# National Housing First Implementation Evaluation Findings Prepared for the National Housing First Implementation Committee

**Technical Report** · November 2022

DOI: 10.13140/RG.2.2.13376.20482



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# National Housing First Implementation Evaluation Findings

**Prepared for the National Housing First Implementation Committee**
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# List of Abbreviations

| | |
|---|---|
| A&E | Accident and Emergency |
| ACT | Assertive Community Treatment |
| AHB | Approved Housing Bodies |
| AOD | Alcohol or Other Drugs |
| CSI | Colorado Symptom Index |
| GAIN | Global Appraisal of Individual Needs |
| GDPR | General Data Protection Regulation |
| GP | General Practitioner |
| HAT | Homeless Action Team |
| HF | Housing First |
| HSE | Health Service Executive |
| ICM | Intensive Case Management |
| LA | Local Authority |
| LTA | Long Term Accommodation |
| MDT | Multi-Disciplinary Team |
| MH | Mental Health |
| MHS | Mental Health Services |
| NGO | Non-governmental organization |
| NHFIE | National HF Implementation Evaluation |
| OT | Occupational Therapy |
| PASS | Pathway Accommodation and Support System |
| PEA | Private Emergency Accommodation |
| PHF | Pathways Housing First |
| PTSD | Post-Traumatic Stress Disorder |
| QoL | Quality of Life |
| RAS | Recovery Assessment Scale |
| STA | Supported Temporary Accommodation |
| TAU | Treatment as Usual |
| TEA | Temporary Emergency Accommodation |

# Executive Summary

HF (HF) is an evidence-based approach to providing housing, services, and supports to adults with substantial histories of living in homeless situations and who have complex health and social needs. It is a "streets to homes" programme that provides independent, scatter-site accommodation integrated into the community for adults who have spent much of their lives cycling through rough sleeping, emergency accommodation, hospitals, and prisons. Clients live in normal tenancies with standard tenancy agreements. HF was developed in New York City by Dr Sam Tsemberis, who introduced the first programme, "Pathways to Housing" in 1992. Since then, HF has been disseminated and adopted in North America, Europe, Brazil, Australia, and New Zealand. HF programmes show high housing retention rates that consistently average 85%, significantly higher than traditional congregate, 'staircase' approaches to homeless accommodation (Padgett, Henwood, & Tsemberis, 2016). Based on international evidence for the effectiveness of HF, it was introduced to Dublin in 2011 with the Dublin HF Demonstration.

*Housing for All – A New Housing Plan for Ireland* is the Government's plan for addressing housing needs and homelessness through the year 2030. For people experiencing homelessness, the plan specified: 1) a target of 1200 occupancies, which was later increased to 1319 (but not limited to that number), to be established over five years, 2) a new National Homeless Action Committee, and 3) personalised, Integrated Healthcare (Department of Housing, Local Government, and Heritage, 2021). This evaluation report describes the findings from the National HF Implementation Evaluation (NHFIE), a two-year, nationwide assessment of HF programmes in all nine HF regions. The evaluation assessed the effectiveness of interagency coordination of homeless NGOs with local authorities and the HSE to deliver housing and supports to individuals with substantial histories of homelessness who also have complex support needs.

The findings in this report represent a point in time during the initialisation of new HF programmes across the country. They provide insight into the opportunities, challenges, and achievements of stakeholders who innovated HF programmes in urban, suburban, and rural areas. Although the approach taken varied depending on the local context, all programmes were responsible for delivering housing and supports to the target population. Tenancy targets were set with reference to homeless administration regions. Across the nine regions, HF programmes exceeded the tenancy target for the pilot timeframe by 14%. Housing retention rates for this pilot match or exceed internationally reported rates from North America and other countries in the European Union. Overall, this evaluation found robust evidence that without exception, HF programmes across Ireland are housing members of the target population, keeping them housed, and supporting them on their journeys to recovery and well-being.

Data for the evaluation were collected between April 2020 and December 2021. The evaluation activities consisted of interviews, focus groups, and questionnaires with HF team members, programme managers, and stakeholders from NGOs, Local Authorities, and the Health Services Executive. In total, the team conducted 77 interviews and focus groups with providers and stakeholders and obtained 50 fidelity self-assessments and 180 provider assessments from HF team members. The evaluation team completed 143 questionnaires and 25 interviews with HF clients. Virtually all data were collected remotely by phone or online via meeting platforms due to the Covid-19 pandemic and physical distancing that co-occurred with the evaluation. The evaluation team wishes to acknowledge the huge time contributions of HF clients, team members, and stakeholders across all the regions. We are grateful for their contributions and, because of the significant buy-in to the evaluation we experienced across all the regions, we are confident that our findings represent HF operations and achievements at this point in time. We offer ten key findings and ten key recommendations from what we learned from the evaluation activities.

**Ten Key Findings**

1. HF programmes are housing the priority population. Individuals in HF tenancies have substantial histories of rough sleeping and emergency accommodation use. On average, HF clients have lived 9.66 years in homeless situations. Of those sampled, 65% of HF clients reported having at least one mental health problem, and 47.9% reported that they had been hospitalised for psychiatric reasons on at least one occasion. Case managers reported that almost half (48.3%) of their clients regularly used alcohol and/or other substances.
2. HF programmes are achieving their targets. Across the regions, HF programmes demonstrated an impressive housing and tenancy retention rate. The target number of tenancies for the pilot period was 663, and 756, or 114% of the target, was achieved.
3. HF clients are staying housed. Data from provider assessments indicate that 88.9% of clients were in their first HF tenancy, and only 11% (12 persons) had moved tenancies for any reason, including choice, inpatient residential treatment, incarceration, or tenancy loss.
4. Successful interagency coordination has yielded effective processes for delivering HF. These include procedures for identifying, nominating, and enrolling members of the priority HF population and for sourcing accommodation, setting up new homes, and putting appropriate supports in place to sustain their tenancies and link in with community resources.
5. In general, HF clients have access to general practitioners in the community and their physical health care needs are being met. Substance use treatment is also mostly accessible to HF clients. Access to treatment for dual mental health and substance use diagnoses, and for mental health needs that do not qualify for community mental health services is more variable. Clients who live in urban areas, who are engaged with multidisciplinary HF teams or with teams with extensive in-house supports have easier access to these services than clients living in other types of locations.
6. There are five key dimensions of fidelity to the HF model of homeless service delivery, and across the regions, HF programmes demonstrated a high level of fidelity on every dimension. This means that HF programmes provide housing that matches clients' needs, services that match clients' needs, that their approach to case management is client-led and recovery-oriented, and their programme operations closely map onto the operations of a well-functioning HF programme. Fidelity scores observed in the NHFIE were higher than Irish and European averages reported in a multi-country study of HF fidelity (Aubry, Bernad, & Greenwood, 2018).
7. Clients' self-reports of community integration, quality of life, achieved capabilities, rates of psychiatric symptoms, and harm-related substance use are similar to those reported in research and evaluation studies with other HF samples, and indicate better functioning in these domains compared to previous reports from samples of adults engaged with traditional staircase of transition homeless services.
8. Overall, HF clients report a high level of satisfaction with their housing and the supports they receive from their case managers. To the extent possible, given the constraints of physical distancing and the Covid-19 pandemic, from the secure platform of their own home, HF clients engage in personally meaningful, purposive activities, repair relationships with family, and have strong personal development aspirations in areas of health, meaningful occupation, hobbies, and leisure. Many clients aspire to further education and training, and HF was seen as the beginning of a 'new chapter' for many.
9. HF programmes' successes in housing highly visible rough sleepers who are well-known in their communities have mobilized broader community support from, for example, Gardaí and local councillors, who have observed first-hand how the model can end chronic homelessness.
10. Taken together, the findings from this evaluation indicate that across the nine regions, HF programmes are housing individuals who have spent significant portions of their lives homeless and

on society's margins. Case managers support them to successfully maintain their tenancies and embark on recovery journeys toward secure, healthier futures.

Based on evidence obtained from clients, team members, managers, and stakeholders, we offer the following ten recommendations for the future development and expansion of HF across the regions. These recommendations arise from an overall appraisal of a highly successful and remarkable, cutting-edge and innovative approach to nationally coordinated implementations of regional HF programmes that can serve as a model for effectively implementing HF in other national contexts with histories of seemingly intractable, yet solvable, chronic homelessness.

**Ten Key Recommendations**

1. Sustain and strengthen commitment to HF at local, regional, and national levels.
2. Address gaps in housing unit availability with flexible guidelines tailored to regional contexts.
3. Develop standardised procedures for HF eligibility, nominations, and intake.
4. Increase availability of specialist supports and supports to increase social integration and access to education, employment, and other meaningful occupation to HF clients.
5. Deliver training to professionals in the needs of clients with significant histories of homelessness.
6. Increase availability and accessibility of treatment for dual diagnoses.
7. Resource and increase HF clients' involvement in programme operations and strengthen the role of experts with lived experience in services.
8. Reassess staffing and resource needs of HF programmes in geographically dispersed regions.
9. Investigate and address sources of high case manager turnover in HF teams.
10. Implement a schedule of routine HF fidelity assessments in each region.

# National Housing First Implementation Evaluation:

# Final Report

## 1. Overview and Introduction

Housing First (HF) is an evidence-based approach to providing housing, services, and supports to adults with substantial histories of homelessness and complex health and social needs. It is a "streets to homes" programme that provides independent, scatter-site accommodation integrated into the community for adults who have spent much of their lives cycling through rough sleeping, emergency accommodation, and other institutional settings. Clients live in normal tenancies with standard tenancy agreements. Choice over housing and services is paramount in HF, so clients have choice over housing type and location, to the fullest extent possible given local availability of affordable housing. HF is not 'housing only', however. Clients are intensively supported by a case management team to sustain their tenancies and live independently in their communities. A HF team may be multidisciplinary and provide supports to clients directly in their homes, they may broker community-based services for clients, or they may use a blended approach. Table 1.1. displays the five key HF principles. The only requirements in HF are that clients abide by the rules of a standard tenancy agreement and meet regularly with a member of the HF team, usually their case manager. In the early stages of a tenancy, visits may occur daily, but the frequency will decrease as the client becomes comfortable and confident in their new home.

**Table 1.1. Housing First Key Principles**

| |
|---|
| **1. Consumer Choice** |
| **2. Separation of Housing & Services** |
| **3. Matching Services to Client Needs** |
| **4. Recovery-Focused Services** |
| **5. Social Inclusion & Scattered-site Housing** |

In HF programmes clients determine the order, frequency, intensity, and duration of the services and supports they receive. Case managers work with clients to identify and pursue their rehabilitation-focused and growth-focused goals. Examples of rehabilitation goals include reduced harm from symptoms of mental illness or from substance use, recovery from trauma or from physical illness. Examples of growth-related goals include reconnecting with family and friends, integrating into the community, developing new interests, identities, and activities, all of which support the person to move beyond their past experiences of homelessness.

The evidence base for HF is robust and consistently demonstrates -- across a diverse range of contexts and clients' needs -- that HF gets people housed faster and keeps them housed longer compared to staircase approaches to homeless services (see e.g., Aubry et al., 2016; Greenwood et al., 2020; Stefancic et al., 2007; Tsemberis et al., 2004). HF is also associated with lower rates of costly emergency services (Gulcur et al., 2003; Ly et al., 2015; Tsemberis, 2010). Although findings vary across studies, evidence from rigorous evaluations of HF programmes conducted in the United States, Canada, and Europe, including Ireland, demonstrate that HF is associated with better community functioning and quality of life, achieved capabilities, fewer psychiatric symptoms, and less harm-related substance use (Aubry et al., 2015; Greenwood et al., 2005; Greenwood, Manning et al., 2020a; Greenwood, et al., 2022). In sum, HF is a cost-effective strategy that ends homelessness instead of simply managing it, and it promotes both rehabilitation- and growth-related recovery through choice-driven, client-led, individualised, community-based supports.

