos and practice of Housing First delivery is not about 'policing the rules' but more about working with the service user to enable them to get the best out of their tenancy and the support available;
- That the ethos and practice of Housing First delivery is around building strengths and skills, so that the individual's long-term resilience in their tenancy is built up and protected.

Duration and intensity of support

The overall success of the proposed model will be around enabling service users to maintain their tenancy as a result of the right timing and level of support, whilst over time potentially reducing the intensity of support, thus enabling service users to become fully independent[265], if that is possible within their support needs. The model recognises that some individuals will remain in the Housing First service for their lifetime, whilst others will develop the skills and capacity to live more

[264] PIE – Psychologically Informed Environments.

[265] Note – terminology of maximising independence and wellbeing is often used. Research evidence suggests that full independent or graduation from Housing First is relatively infrequent in practice. Success is defined as housed, stable and engaged with the right support, in many European jurisdictions.

independently with Floating support. No throughput level or resettlement rate is set for Housing First, as in a sense this defeats the ethos of the model.

The model, based on a caseload of typically up to five service users per support worker, enables the staff member to provide different levels of support to service users as they come into the service. For example, based on the chaotic nature of chronic homelessness, the model would provide intensive (usually daily, and in some cases multiple times per day) support at the outset (and this period could vary from weeks to months to years), with support then reducing over time.

The Housing First model holds the expectation that support will taper off as service users are linked into other networks, activities and services and are better able to maintain their own tenancy. However, there is no predictive or established timescale in which this tapering off occurs; each individual service users' needs are different and different responses are necessary. It is acknowledged that the level and intensity of support may need to vary for certain groups of service users e.g. for young care leavers. In addition, there is acknowledgement that even in cases which appear to produce enduring tenancy sustainment, the vulnerability of the client group means that service users often need increased support at different times.

The proposed model incorporates the opportunity for support to increase or decrease as required, in response to a person's fluctuating needs and/or sudden or extreme incidents or issues. As noted earlier no service user should feel 'rushed' out of the Housing First service, and cases should remain steady or dormant for a period of time before being closed off. The rationale behind this is to ensure that the service user really is ready and able to sustain their own tenancy and maintain their independence. This phased route out of Housing First should also include an option of one-off crisis intervention for any cases which encounter a specific crisis after being steady for a period of time (enduring support referenced above). Life after Housing First should not be a complete cut-off from support. Two main approaches are recommended, and both of these could be relevant in different areas/types of Housing First. Firstly, the provider (Complex Lives or the Housing provider) could provide a low-level support even when the case is closed[266]. Or secondly, when a case is closed from Housing First it could be passed to a Floating Support service for ongoing support (within the parameters of Supporting People – time limited up to two years and 'low level' support of in or around 2.5 hours per person per week). However, this latter provision is time-bound and may not cover situations where the individual's needs fluctuate and the tenancy is in danger of ending.

[266] Critical Time intervention (CTI) is designed to work on this basis. https://www.criticaltime.org/cti-model/

Duration of support

As noted earlier the duration of Housing First support differs for all service users. The Liverpool study provided the following estimate of the proportions of Housing First service users who receive services for different periods of time. These are as follows:

Different outcomes for Housing First service users	Estimated % of service users	Average time in receipt of Housing First
People who withdraw from Housing First services	20%	9 months
People who move out of needing intensive Housing First, but may need some ongoing support	20%	5 years
People whose health deteriorates and need to move into health/care facility or they pass away	10%	3 years
People who continue to need the full Housing First support provided	50%	10 years

These assumptions were based on the results of the largest UK evaluation of Housing First (at the time of the Liverpool study), which was of the Depaul Housing First service in Northern Ireland.[267] Based on these assumptions in practice the numbers of Housing First arrangements will be reduced year-on-year by the different circumstances identified above. The average time in receipt of Housing First results in the following reductions:

- 20% reduction at end of Year 1
- Further 10% reduction at end of Year 3
- Further 20% reduction at end of Year 5

These figures and reductions will vary as more service users are added into the front-end of Housing First – with new places provided and tenancies secured.

Workforce development

The proposed expansion of Housing First across Northern Ireland will require a shift in how providers and Complex Lives deliver this model. This will undoubtedly require a targeted focus on skills identification and development in line with the proposed service and team structures, as well as the possibility of the NIHE developing a framework of viable and suitable potential Housing First providers to respond to the expansion. The original model, and the North-Western European and Nordic implementation of Housing First frequently use social workers for the support team, and this approach should be considered within the Northern Ireland model.