Because of its evidence base for ending long-term homelessness, HF was introduced into Ireland in 2011 with a demonstration project overseen by the Dublin Regional Homeless Executive (DRHE). A key finding from the Dublin demonstration evaluation was that for the duration of the project, participants engaged with HF spent more time in stable housing than the participants in the comparison group did (Greenwood, 2015). The demonstration project ended in 2014, and building on its foundation, the Dublin HF programme was tendered to a collaboration between Peter McVerry Trust and Focus Ireland. By March 2019, this Dublin region HF programme had provided more than 300 tenancies and reported a tenancy sustainment rate of 86.8% (Peter McVerry Trust, n.d.).

In 2018, a National HF Implementation Plan was announced. The plan's objective was to deliver permanent housing solutions and associated supports for rough sleepers and long-term users of emergency accommodation in all nine regions in Ireland. The Plan contained individualised targets for each local authority, with an overall national target of 663 tenancies to be delivered by 2021. By December 2021, the overall tenancies established exceeded the target number specified in the original Plan.

Implementation of the Plan was a joint initiative of the Department of Housing, Local Government and Heritage, the Department of Health, the HSE, the local authorities, and homeless NGOs. This implementation was supported by Genio as part of the Service Reform Fund. HF programmes are now active in all regions in the country. Each region developed its own approach to sourcing housing, coordinating services, and supporting clients in their newly established homes. Although each region developed an individualised plan to implement HF, each was responsible for adhering to the core principles, practices, and values of HF and to deliver the programme with a high degree of fidelity to the Pathways HF model.

# 2. Methods & Respondents

In this section, we describe our evaluation protocol, recruitment and data collection procedures, and the individuals who participated in the evaluation. Beginning in January 2020, the lead evaluator worked closely with the HF Implementation Committee to develop a protocol for the evaluation and ensure that process and outcome measures were robust and would yield trustworthy information about the implementation, coordination, and delivery of HF within each region. The process component focused on implementation, interagency coordination, access to housing and supports, and fidelity to the Pathways HF model. The outcomes component focused on clients' experiences of the HF programme, access to needed community services and treatment, and health and well-being indicators. It also included measures of clients' characteristics so that we could describe their histories of homelessness, their physical health, mental health, and their substance use support and treatment needs.

After the protocol was agreed, ethical approval was obtained from the Faculty of Education and Health Sciences Research Ethics Committee (EHS REC) at University of Limerick, where the research team is based. Because of the Covid-19 pandemic, all data for the process component were collected online, and virtually all data collected from clients were collected over the phone. Every respondent received information sheets and informed consent forms that described the purpose of the evaluation and risks and benefits of participating. At the beginning of every interview, focus group, and questionnaire administration, participants were given a summary description of the purpose of the evaluation, what was being asked of them, their rights in relation to participating in the evaluation, and our procedures for protecting personal data and confidentiality. Participants were reminded that this was an externally funded evaluation conducted independent of their organisation, that their participation was voluntary, and their employment, role, or services would not be affected by their choice to participate. We assured participants we would, to the fullest extent possible, hold their contributions in confidence and that we would never link their identities to their responses. Participants were also asked to keep in mind the context of close working relationships within a small community of individuals delivering and receiving HF services across Ireland, which rendered anonymity impossible, and participants were asked to bear this in mind when considering whether and how to respond to our questions.

**Evaluation Components**

*Programme Implementation & Inter-agency Coordination (Work packages 1 & 2)*. Data collection commenced in May 2020 with an exploration of programme implementation and inter-agency coordination within each region. We aimed to interview a representative from each local authority, the partner NGO, and the HSE in each region. In the regions where we were unable to obtain these initial individual interviews (Dublin, Mideast, Northeast, and Midlands), we conducted focus groups composed of stakeholders, team managers, and team members at the very end of the data collection period, which facilitated a complete representation of all regions in the evaluation. In total, we completed 77 interviews and focus groups with team members, managers, and stakeholders (See Table 2.1).

Our goal for this component of the evaluation was to learn about housing, intake, and supports: How HF programmes in each region developed their intake and eligibility procedures, how they sourced and allocated housing, and how they worked together with other community-based services to meet their clients' needs. We asked respondents to describe the facilitators and blocks they experienced in accessing housing and services in their regions. Findings from this component of the evaluation are described in Section 3.

**Table 2.1. Provider & Stakeholder Interviews and Focus Groups by Region**

| | Dublin | Mideast | Midlands | Midwest | Northeast | Northwest | Southeast | Southwest | West | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Implementation & Coordination Interviews -- Early | 1 | 2 | 3 | 7 | 2 | 3 | 6 | 9 | 7 | 40 |
| Fidelity Consensualization Meetings | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 9 |
| Fidelity Stakeholder Focus Groups | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 8 |
| Implementation & Coordination Interviews & focus groups - later | 4 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 3 | 20 |
| Totals | 6 | 6 | 7 | 10 | 6 | 7 | 10 | 13 | 12 | 77 |

*Pathways HF Fidelity Assessments (Work Package 3).* Data collection commenced in November 2020. Members of each HF team in all regions were invited to complete a fidelity self-assessment tool (Stefancic et al., 2013; see Tsemberis, 2020) individually and then participate in a focus group together to discuss and agree scores for each fidelity indicator. After the team focus group, another focus group was arranged with key stakeholders in each region. The purpose of the stakeholder focus groups was to discuss the scores in each of the five fidelity domains to identify blocks and facilitators to programme fidelity in their region.

The fidelity self-assessment tool consists of 41 items that represent the five key domains of HF fidelity: 1) Housing to Match Clients' Needs, 2) Services to Match Clients' Needs, 3) Separation of Housing and Services, 4) Recovery-oriented Approach, and 5) Programme Operations (See Tsemberis, 2020). We conducted three focus groups with Dublin-based HF teams, and one focus group representing the Mideast, Midlands, and Northeast, because at that time one team was operating across those three regions, and one focus group each with teams in Limerick, Cork, Galway, Southeast, and Northwest. Table 2.2 shows participants from each region.

In 2018, Aubry, Greenwood, and Bernad published a study of HF programme fidelity in 10 countries including Ireland. Although the original version of the Stefancic (2013) measure was used in the multi-country study, we are still able to benchmark findings from this evaluation against them in the relevant subsequent sections of this report.

**Table 2.2. Data Collection Activities for Fidelity Assessments**

| Region | Self-assessments Number completed | Team Focus Groups Focus groups/Participants | Stakeholder Focus groups NGO |
|---|---|---|---|
| Limerick | 4 | 1 FG/4P[1] | 1 FG/4P |
| Cork | 7 | 1/4P | 1/4P |
| Northwest | 6 | 1/5P | 1/5P |
| Galway | 6 | 1/4P | 1/5P |
| Dublin | 17 | 3/6P; 4P; 2P | 0 |
| Southeast | 6 | 2/2P; 3P | 1/4P |
| NE, Midlands, ME | 4 | 1/2P | 1/2P |
| Total | 50 | 10/36P | 6FG/24P |

[1]P = number of participants, e.g., 1 FG of 4 participants

## Clients' Characteristics, Support Needs, and Experiences

Data collection consisted of both a quantitative, questionnaire-based component and a qualitative, interview-based component. The evaluation team and National HF implementation committee worked

together to identify the key domains of clients' health and well-being that should be included in the questionnaire. Where possible, we included measures that had been used in earlier HF evaluations so that previously published findings could serve as benchmarks against which we could assess our results. We organised these indicators into two components: a clients' self-report questionnaire that the team administered individually with each participant, and a providers' assessment questionnaire, which HF team members were asked to complete on clients' behalf, with their consent. The full list of measures included in these two questionnaires is presented in Table 2.3.

**Table 2.3. Measures: Clients' Self-Report and Provider Assessments**

| **Provider Assessment Questionnaire** |
|---|
| Psychosocial Toolkit |
| Physical Health Conditions |
| Residential History |
| Access and Barriers to Services |
| **Client Self-report Questionnaire** |
| Recovery Assessment Scale |
| Community Integration |
| Colorado Symptom Index |
| Global Assessment of Individual Need (GAIN) Problem-related alcohol and drug use subscale |
| Perceived Housing Quality |
| Consumer Choice |
| Physical Health-related Problems |
| General Health Measure |
| Quality of Life |
| Mastery |
| Working Alliance |
| Core Service Satisfaction Scale |

*Clients' self-reports.* HF team members served as gatekeepers between the evaluation team and clients in each region. Our standard protocol for questionnaire administration in research with HF clients is for case managers to simply ask clients' permission for us to contact them and invite them to participate. If the client gives permission, then our next step is to contact them, describe the evaluation to them, and, if they agree to meet with us, we arrange a time and place in a location of their choice, usually their home. When we meet them, we follow a standardised procedure to obtain voluntary informed consent, read each questionnaire item to participants, and record their responses. However, data collection for this evaluation component commenced in November 2020, which co-occurred with a surge in the Covid-19 pandemic. We had already delayed data collection with clients in hope that infections would subside, and we would be able to follow our standard procedures. As cases surged, we realised we would need to develop a protocol for phone-based data collection. This posed an additional challenge for us because we needed to document written informed consent from participants, which was not possible over the phone. Our only viable option was to ask case managers to do the work of explaining the evaluation to their clients and obtain informed consent for us. This change required meetings with team members and programme managers in all regions to explain our revised recruitment protocol. We arranged virtual meetings with teams in every region to enlist their support. Fortunately, team members in every region agreed to support

us with this work, and we are grateful for their important contribution to this component of the evaluation.

When we the evaluation team received a clients' signed consent form, a research assistant contacted them to arrange a time to complete the questionnaire by phone. On average, research assistants made approximately three attempts to contact clients, and they completed the questionnaire over several phone sessions when required. At the end of the data collection period, in November and December 2021, the evaluation team had an opportunity to increase the number of participating clients from the Dublin, Mideast, Midlands, and Northeast regions by travelling to those regions and administering questionnaires in person. Thus, while most questionnaires were administered by phone, some were administered face-to-face. As of December 2021, 680 individuals were engaged with HF services across the nine regions. For the National HF Implementation Evaluation (NHFIE), 143 HF clients completed self-assessments, representing 21% of the total number of HF clients. A breakdown by region is presented in Table 2.4

**Table 2.4. Completed Clients' Self-Reports by Region**

| Region | Dublin | ME | Mid-lands | MW | NE | NW | SE | SW | West | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| # Respondents | 70 | 12 | 9 | 13 | 8 | 6 | 13 | 8 | 4 | 143 |
| Client total Dec 2021 | 400 | 45 | 21 | 23 | 30 | 23 | 71 | 37 | 30 | 680 |
| % Representation | 17.5 | 26.6 | 42.8 | 56.5 | 26.6 | 26 | 18.3 | 21.6 | 13.3 | 21.0 |

*Provider Assessments.* The provider assessment questionnaire consisted mostly of the *Toolkit for Measuring Psychosocial Outcomes* (The Research Committee of the International Association of Psychosocial Rehabilitation Services, 1995). Additional measures were constructed for this study to assess clients' health care needs, access, and barriers to needed health and community services (See Table 2.3). Case managers were asked to complete a provider assessment for each of their clients who completed a self-report questionnaire. The provider assessments were programmed into Qualtrics, a GDPR-compliant platform for survey administration. The link was shared with case managers in each region so that they could directly enter their responses for each participant online. We also created a Word document version of the instrument and sent them by post and email attachment to team members who preferred that format for completing the assessments. As mentioned above, to protect personal data, we created a unique ID for each client that we could use to track completion of provider assessments and ultimately link clients' self-report data to the provider assessment data. Table 2.5 presents the number of provider assessments collected by region.