In terms of housing support workers this will require a movement away from the traditional hostel model of delivery to new Housing First services, with a key focus on workforce development. This may include introducing and supporting a workforce development and skills programme, with

[267] Boyle, F. and Palmer, J. with Ahmed, S. (2016) *Efficiency and Effectiveness of the Housing First Support Service piloted by Depaul in Belfast: an SROI evaluation* (2016), NIHE.

training provided in specific Housing First approach skills. This may be done by the NIHE or through a partner in the community/voluntary sector such as Housing Rights and/or Homeless Connect.

Team structure

The proposed team structure for the development and expansion of Housing First in Northern Ireland, irrespective of whether this is done via Complex Lives, individual housing and homeless services providers or a combination of both, is outlined below based on a caseload of 20 people.

Manager

(may be managing other delivery aspects as well as Housing First – costs are assumed within 15% overheads for staffing below)

Team Leader

(specifically for Housing First)

4 Housing Support workers

based on support of 20 service users (caseload of 3 – 8 per worker at any one time)

Mental Health Support

0.3 FTE – to provide mental health/clinical support across 20 service users, and to act as a support mechanism to Housing Support workers

Based on practice elsewhere in the UK and internationally, it is recommended that the team structure also includes the input or services of a dedicated mental health worker and/or addictions support. It is proposed that this role would require a clinical psychologist or other trained therapeutic practitioner, at 0.3 FTE. This could be further reduced to 0.1 FTE (half day a fortnight) if the role was just providing clinical supervision and occasional training for the team. The above structure and inclusion of different roles will differ based on whether the Housing First model is delivered through (a) Complex Lives or (b) homeless/housing providers.

Based on practice in other Housing First services it is recommended that the model includes access to some level of 24/7 support. In the Liverpool model this was managed via a telecare package and a response package[268]. As part of this study we noted that this approach may have moved on over the last 10 years, and we have therefore included a personalisation budget in the costing below. This would enable the provider to 'personalise' the service for individual or groups of service users. In some cases this may be used to provide an out-of-hours phone service, and in other cases it could be used to directly purchase a basic mobile phone handset and package for the service user so that

[268] Telecare package - £5 p/w per service user and response package – 4 hours p/w at £17.46 per hour.

they can contact the appropriate crisis, welfare or safeguarding services. The usage of the NIHE out-of-hours service[269] has increased significantly in the last five years from 754 in 2019 to 11,087 in 2023, and any suggestion that this service could provide out of hours support would need to be considered in detail alongside NIHE.

In addition, the team structure may, in different areas, require another level above manager; this will depend on how big any structure becomes in the one organisation, e.g. if one provider is delivering Housing First to 80 service users the above structure will be multiplied by four. Whilst this will produce 16 Housing Support workers and four team leaders, it may be necessary to include more than one manager – or a senior manager above the manager's role. The overall (for Northern Ireland) and delivery (by provider) team structures would be finalised in a detailed implementation plan, and would depend on whether these are stand-alone services, developed alongside Complex Lives, or latched on to other existing services. A single Belfast service, with regional hubs for expanded delivery (as outlined earlier) would ensure that the service is regional specific, and would curtail difficulties experienced in some English cities where there was no central point of control for different Housing First services across the city.

The idea of the Hub model outlined above, with hubs in different regional locations which then serve a much wider geographical area, is that Housing First in these areas, because of the numbers involved and the availability or lack of availability of services, will be delivered from the best placed organisation in that area, who can draw on their wider current team. For example, in one area this may be delivered through a homeless hostel or service hub, which trains up one or more current staff to deliver the Housing First service, alongside other services such as Floating Support. In another area, Housing First may be delivered through a partnership between the NIHE and the HSC Trust in the area, again utilising and training the most relevant staff with the necessary skills. Delivery through this hub approach should not diminish the quality and fidelity of the model. However, it should be emphasised that since this approach may involve a number of different homeless providers and delivery organisations there is a need to have some level of central support and assurance resource to promote, reflect on and strengthen the model's fidelity. Fidelity is discussed later in this section.