**Table 2.5 Completed Provider Assessments by Region**

| Region | Dublin | ME | Midlands | MW | NE | NW | SE | SW | West | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| # Respondents | 62 | 31 | 11 | 13 | 14 | 12 | 23 | 8 | 6 | 180 |
| Client total Dec 2021 | 400 | 45 | 21 | 23 | 30 | 23 | 71 | 37 | 30 | 680 |
| % Representation | 15.5 | 68.9 | 52.3 | 56.5 | 46.7 | 52.2 | 32.4 | 21.6 | 20.0 | 26.5 |

*Interviews with Clients.* Two waves of interviews with HF clients were conducted. Case managers and research assistants who completed questionnaires with HF clients were asked to nominate clients who they believed would engage well with the content of the interview over the telephone. The first wave of interviews was conducted with 15 clients. For this group of interviews, the evaluation team worked with the National HF Implementation Committee to develop an interview guide designed to gain insight into clients' subjective appraisals of their experiences of independent living and supports. The interview guide

included questions about their satisfaction with their housing and their relationships with the HF team members. We also asked about relationships, meaningful activities, goals, and aspirations. In the second round of interviews, we focused on these latter indicators of psychological well-being.

**Data Processing and Analytic Approaches**

*Questionnaire data.* We were able to match 136 provider assessments to the clients' self-report questionnaires (72.7%). We completed self-report questionnaires with seven clients who did not receive a matching provider assessment, and we received 44 provider assessments for clients who did not complete a self-report questionnaire. The findings we report in the following sections reflect minor discrepancies between clients' self-reports and provider assessments of clients' characteristics, support needs, and service use. These discrepancies arise from differences in samples and from differences in perceptions. We would not expect, for example, that service providers' assessments of their clients' physical health problems or substance use to perfectly map onto clients' own self-assessments of these problems and needs. We used the two data sets (provider assessments and client self-reports) to extrapolate missing information where possible, for example, historical residential patterns. It is important to remember that data were missing from most provider assessments, and so our reported findings often do not add up to 100% of the obtained sample. Questionnaire data were analysed using descriptive and inferential statistics to develop client profiles, residential histories, community health services needs and access. We benchmarked our scores against previously reported measures of key outcomes, and the data we report here can be used to benchmark future assessments of the same outcomes.

*Interview and focus group data.* All interviews and focus groups were audio recorded and transcribed verbatim by members of the research team. We applied the principles of thematic analysis (Braun & Clarke, 2006; 2021) to the data corpus. Our analytic approach was both deductive and inductive. For example, there are five HF fidelity dimensions that specify best practices for HF programmes, so we took a deductive approach to coding data relevant to these five dimensions. We took an inductive approach to coding the data in terms of facilitators and blocks to fidelity because we had very few *a priori* expectations about them. We repeated this process for the sections of this document that report qualitative findings. Findings presented in this report represent patterns that occurred across transcripts as well as vivid exemplars that illuminate a specific and important finding. Excerpts from individual transcripts were selected to illustrate the patterns we observed in the data.

# 3. Housing First Client Profiles

> *"The National Implementation Plan states that 'the priority target group for a HF response are people with a history of sleeping rough and long-term users of emergency homeless accommodation with high and complex mental health and addiction needs.'"*
>
> *–Tsemberis, 2020, p. 29*

**Demographic Characteristics**

Table 3.1 presents a profile of HF clients' demographic characteristics drawn from the clients' self-assessment data. On average, participants were 43 years old, single, White, and male. This profile is consistent with the typical demographic characteristics of individuals with substantial histories of homelessness. Only 12 (8.4%) participants were not Irish. More than one-fifth (21.7%) had no children, but the number of children participants reported ranged from 0 to 15, with a sample average of 1.74. Among those with children, 54 (38%) reported that one or more of their children is under age 18. Fourteen (9.8%) reported that one or more of their children were in residential care.

**Table 3.1 Service Users' Demographic Characteristics**

| | | |
|---|---|---|
| **Age** | | |
| Mean (M) | 43.73 | |
| Median (Md) | 43 | |
| Standard deviation (SD) | 11.66 | |
| Range | 23-73 | |
| Quartiles | 25th | 34 |
| | 50th | 43 |
| | 75th | 53 |
| | **Number** | **Percent** |
| **Gender** | | |
| Male | 108 | 75.5 |
| Female | 35 | 24.5 |
| **Ethnicity** | | |
| White | 138 | 96.5 |
| Black | 3 | 2.1 |
| White Traveller | 2 | 1.4 |
| **Nationality** | | |
| Irish | 131 | 91.6 |
| Other | 12 | 8.4 |
| **Relationship status** | | |
| Single | 96 | 67.1 |
| Married | 26 | 18.2 |
| Separated | 8 | 5.6 |
| Divorced | 6 | 4.2 |
| Widowed | 6 | 4.2 |
| **Highest level of education** | | |
| No formal education | 31 | 21.7 |
| Lower secondary | 52 | 36.4 |
| Upper secondary | 30 | 21.0 |
| Some third level | 14 | 19.8 |
| Completed third level | 14 | 19.8 |
| Postgraduate | 1 | 0.7 |
| **Children** | | |
| Range | 0 – 15 | |
| Mean | 1.74 | |
| Mode | 0 | |
| Median | 1 | |
| Children under 18 | 54 | 38 |
| Has children living with | 8 | 5.6 |
| Has children in care | 14 | 9.8 |

**Residential Histories**

Although it is difficult for individuals with long and complex histories of homelessness to give precise accounts of where they have lived and how long they lived there, we asked participants to give us their best guesses for where they lived most of the year prior to entering HF and where they were living right before they moved into the place where they currently reside. We wrote down their responses and categorized them according to the "ETHOS light" typology (Edgar, Harrison, Watson & Busch-Geertsema, 2007; See Appendix I).[2] We also asked participants to report how much time, if any, they had spent in residential care as a child, and to describe their pattern of rough sleeping, if any, in the year prior to joining their HF programme.

Tables 3.2 and 3.3 present clients' self-reported residential histories. On average, participants reported a lifetime average of 9.6 years living in homeless situations. More than 60% had spent the year prior to accessing HF in either accommodation for the homeless or emergency accommodation. More than 40% had rough slept at least a few days in the year prior to accessing HF.

**Table 3.2 Participants' Self-Reported Residential Histories**

| | Mean | Standard Deviation | Range |
|---|---|---|---|
| **Lifetime homelessness (years)** | | | |
| Mean | 9.66 | 8.67 | 0-50 |
| **Total time homeless before age 18 (years)** | | | |
| Mean | 0.78 | 1.95 | 0-11 |

**Table 3.3. Participants' Self-Reported Living Situations Prior to HF**

| | Number | Percent |
|---|---|---|
| **Primary Residence in 12 months prior to HF** | *n* = 142 | |
| Accommodation for the homeless | 66 | 46.5 |
| Emergency accommodation | 22 | 15.5 |
| Rough sleeping | 20 | 14.1 |
| Institutions | 20 | 14.1 |
| Family or friends | 5 | 3.5 |
| Own accommodation | 8 | 5.6 |
| Nonconventional dwelling | 1 | 0.7 |
| **Immediately Prior to HF** | *n* = 142 | |
| Accommodation for the homeless | 70 | 49.3 |
| Emergency accommodation | 24 | 16.9 |
| Rough sleeping | 24 | 16.9 |
| Institutions | 10 | 7.0 |
| Family or friends | 7 | 4.9 |
| Own accommodation | 6 | 4.2 |
| Nonconventional dwelling | 1 | 0.7 |
| **Rough sleeping in Year Prior to HF** | *n* = 134 | |
| Never | 79 | 59.0 |
| A few days | 9 | 6.7 |
| A few weeks | 8 | 6.0 |
| A few months | 8 | 6.0 |
| About half the year | 4 | 3.0 |
| More than half the year | 9 | 6.7 |
| The whole year | 17 | 12.7 |

[2] https://www.feantsa.org/download/fea-002-18-update-ethos-light-00324174417886874191 54.pdf

**Physical Health**

Clients' self-reported health conditions are listed in Table 3.4. Although 11% reported having none of these health conditions, 70% reported having two or more, and nearly 24% of the sample reported having at least 6 of the 30 health conditions listed in Appendix II. On average participants reported 3.65 health complaints. The most frequently reported condition was dental problems. On a scale from 1 = *Poor*, 3 = *Good*, and 5 = *Excellent,* on average, participants rated their overall general health at 2.84, and 2.75 compared to others. In comparison, in the Dublin HF demonstration, at the 12-month time point, HF participants rated their general health 2.69 and the comparison group rated their health 1.97 (Greenwood, 2014).

**Table 3.4 Participants' Self-Reported Physical Health Conditions**

| Ten Most frequent health conditions | | Comorbidities (0 to 14) | |
|---|---|---|---|
| Dental | 77 (53.8%) | No conditions | 16 (11.2%) |
| Back problems | 42 (29.4%) | 1 condition | 27 (18.9%) |
| Asthma | 41 (28.7%) | 2 conditions | 16 (11.2%) |
| Migraines | 40 (28%) | 3 conditions | 25 (17.5%) |
| Arthritis | 32 (22.4%) | 4 conditions | 12 (8.4%) |
| Epilepsy/seizures | 30 (21%) | 5 conditions | 13 (9.1%) |
| Foot problems | 23 (16.1%) | 6 or more conditions | 34 (23.78%) |
| Skin problems | 23 (16.1%) | | |
| Urine incontinence | 17 (11.9%) | | |
| Anaemia/low iron | 17 (11.9%) | | |

We asked service providers to describe their clients' physical health care needs. According to their reports, approximately half have no significant health conditions, while 41% have one or two and 8% have three or more. Figure 3.1 shows the prevalence of health problems among clients as reported by HF team members.[3] Service providers also rated the severity of their clients' health problems on a scale from 0 = *not applicable* to 10 = *very serious*. These scores were recoded as "no need", "low need", "moderate need", and "high need". Figure 3.2 illustrates how many clients have no, low, moderate, or high needs in each of these health domains (See also Section 6 Services to Match Clients' Needs).

[3] Please see Section 2 for description of differences between the provider assessment data set and the clients' self-assessment data set. It is important to remember that there were missing data in the provider assessment data set on these measures.