Hours of operation

The Housing First model proposed would include a team operating on a flexible rota Monday to Friday, covering normal working hours with weekend cover at lower levels and emergency only cover at night. Whilst not advocating a full 24/7 type service, stakeholder feedback and learning from other jurisdictions does point to the need to have provision via some sort of system for emergency issues and incidents. The details of this element of the model would need to be considered and refined at regional level, given the geographical areas and rurality of locations outside of Belfast and Derry. Options may include an emergency call system, potentially via a basic telecare system or out-of-hours system or a 24-hour crisis helpline, with help provided at local levels by 'trusted partners' or, as practice has recommended in GB, that emergency cover is part of the

[269] The Out of Hours Homelessness Service was provided by the Regional Emergency Social Work service up until January 2020, then transferring to the NIHE.

core system. It is acknowledged that any emergency call element of Housing First may need to be expanded for certain groups e.g. women experiencing domestic abuse/violence.

Access to housing and types of housing

During the course of this Feasibility study, access to and availability of suitable housing, has perhaps been the most highlighted item, both in terms of being a stumbling block to enabling access to current Housing First provision and in relation to thinking about scaling up and expanding Housing First across Northern Ireland. Affordable and accessible housing is key to Housing First; without this the service is housing support within temporary accommodation provision.

Feedback from the NIHE and other key stakeholders during the study provided opportunities for frank and realistic discussions on how and where any housing will be provided from. A range of potential options were outlined in detail in Section 6. It is worth repeating the following statement from the NIHE, as their considered proposal to ensure a dedicated consistent and reliable housing supply for Housing First:

"Establishing a supply of accommodation that is both suitable and accessible is central to the challenge of developing the Housing First model, and it is envisaged that a range of mechanisms for sourcing properties will be utilised. To this end NIHE have been exploring several potential routes to secure a sufficient and sustainable supply of accommodation to meet demand and varying need and will involve both private rented sector and social sector properties. NIHE is in the process of seeking Departmental approval for a 3-year programme of private rented sector acquisitions by NIHE's Landlord body. Many of these properties are likely to be former NIHE properties that are now available in the private market. These properties could be used to meet a range of supply pressures, where there will be a focus on increasing the temporary accommodation portfolio, and also the opportunity to directly contribute to the Housing First supply. This initiative could also indirectly contribute to Housing First by reducing the overall pressure within the competing priorities across the Homeless sector though the introduction of more choice and more cost-effective options, potentially allowing more flexibility in budget management.

Within the social housing sector, NIHE have been reviewing the existing stock and are seeking to identify void properties that may be in suitable locations and of suitable size for Housing First clients. NIHE are also exploring how these properties may be allocated specifically to Housing First clients, and are in consultation with DfC in relation to establishing a policy variation that would permit, in a limited number of cases, deviation from the normal allocations process for those identified as chronic homeless and eligible for Housing First[270]*. This approach could also be utilised in relation to Housing Association stock, and in a broader sense, NIHE will seek to engage with Housing Associations to identify opportunities to utilise vacant Housing Association stock with a view to maximising the overall supply that exists which will directly or indirectly contribute to the development of the Housing First supply."*

[270] This would be under Rule 84 of the Housing Selection Scheme; this states: The Board of the Housing Executive may, after consultation with the Department of the Environment, make allocations otherwise than in accordance with this Scheme… In particular the Board may, after consultation with the Department, authorise the making of allocations in specific designated 'difficult to let estates', to Applicants who have not applied for housing in that estate. www.nihe.gov.uk/getattachment/b997e1f4-969f-467b-9e91-03f77c1c6ae9/Housing-Selection-Scheme-Rules.pdf

Based on the proposed numbers of Housing First spaces, there is a clear connection to the need to ensure the required appropriate accommodation is in place year on year as Housing First is expanded across Northern Ireland. In addition, we recommend that a minimum requirement is established for Housing First housing which covers housing costs, low risk of fuel poverty, suitable location with access to necessary services including transport and green space etc. and is in the appropriate community location for the service user.

Access to health & social care and mental health services

The proposed model is based on access to mental health services through mainstream services rather than via a specialist mental health team for Housing First. In other words rather than having ACT[271] teams, the proposed model will operate through an Intensive Case Management (ICM) approach – in this case, we are proposing that this is dovetailed to the Complex Lives team which is already in place in the Belfast setting (and Belfast Metropolitan area) but would need to be expanded as Housing First expands, and is delivered via 'trusted partners' in Derry and regionally. The latter may be homeless services/housing providers or other community organisations. We strongly recommend that the proposed model (either via Complex Lives or separately) has the capacity to handle a psychiatric/personality disorder diagnosis and addiction diagnosis simultaneously (dual diagnosis). We have included the role of mental health support in the model; based on a clinical psychologist or other trained therapeutic practitioner, at 0.3 FTE. This could be further reduced to 0.1 FTE (half day a fortnight) if the role was just providing clinical supervision and occasional training for the team.