**Figure 3.1 Percent of Clients with Physical Health Problems**

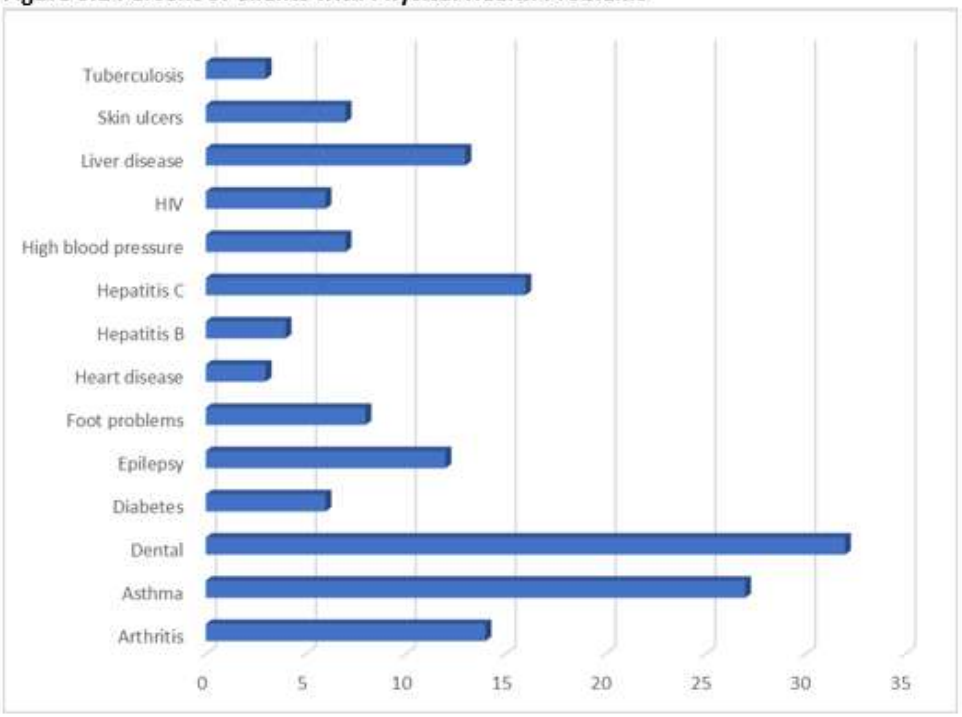
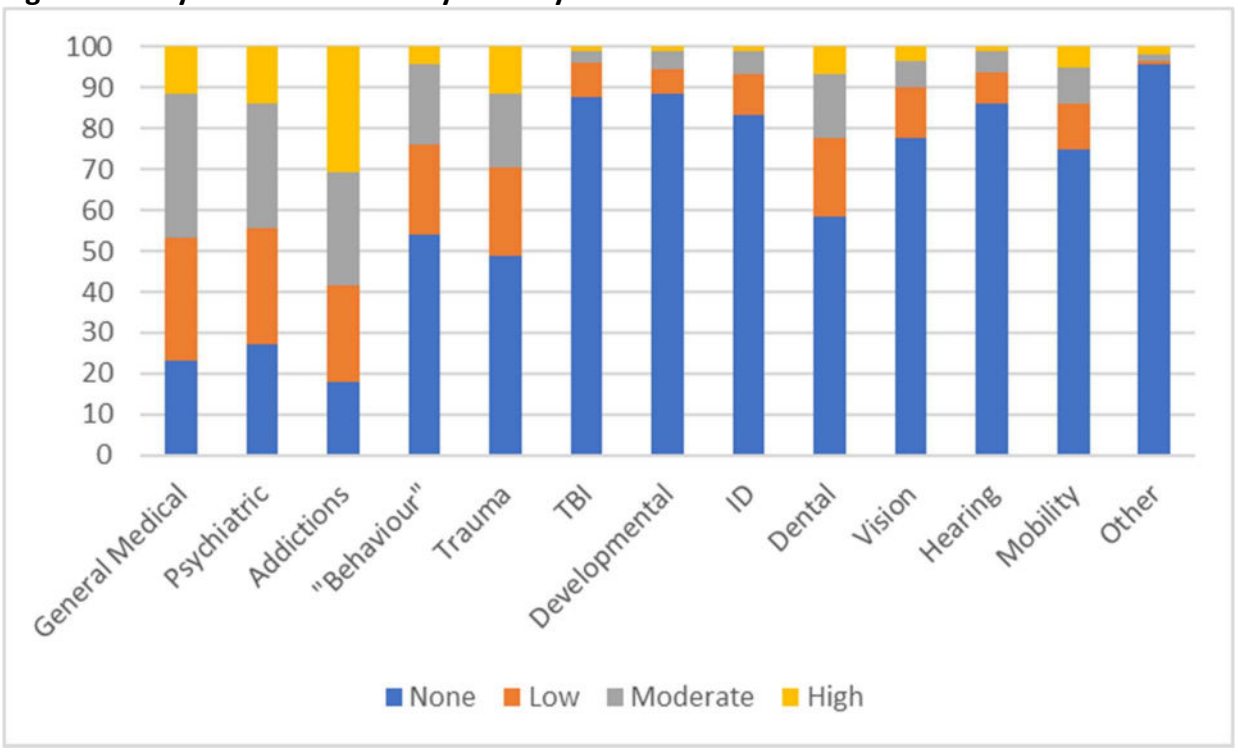



**Figure 3.2 Physical health need by severity**




**Mental Health**

We asked clients to report whether they have any problems with their mental health, and if so, to describe them. We coded their responses to this question into the categories listed in Table 3.5. Almost two-thirds (65%) reported having at least one significant mental health problem. The most frequently reported were psychotic disorders and unipolar depression. Slightly less than half of the sample (47.9%) reported having been hospitalized for psychiatric reasons during their lifetime, and participants' estimates of their lifetime psychiatric hospitalizations ranged from 1 to 50. Two participants who reported having

been hospitalised for psychiatric reasons did not report the number of hospitalisations. The number of participants who reported psychiatric diagnoses closely maps onto the number who reported they were engaged with a community mental health clinic (68 and 64, respectively). Service providers reported that 9.4% of their clients experience more than one psychiatric problem.

**Table 3.5: Participants' Self-Reported Mental Health Diagnosis and Care History***

| Psychiatric Diagnosis | | Lifetime Psychiatric Hospitalization | | Engaged with Community MH Clinic? | |
|---|---|---|---|---|---|
| None | 50 (35%) | Yes | No | Yes | No |
| Psychotic disorder | 33 (23%) | 68 (47.9%) | 74 (52.1%) | 64 (45.7%) | 76 (53.1%) |
| Unipolar depression | 40 (28%) | Lifetime Number of Psychiatric Hospitalization Occasions | | | |
| Bipolar disorder | 8 (5.6%) | 1 | 18 (12.6%) | 5 – 9 | 7 (4.8%) |
| Anxiety disorder | 5 (3.5%) | 2 | 14 (9.8%) | 10 – 15 | 5 (3.5%) |
| Trauma/PTSD | 3 (2.1%) | 3 | 10 (7%) | 16 – 19 | 2 (1.4%) |
| Borderline PD | 3 (2.1%) | 4 | 4 (2.8%) | 20 or more | 6 (4.2%) |
| Unspecified | 1 (0.7%) | | | | |

*Total sample sizes vary due to missing data.

**Head Injuries**

Head injuries are a common occurrence among the chronically homeless population (Svoboda, et al., 2014; Oddy et al., 2012; Topolovec-Vramic, et al., 2017). Nearly 60% (85) of participants reported having received at least one head injury that left them dazed, confused, or disoriented in their lifetime. Of these, 63 reported having had more than one head injury and one participant reported having had head injuries 'hundreds of times.' Approximately half (73, 51%) reported having been knocked unconscious by their head injury on at least one occasion (See Table 3.6).

**Table 3.6 Head injuries with unconsciousness**

| Occasions | Number | Percent |
|---|---|---|
| 0 | 61 | 42.7 |
| 1 | 19 | 13.3 |
| 2 – 5 | 36 | 25.2 |
| 6 – 10 | 17 | 11.89 |
| 11-15 | 3 | 2.1 |
| 16 or more | 7 | 4.9 |

**Problematic Substance Use**

Because harm reduction is both HF principle and practice, our focus with clients was on the extent to which they experienced problems related to their alcohol or other drug use rather than type and quantity. The evaluation team completed the GAIN Substance Problems Subscale (Dennis et al., 2006) with participants in the clients' self-assessment questionnaire. The GAIN consists of six items that assess problem related AOD. Response options were coded as 0 = *never,* 1 = *one or more years ago,* 2 = *2 to 12 months ago* and 3

**Table 3.7 Distribution of Average Problem-related Substance Use Scores**

| Score Range | Frequency | Percent of sample |
|---|---|---|
| 0 | 18 | 0.13 |
| 0.17-0.83 | 40 | 0.28 |
| 1 to 1.83 | 29 | 0.20 |
| 2 to 2.83 | 29 | 0.20 |
| 3.0 | 3 | 0.02 |

= *past month.* The distribution of clients' scores on the GAIN-SPS is presented in Table 3.7. The median score and modal scores were 1.0 (*Mean* = 1.9), indicating that for most participants, it had been one or more years since they experienced these AOD-related problems. In comparison, in the Dublin HF Demonstration evaluation, the average GAIN response fell between *in the past year* and *more than a year ago* for participants in the HF group and the comparison group (Greenwood, 2014).

We also asked service providers to if they knew whether their clients had any diagnosed alcohol or substance use disorders. They described fewer than half of their clients as having a substance use disorder (48.3%). The most common were alcohol (27.8%), opioids (26.7%), cannabis (11.1%), and anxiolytics (10.6%). More than one in five (21.1%) had poly-drug use and nearly one in five (18%) had dual psychiatric and substance use problems (See Table 3.8).

**Table 3.8. Provider Assessments of Clients' Alcohol and Other Drug Use**

| | |
|---|---|
| **AOD** | |
| None | 93 (51.7%) |
| Alcohol | 50 (27.8%) |
| Opioid | 48 (26.7%) |
| Cannabis | 20 (11.1%) |
| Anxiolytics | 19 (10.6%) |
| Amphetamines | 6 (3.3%) |
| Other | 6 (3.3%) |
| | |
| **Multiple MH** | 17 (9.4%) |
| **Dual MH-AOD** | 32 (18%) |
| **Poly-substances** | 38 (21.1%) |

Overall, the client profiles presented in this section demonstrate that across regions, HF programmes are successfully housing individuals who have substantial histories of homelessness, rough sleeping, emergency accommodation, and longer-term homeless accommodation, who have complex support needs arising from physical health, mental health, and substance use problems.

# 4. Housing to Match Client Needs

> *Ireland's National Housing First programme provides an opportunity for local authorities, AHBs, the HSE and NGOs in the homeless sector to take a new approach to both housing and treatment /support services* (Tsemberis, 2020, p. 33).

HF programmes should provide immediate access to housing integrated into the community for individuals who have not been able to obtain and maintain a home of their own (Tsemberis, 2010, 2020). In HF, there are no treatment pre-conditions or any disqualifying criteria for eligibility. Individuals are *screened in,* rather than *screened out;* that is, HF programmes prioritise clients who have substantial histories of rough sleeping and emergency accommodation, and who have significant support needs arising from physical health, mental health, and/or problem-related alcohol or other drug use. HF programmes support new clients to move quickly into affordable, private accommodation of their choice and to choose furnishing, decorations, and other features of their housing.

In each region, NGOs, LAs, and the HSE worked together to develop a plan for governance and to coordinate services delivered to the target population of homeless adults in their region. Successful HF programme implementation depended on these organisations figuring out how to work with one another. The evaluation team sought to gain insight into how partners in each region created local systems of inter-agency coordination to procure housing, determine priority eligibility criteria, nominate clients, and complete the intake and move-in processes.

The overall average score in the fidelity domain 'Housing to Match Client Needs' was 3.70 (out of 4.0) and ranged from 3.50 to 3.89. In comparison, the overall average from the multi-country study of HF Fidelity (Greenwood et al., 2018) was 3.5, and the average specifically for Ireland was 3.0. These findings indicate that across the regions, programmes are operating with a high degree of fidelity to the model in terms of Housing to Match Client Needs despite some difficulties sourcing housing.

**Housing Procurement**

In most regions, housing units were sourced from local authorities, the NGOs, and other approved housing bodies. Availability of one-bedroom units varied across the regions, with more rural regions such as the Northwest, the Southeast, and the Southwest reporting more challenges in sourcing one-bedroom flats than programmes in Dublin or other urban areas.

> Our biggest problem at the moment is housing. Getting one-beds. We basically ground to a halt…we've only just hit our one-year target, our one year would have been February, we just hit eight. And […] we're going to struggle. (NGO manager).

Another informant stated:

> There [are] one-bedroom units and, you know, that's a recognition of the serious lack in the, even on the private, you know, the private rented market or buying. People did not build one-bedroom units [here]. I mean, it's just, I'm told it costs almost no difference to make a two-bedroom unit in terms of the development of it than a one-bedroom unit. One-bedroom units are selling here for €80,000 or €85,000, two-bedroom units are selling for €120,000. You know, who builds one-bedrooms, privately, I mean developers? So, through the boom, there was no council housing built, no local authority units. So, it was all private, and there's very little one-bedroom units. (NGO manager).

According to the HF model (e.g., Tsemberis, 2010), clients have some choice over their location and housing unit. They may be shown three units and asked to indicate their preference. In practice, however, HF is often implemented in places with housing shortages, high rents, and other structural and economic factors that limit choice (Aubry et al., 2018). This is the case in Ireland, where affordable housing through private rented, approved housing bodies, and local authorities is scarce. Compounding the existing housing shortage was the one-bedroom requirement placed on HF programmes. Accordingly, HF clients may be shown one unit and, if they are dissatisfied with its location or another feature, they have the option to

turn it down and wait for something that more closely matches their preferences. However, most clients accepted the first unit offered to them rather than wait an indeterminate period for an alternative. Further, in almost all circumstances, clients were offered housing based on their perceived match with a neighbourhood and their support needs, informed by their preferences, especially regarding location. HF programmes considered many factors when matching clients to available units, including existing relationships (positive or negative) with neighbourhood residents, and limited physical mobility (e.g., use of wheelchair, difficulty climbing stairs).

Procurement of one-bedroom units was the most intractable challenge reported to the evaluation team by HF team members, managers, and stakeholders. Programme managers expressed frustration and concern over the scarcity of one-bedroom units and their inability to offer other types of housing to HF clients. Shortages of one-bedroom units were the most frequently cited cause for delayed move-in and, at times, had significant knock-on effects. The situation was described as "droughts and floods" of housing units coming on board, which overburdened the teams and made it difficult to match housing type and location to client choice and need. In counties with large geographical spread, when a one-bedroom unit became available, it was often in a location either too distant from services, amenities, and transportation lines. One respondent provided the following example:

[A property offered to us] was a beautiful property, an absolutely gorgeous cottage right on the lake, it was gorgeous but I was like, you cannot put a non-driver out here because it took me an hour and a half to get there… they will love it but [after a week] they will be bored and they will be back rough sleeping because there's no shop, there's no school, there's no clinic, there's no GP and there is no bus. (HF team member)

Despite the challenge to procure one-bedroom units in regions where they are scarce, the HF teams are on target to achieve their enrolment goals. Table 4.1 shows the target number of allocations by region and the percent achieved by December 2021, when data collection for the evaluation was completed. Overall, across the regions, the target number of tenancies was surpassed by 14%. A total of 593 individuals were housed in those 756 tenancies, indicating that some individuals have had more than one tenancy during the pilot period. What these numbers cannot tell us are the reasons why tenants moved or how many times they moved.

**Table 4.1 Housing Procurement by Region**

Individuals Housed by Region

| Region | Dublin | ME | Midlands | MW | NE | NW | SE | SW | West | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| # Housed | 313 | 45 | 21 | 23 | 30 | 23 | 71 | 37 | 30 | 593 |
| Target Dec 2021 | 273 | 64 | 34 | 41 | 35 | 41 | 30 | 84 | 61 | 663 |
| % Achieved | 114% | 70% | 62% | 56% | 86% | 56% | 236% | 44% | 49% | 89% |

Tenancies by Region

| Region | Dublin | ME | Midlands | MW | NE | NW | SE | SW | West | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| # Housed | 424 | 56 | 26 | 25 | 36 | 25 | 81 | 53 | 30 | 756 |
| Target Dec 2021 | 273 | 64 | 34 | 41 | 35 | 41 | 30 | 84 | 61 | 663 |
| % Achieved | 155% | 87% | 76% | 61% | 103% | 61% | 270% | 63% | 49% | 114% |

We asked service providers to report how many tenancies their clients had obtained, and the findings are presented in Table 4.3. According to these figures, 88.9% of clients were still residing in their first tenancies, indicating that moves for any reason were very occasional. In interviews and focus groups, team members and managers explained to us that some moves from one unit to another were in response to clients' preferences or arranged to prevent tenancy loss. In other cases, clients received prison sentences or went into the hospital for indeterminate periods of time and so had to give up their tenancies. Moves due to tenancy breakdowns or evictions also occurred. In all cases, when a unit was vacated, the team worked with the client through their housing loss and laid the groundwork to rehouse them once released from prison or hospital.

**Nominations and Eligibility**

The process of deciding eligibility criteria and nominating processes was easier in some regions than others. In some regions, working relationships between the partners facilitated these processes, but in other regions, where relationships prior to HF were described as 'siloed', it was more difficult and took more time. Nevertheless, the client profiles presented in Section 3 demonstrate that across the regions, HF programmes are successfully housing individuals who have substantial histories of homelessness in rough sleeping and temporary emergency accommodation, and who have complex support needs arising from physical health, mental health, and substance use problems. Impressive housing retention rates have been achieved across all regions and there have been very low levels of housing loss for any reason. These data confirm that the most important objective of the HF implementation has been achieved: Across the regions, HF is ending homelessness for individuals previously believed incapable of independent living. The evaluation team spoke to HF team members, managers, and stakeholders to learn how they developed their procedures for identifying and nominating individuals for HF according to an agreed set of eligibility criteria.

Many potential clients were already known to the LA, NGO, and the HSE in their communities as individuals with significant histories of homelessness, and so compilation of nominations lists was straightforward in these regions. Some programmes cast a wide net to solicit nominations from services including the Homeless Action Teams (HATs), homeless NGOs, and HSE. In other regions, the local authority made recommendations to the HF team from the individuals on their housing lists. In most instances, the process from nomination to intake was unproblematic. In some regions, however, where there were interagency nominating committees, the process was not always straightforward or satisfying. In the early stages of implementation, there was a lack of consensus among some partners about whether individuals could be nominated for HF unless they were eligible for community mental health services. Many homeless individuals with mental health problems who are excluded from community mental health services have diagnoses of personality disorders (labelled 'behaviour'), and/or dual mental health and addictions (See Section 6), and case managers reported that individuals who urgently needed HF were being disqualified on this criterion.

…They said, okay so they have to be homeless and have mental health impairments. The top tier. And I think that that was a real, real struggle because it was that bit around, you know, that was an exclusionary kind of piece that [ORGANISATION] and [ORGANISATION] were really struggling with. … I suppose at the very beginning the thing that was being agreed, that people would be nominated who had severe and enduring mental health conditions, which we weren't very happy about. … Now, there's definitely been a lot of movement on that. You know, we kind of got out of that, it's not as rigid. (NGO manager)

In the HF manual, a "Venn diagram approach" (see Tsemberis, 2020) to nominations is recommended. In this approach, data from PASS, emergency department visits, and homeless services is used to prioritize nominations. Respondents who used this approach to nominations found it very effective:

So, the objective measure is through the emergency department and crisis mental health admissions data, people who are the most frequent attenders will have a homeless address …and we get a list from the hospital leads there. And then we also survey the adult homeless health team, the GP, community health nurses and the psychiatric team and addiction counsellor. [We] ask

them to put forward the people they're engaging with, who they feel have the most complex needs that would benefit from this kind of wraparound support. And then the third circle is the … emergency shelter providers and the outreach providers in the city. …[W]e ask them each to put forward, you know, say the 10 people who they feel are really in need of HF and might otherwise be off their radar. And then…we meet… the people who overlap all three areas are…top tier priority, and the people who overlap at least two areas are also on the radar… if we have a good housing match for them and if there is nobody in the top tier who can take it up [then we will offer HF to them]….it isn't a referral process, but it is kind of consultative process in the sense that we survey existing services. (NGO manager)

Although this approach ensures that stakeholders from all three bodies contribute to the decision-making process, one respondent worried that it was not infallible:

What's kind of come to light [in] the last few days is that we have some entrenched rough sleepers that keep a very low profile. We know they're there, [but] they're not ticking all three boxes…They may not be in the A & E, the HSE, or they may not have actually been on the local authority's radar either. But I'm kind of familiar with them because of our outreach, we are linking in very close. So, I guess they may not fall into that Venn diagram category…. They need to be noted and documented. (NGO manager)

Some respondents mentioned a "vulnerability index" for assessing eligibility for HF and suggested they had considered whether to adopt it. We learned from respondents in one region that they had originally used this index to make (non-HF) housing allocations when demand was far greater than supply. The index was described as useful for identifying individuals with urgent needs to exit emergency accommodation. However, it was also described as imperfect, and this respondent worried that, if used on its own, could result in systematically excluding people whose score indicates they are insufficiently vulnerable to qualify for HF:

…it started to feel like we were making people have to be sick enough and long-term homeless enough to be at the top of our list, it was almost like we were actively deprioritising people who were engaging with stability programs because that lowered their score [on the vulnerability index] ...I realised there was a problem there. (NGO manager)

Another respondent described the difficulties they initially encountered in identifying eligible individuals in their region. They believed that in their rural region, the stigma associated with homelessness seemed to keep people from coming forward for services. Importantly, the introduction of HF seemed to shine a light on homelessness in this region and began to make it easier to identify individuals living in homeless situations:

And you know, there's a lot of hidden homeless. There is a much bigger stigma in rural areas. People wouldn't be... they would be much more inclined to hide it, a lot of people living in very bad conditions, who technically really are homeless but don't come forward as homeless. They are there, and I said, "how come you can't identify those?" But they can't identify them because again, they don't really have homeless services to deal with them. So, nobody seems to know who they are. …But interestingly enough, they starting to come up with names for us. They are now going back to the records and finding people who they have been dealing with… episodically. These people come and present as homeless and then they disappear for a year or two and then they present again, or the mental health service gets on to them again. (NGO manager)

Whether or not a given region has adopted the Venn diagram approach, stakeholders across the regions appear to have worked out strategies that effectively screen in members of the priority HF population. The Venn diagram approach to nominations appears to be a robust, valid, and reliable procedure for identifying eligible HF clients. It also ensures stakeholders from the different organizations can nominate potential clients and participate democratically in this important process. However, as noted above, in practice, it should be flexibly applied so that individuals who belong to the priority population are not deemed ineligible for HF because they have not been identified by all three partner organisations.

**Intake**

Some regions initiated the intake process with eligible clients when a unit became available, while other programmes compiled full lists of potential clients to meet their targets and then matched them to units as they became available. This latter process was generally perceived as transparent and helped programmes set timelines for meeting their HF targets. Problems arose when nominated individuals were told they were selected for HF before housing was available. Shortages of one-bedroom apartments and

other blocks to housing units sometimes resulted in extended intake periods, ranging from several weeks to several months.

... just because you're on a list for HF doesn't mean you are going to get a house straight away. It could be months, quite a significant number of months, while they wait until the house comes up. And then depending on where you are on the list and how ready you are at a particular moment of time will determine whether or not you're going to get [housed]." (HF team member)

Extended intake periods are frustrating for clients and difficult for teams to manage. To prevent these situations from occurring, most programmes stopped informing clients of their HF nomination until a unit became available. Some programmes changed the ways in which they complete necessary intake paperwork with new clients and used the time between nomination and move-in to build relationships and mutual trust.

...we don't make customers re-fill out forms and re-fill out forms. They gave us their information in the initial assessment. We fill them out. If they're happy with how they're filled and all their information is correct, they sign off. And that that gets us to send off the living alone allowance... So, a person doesn't need to be overwhelmed with paperwork when they come into a new apartment and are filling out forms after forms after forms. We kind of we take that heaviness off the customer. And then I suppose, the great thing is, we're building that relationship before they ever move in. And again, I'd say that's key because it puts out that feeling of [being overwhelmed by leaving the] environment that they may have been in for years…and putting a roof over their head, where they have to pay bills and they have to cook for themselves because like, bear in mind that if you're in a hostel or you're in emergency accommodation... you've very little choice. (HF team member)

Restoring choice to individuals who have had very little to no choice over the most basic aspects of the activities of everyday living is a high priority in HF, and it begins with housing allocation and move-in.