The focus of the intensive case management team will be to have a team of generalist housing support workers providing intensive support around tenancy management and sustainment, community integration and wider goals (around training, education and employment). This team will also support individuals to access and engage with wider health and social care services including mental health and addiction services (if required); with support workers providing the additional support of 'brokering' or 'navigating' access. Opportunities for fast-tracking or additional access for service users may be an option.

It is worth reflecting on the core elements of the Housing First model and research evidence from existing Housing First projects in England, where this element has resulted in one of the risks to successful delivery of the service and outcomes for the service user. In summary, this part of the service will result in Housing Support Workers spending considerable time advocating on behalf of the service user, trying to initiate multi-disciplinary team meetings and approaches in an ongoing and repeated manner (if a case gets closed) in order to achieve the care and ongoing support required for sustained engagement and tenancy sustainability.

Lived experience engagement

One of the tests within the Fidelity scale is around service array and includes reference to the engagement of peer activity within a Housing First service. Section 7 outlined service users' views on Housing First, with an emphasis on their lived experience, and how this can assist in service development and delivery. Wider international practice on fidelity, highlighted in Section 8, pointed

[271] Assertive Community Treatment teams specifically for Housing First.

to the input of lived experience into the implementation and delivery of Housing First, within good practice guidance.

The Homelessness Strategy[272] highlights the importance of lived experience in the development and evaluation of current and future services. The proposed development of a Homelessness Lived Experience programme, aligned to the Homelessness Strategy, may provide an opportunity and funding for co-production in this way around Housing First. Examples across other jurisdictions point to the importance of co-production and inclusion of those with lived experience. The Greater Manchester Housing First service includes a co-production panel which meets monthly to include feedback from Housing First service users[273].

Fidelity of the model

Section 8 provided insight to the question of fidelity to the Housing First model and principles and examples of systems developed in other UK jurisdictions to promote/protect this including accreditation schemes. The research team confirmed that services with high fidelity to the principles achieve better outcomes for service users, and ensure the most effective use of resources. Whilst recognising the potential for model drift, discussion with the Research Advisory Group concluded that it would not be helpful to incorporate a full-blown fidelity accreditation system into any planned Housing First expansion at this point, albeit that some level of checks and balances should be put in place by the funder (Supporting People) to monitor the integrity of the service. The need for this was highlighted earlier, in particular if a number of providers are contracted across Northern Ireland to deliver Housing First.

Costing the Model

All of the cost components were obtained from a range of sources including Supporting People and Housing First providers, and used to build a projected overall cost for the proposed Housing First model, based on the operating model of 20 service users per core staff team, and taking into account the staffing structure and costs relating to the Liverpool study. This is outlined overleaf.

[272] *Ending Homelessness Together,* Homelessness Strategy 2022 – 2027, NIHE.
Ending Homelessness Together Homelessness Strategy 2022-27 (nihe.gov.uk)
[273] https://www.gmhousingfirst.org.uk/

Model component	Cost Assumptions	Projected cost per 20 Housing First service users (per annum)
The 'core' Housing First staffing team[274]	Team Leader - £34,300 (£38,800 including oncosts and 3% pension)	£38,800
	Housing Support Workers[275] - £28,400 X 4 = (31,900 including oncosts and 3% pension)	£127,600
	Organisational overheads – taken as 15% of all salary costs[276]	£24,960
2nd tier mental health support – 0.3 FTE	Clinical psychologist/trained therapeutic practitioner[277] - £43,742.00	£13,122.60
Personalisation budget	Based on costs included in the Liverpool study for on call system – at £450 per service user	£9,000.00
Total		**£213,482.60**

It should be noted that any housing costs associated with the provision of social housing would be subsumed by the NIHE; and that there is no additional costing taken, for example for a social lettings function as would be the case in other jurisdictions. In addition, these costings are not specific to Complex Lives, but the same level of staffing and component costs would be required, irrespective of the delivery model. In addition, the research team acknowledge that these costs may need to be weighted or adjusted for different contexts, e.g. living costs in Belfast may require Housing First salaries to be weighted up compared to some other locations. Equally, there may be pressures around recruiting in certain contexts, e.g. recruitment for Housing First in more rural areas. The research team notes that Housing First projects need to be able to offer a salary level that can attract and retain people with the right mix of qualifications and experience to work effectively as team members.

[274] Costings used – Depaul and SCNI salary scales (2024), and work undertaken by the Research team (2024)
[275] Depaul noted £23,683.02. SCNI noted salary scale of £22,869 to £25,059 for Specialist Support worker. In addition, work undertaken by the Research team (2024) based on the Liverpool study and current Housing First provision in Great Britain.
[276] To include costs of Manager and Senior Management.
[277] Costing based on Practitioner Psychologist Band 7, £43,742.00 - £50,056.00.

Review and evaluation

Progress towards the further development of Housing First in Northern Ireland and expansion into other geographical areas and with different types of service users, and the desire to include input from service users with lived experience through co-production, points to the need to have a clear and robust review and evaluation system in place.

The research team suggests the inclusion of a formative evaluation throughout the proposed expansion period for Housing First services, rather than a summative evaluation at the end of the delivery period, in order to capture all aspects of project delivery and impact, and to feed back into project delivery. A formative evaluation is primarily viewed as an evaluation that commences at the outset of project delivery, and then feeds into the project development on an ongoing basis throughout the project's delivery timescale. *A formative evaluation is an evaluation that occurs during the development of the programme. Formative evaluations can help improve and enhance the programme as it is developing or occurring. Data from formative evaluations can be used to make changes in programme delivery or methods*[278]. In contrast a summative evaluation usually *concentrates on assessing the effects and effectiveness of the programme*[279].
We suggest that the evaluation should focus on impact, fidelity to the principles/process or implementation learning, cost benefit analysis, and should include lived experience voice.

Another key focus of any ongoing review needs to be an examination, as people move out of hostels and into Housing First, of the opportunity to reconfigure any existing hostels and/or the closure of any specific hostels or types of provision. Factors such as occupancy/voids, reduced levels of referrals, reduced uptake as service users indicate a preference for Housing First, should all be taken into account in longer-term planning.

[278] What is a formative evaluation? – Evaluation (extension.org)
[279] From *Real World Research,* 4th Edition, Colin Robson & Kieran McCartan, 2015, ISBN: 978-1-118-74523-6

Appendix 1 Oversight of Feasibility Study

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RAG Members

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- Kieran Devlin Department for Communities
- Debbie Sharpe Department of Health
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- Kirsten Hewitt Simon Community NI
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- Loma Wilson Radius Housing
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Appendix 2 Research Methodology

The research methods were developed incorporating the requirements outlined above and covered four broad areas.

Stage 1 comprised a desk-based review and comparative analysis of literature on Housing First in England (evidence from Liverpool, London, Manchester, Newcastle, Oxford and rural areas), Scotland, Wales, Denmark and Finland – with a particular focus on areas of similar geographical size and housing markets. This geographical comparative analysis was reviewed by the RAG in June 2023.

The experiences of Housing First in Northern Ireland and the results of the recent strategic review of Housing First and wider homelessness policy in the Republic of Ireland[280] were also included in this stage. This analysis also outlined literature around a range of factors including the building blocks of Housing First, the precursors for provision (resources, funding, policy considerations), the need for strategic integration, the variation in delivery models, comparative costs with existing service delivery for clients experiencing chronic homelessness, additional client groups of women and young people services, analysis of outcomes with and without Housing First, and best practice.

Stage 2 of the feasibility study provided a review of quantitative data from a range of sources including the HE (operational data from Supporting People and Homeless Services, the House Price Index and Rental Index (HE)) as well as data, reports and information from other organisations and Government Departments (DfC, DoH, DoJ etc.) and from the Housing First providers (Depaul and Simon Community NI). The key focus of this stage was to extract and analyse data, producing an evidence base about the potential client group for a Housing First service/programme of integrated services and secondly the necessary building blocks of putting a Housing First service together.

Collection, collation and analysis of data included the following:

<u>Analysis of the current situation and potential client group</u>

- Production of policy context in Northern Ireland;
- Examination of the number of clients that could be targeted by Housing First and estimation of future need, including range of length of time support may be required;
- An analysis of the strengths and weaknesses of the existing temporary accommodation portfolio in relation to client outcomes e.g., length of placement, lack of opportunities to move-on, repeat homelessness etc. building on previous work in the sector[281]
- An analysis of the available data on the success of Depaul's Housing First service and the Simon Community;
- An analysis of the current costs and savings to the public purse.