**Housing Allocations and Move-in**

Once a housing unit is allocated to a new HF client, the move-in process begins. Case managers described this process as exhilarating and intense. The joy of handing over keys to a new home and being a part of a person's exit from homelessness was remarked on by team members in every region. One team member described the experience this way:

It's -- you know what? It's nervous. Yeah. I'm really honest. Yeah, it is. I'm nervous for them. I'm nervous for me… I had to move [a girl in] last Friday and she had just come out as inpatient from the psych unit… and we had worked like all week to get the furniture, to make sure the curtains were up, you know, to make it really nice and lit up for her. And she had picked out all the furniture as well…. So…I kind of wanted her to be proud of what she was moving into. I wanted to be a really nice space for her… and [think] that we had done a good job for her. I didn't want to let her down, like for her to walk in and be like, oh, my God they made a Hames of my house.…And then on her first night I did, I thought about her kind of even after I went home. Like hoping she was OK. Hoping that she was going to sleep all right, knowing that she wouldn't. No one ever sleeps OK, like in their first night. Moving somewhere. Staying anywhere. So, I'm a little bit nervous when people move in. (HF team member)

It is important to recognise the work that HF teams did to house people when the pandemic began, especially since programmes in several regions got off the ground at that time. The teams' priorities were to get people housed and keep them safe in very unpredictable and frightening circumstances. There was tremendous pressure to move individuals out of congregate housing and into private accommodation where they could isolate. The following excerpt illustrates the intensity and focus of getting clients moved in when the pandemic struck. It also illustrates the commitment that HF teams gave to ensuring they stayed connected to their clients during those extraordinary times:

From early on…. the PPE... keeping distance and sanitizing and going in, coming out, and being very careful about that. No travelling together, even when two staff had to go and visit someone, they travelled in their own cars to that visit, and you know we managed as best we could. But we didn't at any stage stop the home visits. We felt we had to…you couldn't put someone in a house…when they haven't had a house, and then just start ringing them every day, and as I said, I know it's not a huge number…there are seven tenancies and four of the seven really coincided with Covid. So…you can't do…as many of the diverse things as we would like, but people have settled well, they really have a sense of having their own home. [W]e can see that they are kind of pleased or they're relaxed, you know, one or two when they were moving in were kind of quite anxious because it all got a bit rushed in the end because you're trying to do it against a lockdown and get everything furnished and everything sorted and then people have [this reaction], *is this really happen, is this really my home?* … And again, you're talking about people who, through their whole adult lives, haven't really had a home of their own. So, it is a big, it is a big kind of change, and we would

have had to do things, you know, for some because they were cocooning, staff were having to do stuff like helping, you know, maybe do the shopping…picking up their medication and, you know, checking in with them in a socially distanced way because we kept the service going complete, you know, we really wanted to. (HF team member)

**Residential Outcomes**

Clients' self-reports of time in current accommodation are presented in Table 4.2. On average, participants in the clients' sample reported having lived in their current accommodation for 16.57 months (1.38 years) ranging from 9 months to 8 years.[4]

**Table 4.2 Client Self-reported Time in Current Accommodation**

| | Mean | Median | Standard Deviation | Range | Quartiles (months) |
|---|---|---|---|---|---|
| Current Accommodation | 16.57 months (1.38 years) | 10 months | 17.98 months | 9 months to 8 years | $25^{th}$ = 5<br>$50^{th}$ = 10<br>$75^{th}$ = 23 |

Service providers were also asked to provide information about their clients' residences and residential patterns (Table 4.3). Most clients were referred from local authorities and most housing was sourced from local authorities as well. For the sample of clients represented in the provider assessments, 160, or 88.9%, were residing in their first HF tenancy, 12 (6.7%) had moved on one occasion, one on two occasions, one on three occasions, and four (2.2%) on four or more occasions. We do not know the reasons for these moves, but we do know that most were due to reasons other than eviction, such as client choice or return from an extended stay in an inpatient or carceral setting. In comparison, after 12 months, participants in the Dublin HF Demonstration (Greenwood, 2014) were spending 67% of their time in stable housing, compared to participants in the comparison group, who were spending 5% of their time in stable housing.

In the six months leading up to completion of the providers' assessment questionnaire, 34 (19%) HF clients had been arrested and 10 (5.6%) were reported to have entered jail or prison. More than 75% had made at least one visit to the emergency department, while 17.8% had been hospitalised for general medical reasons, 2.78%% for psychiatric reasons, and 21.7% had been hospitalized for AOD treatment.

[4] Some Dublin participants in the clients' self-assessment questionnaire were engaged with HF services (some for years) before the national implementation began. See Section 1 for a summary of the history of HF in Dublin.

**Table 4.3 Provider Reports of Clients' Residential Patterns**

| | Number | Percent | | Number | Percent |
|---|---|---|---|---|---|
| **Accommodation Prior to HF (*n* = 172)** | | | **Referral Source (*n* = 171)** | | |
| STA | 69 | 40.11 | LA/CoCo | 72 | 42.1 |
| Rough sleeping | 29 | 16.86 | HF NGO | 46 | 26.9 |
| PEA | 21 | 12.21 | HSE | 4 | 2.3 |
| TEA | 20 | 11.63 | HAT/HF | 20 | 11.7 |
| Nonconventional | 14 | 8.14 | External homeless NGO | 9 | 5.3 |
| Friends or family | 8 | 4.54 | External charity | 3 | 1.8 |
| LTA | 7 | 4.07 | Prison/Parole | 6 | 3.5 |
| Hospital | 3 | 1.74 | Addictions services | 5 | 2.9 |
| Foster care | 1 | 0.58 | Other | 6 | 3.5 |
| **Current Residence (*n* = 180)** | | | **Housing Source (*n* = 178)** | | |
| HF-sourced unit | 176 | 97.8 | Local Authority | 79 | 44.4 |
| Hospital | 1 | 0.6 | HF NGO | 63 | 35.4 |
| TEA | 1 | 0.6 | Other AHB | 21 | 11.8 |
| LTA | 1 | 0.6 | Private Rented | 11 | 6.2 |
| Other | 1 | 0.6 | Other | 4 | 2.2 |
| **Time in Current Residence (Months; *n* = 180)** | | | | | |
| 0 to 6 | 49 | 27.2 | | | |
| 7 to 12 | 49 | 27.2 | **Six Months Prior to Questionnaire** | | |
| 13 to 24 | 35 | 19.4 | **Hospitalisation (*n* = 180)** | | |
| 25 to 36 | 14 | 7.8 | AOD treatment | 39 | 21.7 |
| 37 to 48 | 8 | 4.4 | General Medical | 32 | 17.8 |
| 49 or more | 25 | 13.9 | Psychiatric | 5 | 2.78 |
| **Housing Moves (any reason; *n* = 178)** | | | **Emergency Dept. (*n* = 180)** | | |
| 0 Occasions | 160 | 89.9 | Yes | 137 | 76.1 |
| 1 Occasion | 12 | 6.7 | No | 43 | 23.9 |
| 2 Occasions | 1 | 0.6 | **Arrested (*n* = 178)** | | |
| 3 Occasions | 1 | 0.6 | No | 144 | 80.9 |
| 4 or More Occasions | 4 | 2.2 | Yes | 34 | 19.1 |

Evidence from clients' self-reports and providers' assessments convincingly demonstrates that the priority population is getting housed through HF programmes across the regions and are staying housed, with impressively low rates of housing loss or moves for any reason whether due to the client's desire to move to another location, entry into residential treatment, remand to custody, eviction, or other cause of failed tenancy. Findings from the evaluation indicate that regional HF programmes successfully house individuals who have substantial histories of rough sleeping, temporary and emergency accommodation, and who have encountered intractable blocks to stable housing. Representatives from every region described how they developed eligibility criteria and intake procedures through which they identified and enrolled the most vulnerable and difficult to house individuals in their areas. Many potential clients were already known to LAs, NGOs, and the HSE and in their communities as individuals with significant histories of homelessness. Some programmes began the work of implementing HF by agreeing on a list of individuals to meet the enrolment targets, while other programmes worked with shorter lists of potential clients and matched them to units as they became available. Waiting times from intake to move-in tended to be longer when intake occurred before a unit was identified for a particular client. Across the regions, programmes aimed to match clients to housing based on their personal characteristics and perceived fit with a neighbourhood. Clients could choose to take a unit that was matched to them or wait for another unit to become available. However, because there was rarely or never a surplus stock of units, most clients took up a unit when it was offered rather than wait an indeterminate period for an alternative. Referring to

this, one service user stated that he would like, "[*A] little more choice in the place where I live*". Nonetheless, many clients were extremely happy with their accommodation. In the clients' self-assessment questionnaire, many clients reported their experiences of being housed as the thing they liked best about HF. Here are some of the ways they described the experience of getting their own home:

- To have a roof over my head, feeling a sense of relief from having been homeless, feeling that my life is worth living which it hasn't been in the past, has changed my life completely to make things for the better.
- I like that I have my own place, that I can lock my door and listen to my music.
- Just the way I got the house. How it was presented to me was great, the furniture and everything.
- They made it so easy for me to transition. It could have been very scary to go into a new place without any help, but they helped me make the change.
- I am delighted. HF gave me confidence and turned my life around.
- Having space, tenancy support work.
- They helped me get my house after ten years. They saw how hard I was trying.
- Everything about [HF] has saved my life and helped me feel like a human again.

The teams' and clients' housing achievements have had positive ripple effects in their communities. For example, in one region, individuals with long histories of visible rough sleeping in town centres have successfully sustained their tenancies over time, and this achievement has convinced some prominent community members of the HF programme's effectiveness and importance. One service provider said:

> [There] would have always been rough sleepers or people bedded down …in doorways and stuff. So, for the businesses, it's been a huge benefit…and …for the people using those facilities and restaurants and…guesthouses… They see a big difference, and the Gardaí tell us … it's easier for them …to patrol those areas [and] that they don't have to patrol them as much because … there aren't people rough sleeping or begging or whatever…. And our … local councillors saw it that way as well…. If you can get your counsellors on board and see the benefits…it's easier to house more of the HF clients…They have been supportive of the scheme because they do see the benefits, you know, to the area as well as to the clients themselves. (LA stakeholder).

HF programmes' achievements in sourcing one-bedroom accommodation in the context of a significant housing crisis reflect programme leaders' creativity and determination. These achievements also demonstrate that HF programmes are mobilising buy-in and confidence of housing sources (e.g., local authorities, AHBs) in their regions. In every region, HF programmes identify and house individuals with long histories of living in homeless situations including rough sleeping, emergency accommodation, and long-term homeless accommodation. They are housing individuals with significant support needs for mental health problems and problematic AOD use, and they are keeping them housed, with impressive housing retention rates. One aspect of their achievements in this area is their commitment to separation of housing and services.

# 5. Separation of Housing and Services

> *Housing First in Ireland uses a 'scattered-site' housing model, with clients being allocated permanent, secure social housing in properties provided by local authorities or AHBs, or in the private rented sector, sourced and secured from landlords by the Housing First service provider. (Tsemberis, 2020, p. 21)*

The average fidelity self-assessment score in this domain across all regions was 3.87 (out of 4.0) and ranged from 3.78 to 4.0. In comparison, the overall average score obtained from the 10-site multi-country Housing Fidelity study was 3.9 (range = 3.3 to 4.0), and the score for Ireland was 4.0. Not once did we hear team members or stakeholders refer explicitly to treatment or sobriety requirements for getting or keeping housing, although at times they did use the language of 'housing readiness'. In some conversations with clients, however, they said that to keep their housing, they needed to take medication or abstain from drugs or alcohol. For example, one participant expressed worry that their alcohol use could affect their tenancy:

Interviewer: And did you feel like you could tell [your case manager] about [your alcohol use]? Were you able to confide in her? How was that?

Participant: I didn't tell her about it, but when I met her, I was much better. And then I felt like it would affect my chances of like staying here or like getting other accommodation…

We did not explicitly ask clients whether they felt pressured to abstain from alcohol or other drugs, or whether housing was used to incentive sobriety, and we do not believe case managers use housing as leverage to encourage abstinence, treatment compliance, or behavioural change. Instead, we believe these comments are either anchored in participants' self-beliefs (that going off medication or using alcohol or other drugs would undermine their tenancies) and their previous experiences of treatment and sobriety requirements in other homeless services. Importantly, we also observed that HF clients do not routinely receive education in HF principles on an ongoing basis (an aspect of fidelity to programme operations), which includes information about choice over treatment compliance and sobriety. Therefore, while we feel confident in concluding that all programmes demonstrated a high degree of fidelity in this area, we believed clients could be better informed about the principle of 'no treatment preconditions'.