[280] https://www.focusireland.ie/wp-content/uploads/2022/09/From-Rebuilding-Ireland-to-Housing-for-All_FINALVERSION.pdf

[281] https://www.nihe.gov.uk/getattachment/48f61a4a-780b-47f8-bb0a-f94417c93555/Strategic-Review-of-Temporary-Accommodation.pdf

Analysis of the necessary elements for Housing First

- An analysis of the availability of suitable 1 – 2 bed units;
- An analysis of potential barriers in accessing the private rental sector;
- An analysis of Northern Ireland unique issues that need to be considered e.g., housing/community segregation, opportunities for/barriers to strategic integration.

Stage 3 comprised qualitative interviews with three distinct groups of key informants as follows. This stage was completed between June and September 2023. The research tools (interview schedules and topic guides) are included in Appendix 6 (Key informants and providers) and Appendix 7 (Service user voice). The list of key informants and providers is listed in Appendix 5.

- Government stakeholders/key informants: A total of nine organisations engaged, with 19 respondents;
- Providers and potential partner stakeholders: A total of 12 provider organisations engaged with 30 respondents;
- Current service users: this element focused on the key objective: to examine the role of lived experience in Housing First and its impact on success. Service users were identified directly with a range of providers[282]. A total of 19 service users with lived experience provided feedback, including five Housing First service users and 14 service users defined as chronic homeless by the service provider(s) involved in their accommodation or support, but had not received Housing First services at the time of the study. This element included accessing Housing First, type of provision, experience of support services and outcomes. Quotes from respondents and anonymised case-studies are used throughout.

Stage 4 of the feasibility study will combine the information from stages 1 – 3 to produce a Northern Ireland scale model for Housing First, including information on sizing the cohort for Housing First, staffing, property requirements, timescales and associated costs/VFM. The latter will assess the savings and efficiencies from implementing Housing First[283], including looking at the inter-dependencies with and implications for existing systems, wider services and strategies. In addition, this stage will provide a comparative component of key lessons from other strategic implementation exercises in GB and ROI.

[282] Depaul Housing First Belfast and Derry, Simon Community Housing First for Youth, Queen's Quarter, Damian House (Derry), MACS (Belfast), Catherine House (Belfast), Extern Women's project, Simon Community (Belfast), Foyle Haven (Derry), Ramona House (Omagh) and the Welcome Organisation (Belfast).
[283] With reference to recent work for Homeless Link - https://homelesslink-1b54.kxcdn.com/media/documents/The_cost_effectiveness_of_Housing_First_in_England_2019.pdf

Appendix 3 Summary of the Housing First principles

Principle 1: People have a right to a home

- Housing First prioritises access to housing as quickly as possible;
- Eligibility for housing is not contingent on any conditions but willingness to maintain a tenancy;
- The housing provided is based on suitability (stability, quality, choice, affordability, community integration) not housing type;
- The individual will not lose their housing if they disengage or no longer require support;
- The individual will be given their own tenancy agreement.

Principle 2: Flexible support is provided for as long as it is needed.

- Providers commit to long-term support with no fixed end date - recovery takes time and varies individually;
- The service is designed for flexibility of support with procedures in place for high/low intensity support provision and for cases that are 'dormant';
- Support is provided for individuals to transition away from Housing First if a positive choice;
- The support links with relevant services across sectors to meet the full range of user needs;
- There are clear pathways into and out of Housing First services.

Principle 3: Housing and support are separated.

- Support is available to help maintain tenancies and address needs;
- Housing is not conditional on the individual engaging with support;
- The choices made about their support do not affect people's housing;
- The offer of support stays with the person – if the tenancy fails, the individual is supported to acquire and maintain a new home.

Principle 4: Individuals have choice and control.

- Individuals can choose the type and location of their housing within reason;
- They have the choice, where possible, about where they live;
- They have the option not to engage with other services if there is regular contact with the Housing First team;
- Individuals choose what, where, when and how support is provided by Housing First;
- They are supported through person-centred planning and can shape the support received.

Principle 5: An active engagement approach is used.

- Staff are responsible for proactively engaging and making the service fit the individual;
- Small caseloads allow staff to be persistent and proactive, especially if engagement is low;
- Support is provided for as long as each participant requires it;
- The team continues to engage and support the individual if they lose or leave their home.

Principle 6: The service is based on people's strengths, goals and aspirations.

- Services are underpinned by a philosophy that there is always a possibility for positive change and improved health and wellbeing, relationships and wider integration;
- Individuals are supported to identify their strengths and goals and develop the knowledge and skills they need to achieve them;
- Individuals are supported to develop increased self-esteem, self-worth and confidence, and to integrate into their local community.

Principle 7: A harm reduction approach is used.

- People are supported holistically;
- Staff support those using substances to reduce immediate and ongoing harm;
- Staff aim to support individuals who self-harm to undertake practices which minimise risk
- Staff aim to support individuals to undertake practices that reduce harm and promote recovery in other areas of physical and mental health and wellbeing.

Appendix 4 Homeless presenters and acceptances by age, gender and Council area, 2018/19 to 2022/23[284]

Table 35: Homeless Presenters by age, 2018/19 – 2022/23

Age (years)	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
<18	438	Not provided	188	14	12
18 – 25	3,545		3,945	2,974	2,666
26 – 35	4,863		4,569	4,327	4,369
36 – 45	3,231		2,769	3,105	3,375
46 – 55	2,562		1,990	2,088	2,168
56 – 65	1,749		1,346	1,709	1,733
66 – 75	1,018		699	896	949
Over 75	796		485	645	693
TOTAL	**18,202**	**16,802**	**15,991**	**15,758**	**15,965**

Source: NIHE

Table 36: Homeless Acceptances (FDA) by age, 2018/19 – 2022/23

Age (years)	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
<18	265	96	90	6	4
18 – 25	2,222	2,359	2,252	1,737	1,607
26 – 35	3,208	2,880	2,705	2,648	2,675
36 – 45	2,129	1,873	1,643	1,950	2,128
46 – 55	1,776	1,589	1,305	1,355	1,390
56 – 65	1,316	1,208	966	1,213	1,228
66 – 75	871	713	539	699	735
Over 75	725	605	389	527	582
TOTAL	**12,512**	**11,323**	**9,889**	**10,135**	**10,349**

Source: NIHE

Table 37: Homeless Presenters by gender, 2018/19 – 2022/23

Gender	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
Female	Information not provided		8,396	8,397	8,563
Male			7,595	7,361	7,402
TOTAL	**18,202**	**16,802**	**15,991**	**15,758**	**15,965**

Source: NIHE

[284] Details relate to Head of Household – age and gender.

Table 38: Homeless Acceptances (FDA) by gender, 2018/19 – 2022/23

Gender	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
Female	Information not provided		5,976	6,175	6,335
Male			3,913	3,960	4,014
TOTAL	**12,512**	**11,323**	**9,889**	**10,135**	**10,349**

Source: NIHE

Table 39: Homeless Presenters by Council area, 2018/19 – 2022/23

Council area	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
Antrim & Newtownabbey	1,336	1,201	1,353	1,199	1,341
Ards & North Down	1,565	1,276	1,276	1,228	1,233
Armagh, Banbridge & Craigavon	1,253	1,099	1,144	1,127	1,217
Belfast	5,747	5,270	4,573	4,553	4,433
Causeway Coast & Glen	1,001	949	885	1,064	1,052
Derry City & Strabane	2,079	1,994	2,084	2,049	2,073
Fermanagh & Omagh	672	669	609	563	614
Lisburn & Castlereagh	946	1,034	845	894	875
Mid & East Antrim	1,516	1,427	1,298	1,319	1,296
Mid Ulster	843	669	659	685	749
Newry, Mourne & Down	1,244	1,214	1,265	1,077	1,082
TOTAL	**18,202**	**16,802**	**15,991**	**15,758**	**15,965**

Source: NIHE

Table 40: Homeless Acceptances by Council area, 2018/19 – 2022/23

Council area	YEAR				
	2018/19	2019/20	2020/21	2021/22	2022/23
Antrim & Newtownabbey	1,052	936	952	873	1,012
Ards & North Down	1,156	947	931	880	898
Armagh, Banbridge & Craigavon	790	694	608	606	641
Belfast	3,790	3,325	2,686	2,820	2,683
Causeway Coast & Glen	689	690	579	746	758
Derry City & Strabane	1,315	1,222	1,146	1,212	1,305
Fermanagh & Omagh	467	467	353	366	414
Lisburn & Castlereagh	716	756	552	569	568
Mid & East Antrim	1,088	1,051	928	895	853
Mid Ulster	542	388	362	419	466
Newry, Mourne & Down	907	847	792	749	751
TOTAL	**12,512**	**11,323**	**9,889**	**10,135**	**10,349**