Service providers expressed their practice-based values and principles in vivid anecdotes that described how they intensively engaged with their clients to prevent tenancy loss and stayed intensively engaged with them through tenancy loss due to eviction, hospitalisation, incarceration, or other reasons. It is worth emphasising the fact that housing loss for any reason has been very low in every region. When it has happened, services have demonstrated a strong commitment to follow clients through housing loss and rehouse them, even on multiple occasions. The instances of multiple housing losses are very few, and combined with the very clear commitment to housing individuals prioritised for HF is testament to the skill and dedication of HF case managers:

And a person [who] … has pretty significant mental health issues, although I'm not sure that he has a formal diagnosis…each time we housed him … going back … nine years ago, he left the apartment because of voices and things he was seeing and hearing and being chased out of the apartment by his belief that people were watching him through the taps and things like that…. He's near 60… he … [has] a very serious [illness] diagnosis … and he's going to need a lot of support …One of the buildings is, you know, quite accessible and the rooms are ensuite, and the staff are onsite and have some training in patient care. … So, he's moved in there ahead of his surgery and will go back there after his surgery and then he may decide that he wants the flat again, and that's fine and we'll do that. I mean, this will be his fourth housing placement … and it's [being] responsive to his changing needs…he would be the best example of where the team has really, you know, really stuck with somebody … And, you know, we look at it in one way and say, like God, like we've tried all these things and none of them have stuck, on the other hand, he has spent probably 90 percent of the last 10 years sleeping rough, and he spent 90 percent of the last six months housed, you know, although in various locations and whatever. (HF NGO manager)

Across all regions and across all information gathered for this evaluation, we obtained very little evidence of any service requiring clients to demonstrate housing readiness to be eligible for housing. Across interviews and focus groups, case managers and programme managers talked about meeting clients 'where they are at' and emphasised to that housing was not contingent on sobriety or treatment. Occasionally, however, some case managers and programme managers did use the language of 'housing readiness', but this rarely occurred and referred to, for example, the period between intake and move-in, when case managers or other social care workers would work with clients to help them prepare to move into their new home, and not in relation to being eligible for services. Very occasionally, a respondent described HF clients who were already housed and receiving supports in terms of housing readiness too, and this was usually in relation to clients who were struggling in their tenancies. Nearly everyone we spoke to rejected any notion of housing readiness. For example:

It's important to differentiate between how the team is working and how the team is orientated in terms of immediate access to housing and moves happening quickly after intake into housing. It's not a matter of readiness or, you know, any kind of requirement around treatment, or stability, or assessments, or anything like that. It's purely a function of the physical properties being available. (HF team leader)

Another important dimension of separation of housing and services is the extent to which social and clinical services are mobile and can meet with clients in their homes or in another location of their choice. HF team members meet with clients in their homes and in a wide variety of public spaces. Clinical services were not as flexible, overall, however, and generally not mobile, except when available from an MDT or some in-house services and in some crisis situations:

I suppose it's gotten better in that we can call on either the public health nurse or the mental health nurses in HAT if we need them. But it's if there is a crisis, you know, like we're asking for a favour as opposed to, this is their job. (HF team member)

It is important to note one of the 'Covid silver linings', which was rapid and intense implementation of virtual supports for clients. This infrastructure can outlive the pandemic and support HF clients who live far from services, especially in circumstances where their case managers cannot get to them quickly. It is envisioned that these virtual infrastructures will be able to facilitate 'telehealth' and improve the ability for healthcare services to meet clients 'where they are at'.

We've tried to do stuff with kind of technology with some people. We got them phones or got them tablets or tried to get them linked in to... other things in their lives. It's been a little bit interesting as well … because when the country was in lockdown some things went more smoothly than we would have expected. (HF manager)

Taken together, findings from fidelity self-assessments, interviews, and focus groups demonstrate a high level of commitment to identifying and housing the priority HF group, to meeting people where they are at, not placing any treatment or compliance conditions on housing or housing tenure and supporting clients through housing loss. In some areas, especially where services are brokered, social and clinical services are not optimally mobile and able to meet clients in their homes.

# 6. Services to Match Client Needs

> *"An array of services is provided either directly by the HF programme or through coordination with other community agencies. As part of the HF programme, HSE clinical staff typically provide services in clients' homes and community settings, rather than office or clinic-based settings" – Tsemberis, 2020, p. 39.*

Across the nine regions, the fidelity self-assessment score for the domain 'Services to Match Client Needs' was 3.47 (out of 4.0) and ranged from 3.11 to 3.85. In comparison, in the 10-site multi-country study of fidelity (Greenwood et al., 2018), the overall average score for 'service array' (the corresponding scale in the original version of the fidelity measure), was 3.2, and the score for Ireland was 3.5. In this fidelity domain, we assessed the extent to which the programme systematically delivers specific interventions that address a range of life areas, the extent to which clients choose the type, sequence, frequency, intensity, and duration of the services they receive, and the extent to which the programme offers peer support and tenancy support services. The intensity and comprehensiveness of supports for social and community integration, and financial services are assessed, as well as the extent to which the programme creates access to and continuity with psychiatric, counselling, and psychotherapeutic services; substance use treatment; nursing and medical services; and education and employment services.

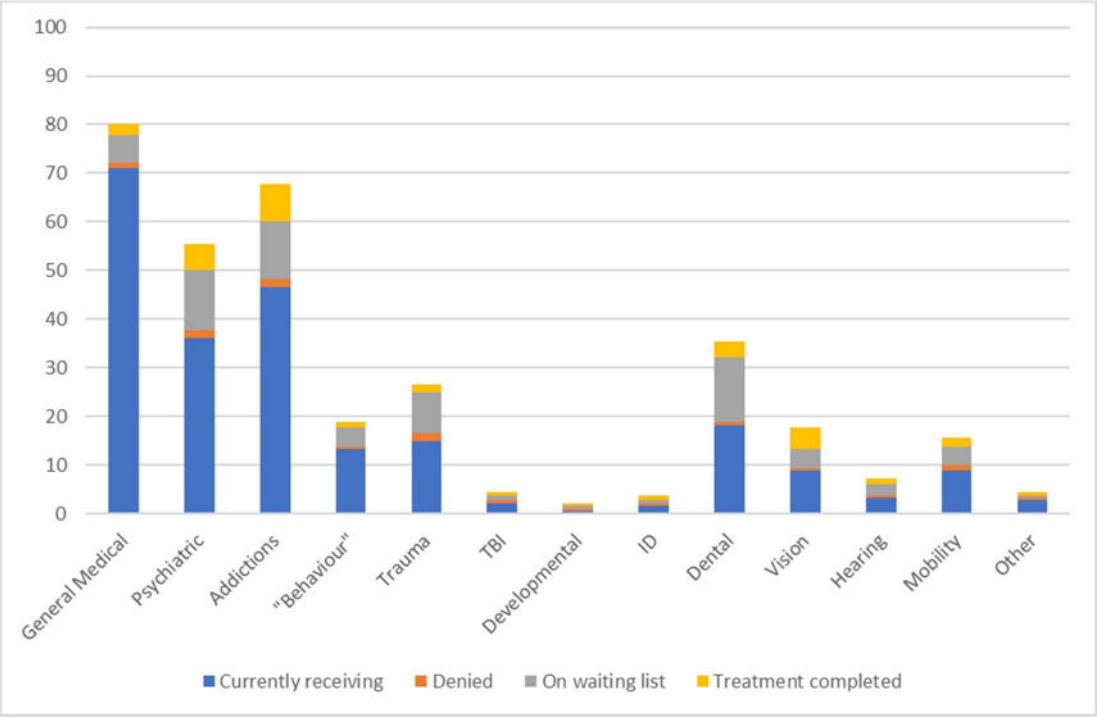
In focus group meetings with team members and stakeholders we explored the blocks and facilitators of fidelity in this domain. Not surprisingly, physical distancing restrictions required to reduce the spread of Covid-19 were the most frequently reported blocks. Facilitators included the use of virtual platforms, which rural areas increasingly use to immediately engage with and support clients. This is important because travel to clients' homes can routinely take one or two hours in large rural regions. Other facilitators included easy access to clinical nurse specialists and psychologists. Fidelity in this area was higher for programmes with in-house supports because they facilitated access to a wider range of services than programmes that brokered services, especially programmes in areas, for example, for clients with dual diagnoses and clients whose support needs were labelled "behaviour" (see below).

Substance use treatment was described in fidelity focus groups as easier to access than mental health supports. One reason for this finding is that at the time the fidelity focus groups were conducted, most teams included addictions support workers, but few included a psychologist. Since then, these teams have added senior psychologists to their teams, and this improved access to psychological supports for clients and for team members. Access to nursing care was variable across the regions, with the easiest access reported by team members and stakeholders of multi-disciplinary programmes and with in-house supports. Links between community nursing and mental health nursing in other regions were described in these focus groups as variable in strength and responsiveness. Teams resourced with occupational therapists (OTs) found this support particularly helpful in addressing their clients' needs, but not all teams have access to OTs, and as can be seen below, this finding converges with the providers' assessments, in which OTs were rated as one of the least accessible services for their clients. Another type of facilitator frequently mentioned by team members and stakeholders in the fidelity focus groups was a good working relationship with people strategically placed in the organisations, especially the NGO and the HSE. Case managers often explained how they worked to cultivate and maintain these relationships.

In the provider assessment questionnaire, we asked team members to report their clients' health service status (See Figure 6.1). This figure shows that very few clients were on waiting lists for or had been denied treatment for conditions that were assessed as very high need.[5]

[5] It is important to remember that there were missing data on these measures in the providers' assessment questionnaire.

**Figure 6.1. Health Service Status**




We conducted interviews and focus groups with team members, providers, and programme managers before we finalized the Provider Assessment questionnaire. In interviews with team members and programme managers, we asked respondents to talk about the supports their clients need and their ability to access them. Across all the regions, respondents from all three stakeholder groups (local authorities, NGOs, and the HSE) differentiated between "mental health" and "behaviour" to explain differences in access and blocks to mental health services, both inpatient and outpatient. We asked our respondents to explain this distinction to us so that we could understand their experiences. They explained that clients whose support needs were labelled "behaviour" were not eligible for community mental health services. This distinction between "behaviour" and "mental health" was made across all the regions and the reason for the distinction was consistently explained with similar language and similar examples across the regions and respondents. For example:

They [HSE Mental Health] would often determine it's behaviour rather than mental health. In that case, we won't get support, but I say you're hearing that around the country. [NGO manager]

A particularly compelling example of how a HF client was admitted to the hospital in acute distress but then discharged without a diagnosis or referral to community mental health came from this respondent:

We have a female, who [was] … going around town naked, barefoot, whatever. And, and she was in a heighted [state] of stress and highly traumatised. And yet when she [went] to A&E, she … she [received medication but was discharged with nothing]. So, you telling me as part of her treatment while she's an inpatient she is getting Benzos? But in the community what does [mental health] input look like? …You're telling me you're really struggling with her in an acute unit, and you want us in homeless services to take this woman without [community mental health supports]? And I'm not an advocate in terms of meds, but it was just that double standard that 'we have to medicate her while she is on the ward and yet she's into the community with nothing.' [NGO Manager]

Because we observed a pattern in which our respondents consistently differentiated 'behaviour' from 'mental health', we began to ask them to explain this to us so we could gain insight into what this

distinction meant and how it was applied in practice. The responses we received focused on the difference between personality disorders and trauma on one hand, and biologically based mental disorders on the other. For example:

It's literally written into the Mental Health Act and that personality disorders are considered behavioural and social difficulties rather than a mental illness… So, by virtue of only having one of those diagnoses, you would not be detained under the Mental Health Act in this country. It's literally in black and white and … probably sustains this idea, I guess, that personality disorder and addiction aren't health and mental health problems. [HF team member]

Another person explained the distinction in terms of the intensity and type of therapeutic supports provided for symptoms labelled 'behaviour' or 'mental health':

Quite a lot of resources [are] required to work with somebody whose behaviour [is] like that. The predominant treatment for doctors, of course, is medication, which doesn't really work when it comes to behavioural stuff. So, there's a reluctance to get involved because it's a very medical model. Even some of my colleagues, social workers, sometimes can be very dismissive and say, like, you know, it's just behaviour. [Respondent from HSE]

Another person said:

But mental health is the thing that presents the hugest challenge to us in homeless services….But yet we have the experience that this is an increasing trend, that homelessness and mental health are inextricably linked and, and there's a bit of an issue that some of the consultants in the mental health service still use a medical model and are not taking into account biological or social or psychological factors in all part of the one person. It's like they're trying to separate out the diagnosis from the behaviour. [NGO manager]

HF team members and managers described the challenges they faced in supporting clients with significant mental health problems without input from mental health services. For example:

I don't know the ways around that for a small town. We're overrepresented in people that are displaying those problems and they're losing their homes and their families' support because of all those issues that come to us and we can't help them. [NGO manager]

When mental health problems and substance use co-occur, mental health treatment is often inaccessible. There are few places in the country where people can receive treatment for both simultaneously.