Source: NIHE

Appendix 5 List of respondent organisations – key informants and providers

Key informants: Organisation	Name of interviewee(s)
Department of Health	Debbie Sharpe and Scott Taylor: Mental Capacity Act Unit
	Fiona McCausland: Adult Mental Health Unit
	Michael Harkin and Gary Maxwell: Health Development Policy Branch
Public Health Agency	Kevin Bailey
Department for Communities	Kieran Devlin and Billy Crawford
Department of Justice	Michele Bell
Belfast City Council	Kelly Gilliland
NI Housing Executive	Brian O'Kane, Deborah Reid, Richard Tanswell, Colin McCloy,
	Supporting People: Sinead Twomey
Housing Rights	Brenda Parker
Homeless Connect	Nicola McCrudden
Radius Housing Association	Loma Wilson and Grainne King

Providers: Organisation	Name of interviewee(s)
Simon Community NI	Kirsten Hewitt and Karen McAlister
Depaul	Deirdre Canavan, and Housing First staff members: Pauline Brunty, Dean Austin and Rachel Dunn
Extern	Kate Harrison, Declan Morris, Florence Tron and other staff members (latter submitted email responses)
MACS NI	Amber Northcott, Molly Holebrook and Rachel Bradley
First Housing	Eileen Best
Triangle Housing Association	Lucy Campfield
Queen's Quarter	Hannah Maguire
East Belfast Mission	Aidan Bryne and Tom Dinnen
Complex Lives	Kerry Rogan and Yvonne Hill
Women's Aid (Causeway & Mid Ulster)	Sharon Burnett
The Welcome Organisation	Colleen Hamilton, Susan Duncan and Keelan Thomas Catherine House/Annsgate: Trina Harper
Harmoni	Natalie Timothy

Appendix 6 Themes and questions for interviews and focus groups with key informants and providers

A Understanding the client group

What are the needs of people with complex housing/homelessness and additional needs? Discuss repeat homelessness and chronic homelessness.

What are the pathways of people with complex housing and additional needs? (Probes: referral sources, past engagement with services – patterns and trends, repeat presentation, involvement of other agencies, move on opportunities and barriers)

How do we estimate (a) the number of people with complex housing/additional needs – 'chronic homeless' and (b) the number of people for whom Housing First (HF) might be the best response?

What do providers think is the likely size/nature of the potential 'core' client cohort intended to benefit from the HF model? What is the evidence?

B Understanding the current homelessness provision

Exploration of the current hostel system in Northern Ireland
What is working well at present? What are the gaps and challenges?

Characteristics of those who do well and those who do less well in the current hostel system in Northern Ireland – from a provider perspective (Probes: what is it about the current model of provision that helps or hinders those with more chronic or complex needs – congregate accommodation, time limited, amount and type of support, pathways for additional support?)

Do you think that HF works for Northern Ireland in its current format and delivery model? (Probe: what is good about it, and what are the limitations?)

C Thinking about a HF model

What does all of the above mean for a HF model in Northern Ireland? What are the specific Northern Ireland factors that need to be taken into account?

Evidencing the need for the model:

- outcomes/savings for providers and Govt stakeholders i.e. cashable savings
- outcomes/savings in social return in investment – for service users

Probe – numbers, who should HF target and why, how should intensive support be provided?
Where should HF be positioned geographically? Are there geographical differences that need to be taken into account?

D Component parts of a HF model

What do you think are the component parts that are essential for HF?
To which existing resources, assets, services, initiatives and structures should the proposed HF model link and how?

What else needs to be developed in order to provide HF?
Probe: housing, housing support, health (physical and mental health), addictions, police service, justice?

Appendix 7 Interview schedule – Interviews with service users

Your story

1. Tell us how you became homeless. What were the things that led to your current situation?

2. What has been the biggest hurdle/barrier so far, in terms of accessing homelessness services and access to a home?

3. How are things for you now?

Your views about services/Housing First

4. What have been your experiences of homelessness services?

5. How do you view homelessness services?

6. What has been/would be helpful in relation to these services?

7. What has not been helpful?

8. What other services or support do you currently need/have previously needed in order to maintain your accommodation? Explore health services, addiction services, probation services etc.

Interviewer to explain the Housing First model: Housing First provides an individual, who has been homeless over a period of time and has additional needs (reference made to definition of chronic homelessness) with their own accommodation/own front door in the community (not in a hostel setting) with the support (description of different types of support for different needs) that they need to live independently.

9. Could this work for you? Could this work for other people?

10. What would need to happen to make it work?

11. What would you need to make it work for you (now or in the past?)

12. (For those who have used HF) Can you compare HF to your other experiences of homelessness services?