I think that would be, that's probably the bigger aspect of all of this for us. In HF, we have the complex, enduring mental health cases and that is an issue. We have issues of non-acceptance within the mental health [service], of the criteria they use for someone being identified as being mentally ill as opposed to having complex behaviours, challenging behaviour, addiction and so forth. Getting people in for that [is very difficult] ... And if [they] have any other comorbidity like addiction or challenging behaviour or whatever…they will say, okay, that has to be addressed first before they will see them. [HF team member]

If you have an addiction, as far as I can see, there's no place for you to go. You know, if there was more talk about maybe some sorts of activities or some sort of, you know, there's a place to go if you have mental health problems, there's a place to go but if you have both, you know no one wants you. [HF Team member]

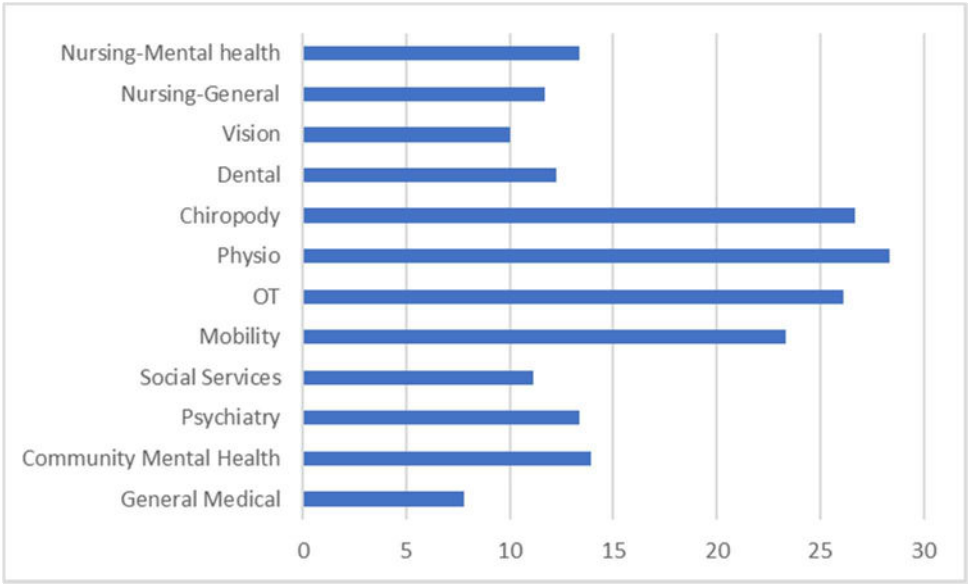
We were just having a staff meeting and it kind of came up about the whole, you know, he has an addiction, so a mental health service can't deal with him, and he has a mental health problem so addiction services can't deal with him. And I am thinking, Jesus, I thought we got over this years ago, you know. [NGO stakeholder]

Because of this widespread and consistent distinction between "mental health" and "behaviour", it was apparent to the evaluation team that our provider assessment questionnaire should assess the extent to which providers perceived there to be differences in access and need for "mental health" treatment versus treatment for "behaviour". It should be noted that one stakeholder described the distinction of 'behaviour' from 'mental health' this way:

> The term 'behaviour' is very contentious within mental health and has connotations to a more historical and now discredited view of mental health challenges being linked to the moral identity of the person. A contemporary understanding of the term 'behaviour' would be that is a manifestation of an underlying mental health or trauma condition. There clearly needs to be a review of the language used in this context and a greater focus on education to give insight to all stakeholders around the impact of this on individuals experiencing it. (HSE Stakeholder)

Providers rated clients' access to services on a scale from 1 = *not accessible at all* to 6 = *completely accessible*. Figure 6.2 shows the percent of clients for whom each service was rated as either '1' or '2', indicating that the service is not accessible. For example, service providers reported that occupational therapy was not accessible for nearly one-third (28.33%) of HF clients. Further information is needed to determine whether the problem is the absence of the services or a problem with staff referrals, their knowledge about services themselves and when to refer someone to OT. In contrast, GPs were reported to be completely inaccessible for only 8% of HF clients.

**Figure 6.2. Percent of Clients for Whom Treatment is Not Accessible**




As can be seen by these figures, the absolute number of clients who experience substantial blocks to community health services is low; most clients are able to access most services. One aspect of care that can be difficult to navigate is continuity of care, when a person changes services because they move from one catchment area to another. Representatives of NGOs and HSE social inclusion described the ways in which they were working together to coordinate services and facilitate case transfers across catchment area lines.

> Actually, continuity of care has been quite positive. One client would have quite high physical health needs. He has various ailments [including] liver cancer. And … our nurse for people who were homeless maintained an uplink with him after he moved in to order to transition him slowly to community care. So, in the future he will be transitioning on to the local health centre. But for now, she is continuing his care because … she knows his care and his disorder so well. …Even another client [who] had moved to an accommodation that broke down and is now in emergency accommodation, his GP has remained constant as well. Now that's been fantastic in regard to providing addiction support to him… she's been fantastic in following him. (HF team member)

In the provider assessment questionnaire, we asked respondents to explain their scores for clients' access to services. We collated their responses and identified patterns. Many providers noted a lack of needed services in their area due to long travel times and inadequate transport links in rural areas. One service provider said, "*The location in which he lives. He would have been long in a stabilisation programme*

*by now if he was from Dublin*." Long waiting lists were often mentioned and described as exacerbated by Covid-19 restrictions. For example, "*counselling supports can be difficult to access due to waiting periods at present*", "*customers are put on waiting lists and can be waiting quite some time for an appointment*," "*Waiting lists are incredible, which really leaves participants vulnerable to harm*". While the time waiting can vary greatly based on the hospital group, type of care required (e.g., inpatient, day care, etc) and type of condition to be treated, waiting lists can be particularly difficult for individuals seeking treatment for addictions. Readiness for treatment can be fragile and fleeting, and case managers described waiting times as windows closing on opportunities.

Others noted the lack of providers who speak clients' first language (when it is not English), delayed file transfers, and the consultation process as blocks to fidelity in domain. Many providers described clients as having "*low motivation"* or as "*reluctant"* to attend a needed service because of negative past experiences with health providers. For example, one participant was described as having "*a long history with MHS and has very little faith in the service and as a result is unwilling to engage*." Others were described as having difficult relationships with GPs, having difficulty trusting service providers because of histories of trauma, and feeling uncomfortable with intrusive questioning by someone who represents a service they have little trust in. Indeed, several case managers mentioned discrimination based on stigmatised identities such as transgender, Traveller ("*being a member of the Travelling community*" or having an addiction ("*prejudices around drug addiction*"). Others described prejudice and exclusion more broadly:

Clients can be afraid of services because of how they are treated in there. Clients are often times stigmatised by their looks. There are also huge waiting lists and exclusive systems which make it hard for people to access services. [For example a] gentleman [who] can't read or write… is very intimidated by services as they're not tailored to his needs. (HF team member)

Strategically placed HF champions within the HSE, such as clinical nurse specialists, health coordinators, and regional rehab coordinators were specifically mentioned as facilitating fidelity in this area because they can remove blocks to needed medical care and treatment. Dental care was particularly difficult to access at the time these interviews and focus groups were conducted, with reports across the regions of dentists not taking on any new patients. For HF clients, dental care is especially important because they may not have seen a dentist for years and may have significant problems that need urgent attention. Dental care is not only important for overall health, but also intimately tied to individuals' recovery in other domains. For HF clients, shame about the state of their teeth can be an important reason for reluctance to engage in meaningful activities with others so getting one's teeth fixed is an important first step before participation in meaningful social and community activities.

The health coordinator has done a lot of advocacy for dermatological appointments for that type of stuff, because waiting lists are high there... Well dentistry is a big one, I suppose… there was a customer who was waiting to get all her teeth removed...I think the waiting list was two years, but with all the advocacy last year she got it done in a couple of months. (HF team member)

In addition to HF champions, programmes devised several "workarounds" to close the gap between needed and available treatment and supports. One programme that operated the brokered services model could not get the psychotherapeutic services they needed from community mental health, so they hired a senior psychologist:

So, with populating the team, the one thing that I think was that I'm really delighted about is that we [hired] a whole time senior clinical psychologist. Because there are so many people meeting the criteria of HF, but outside the remit of the Mental Health Act, things that are kind of seen as behavioural or because of the impact of trauma. … We kind of really need to be able to …have the most kind of skills and competencies at our disposal to build effective support packages, and so now we have a whole-time senior psychologist. (NGO manager)

It is important to note that alongside client advocacy by team members and champions, HF stakeholders, managers, and team members have also built important relationships with community

services. This process is slow and still incomplete, but the following excerpt illustrates the changes that have been achieved so far:

> You move somebody from emergency accommodation where maybe their catchment area was, you know, with one day hospital and they move to an area where now all of a sudden, their catchment area is changed, so, their day hospital is changed, and they don't have the mental health nurse calling into the hostel. … So, what I've been doing … is liaising with the day hospitals and doing a transitionary piece of, you know, going from one day hospital to the next. So, it's not overwhelming and that could be over a couple of weeks, you know, or maybe even month where, you know, you have maybe your wind down piece and in the day hospital that they were initially in and then moving on to the next one. (HF team manager)

Taken together, the evidence from providers' assessments indicates that most of their clients have access to the services they need. However, some HF clients continue to encounter delays to services due to long waiting lists or moves from one service to another. Lack of services in some regions require travel over long distances either by public transportation or transportation provided by their case managers. Case managers in more rural regions spend a substantial amount of time on the road with their clients, which offers valuable opportunities to work with and talk to clients about their recovery goals, but it also reduces the number of clients a case manager can visit each day. Some HF programmes introduced "workarounds" which made it easier for their clients to access supports. These included the use of virtual platforms to provide "telehealth", recruiting staff members such as, senior psychologists and creating good interpersonal relationships with the individuals providing the services. This shows that although challenges arose during implementation, HF programmes created successful strategies to provide their clients with needed supports. Case managers work with many clients who have not had positive experiences with health services, and these experiences have eroded their motivation to engage and their trust in the system. It is important for providers to understand these experiences so they can take clients' perspectives, understand their ambivalence, and meet them where they are at. Across the regions, HF programmes have created opportunities for NGOs and health care providers to coordinate services and work together. HF champions and heath service coordinators have been integral to these changes. Access to community-based health and social supports are integral to HF teams' ability to maximise their clients' choice over the services they receive and the recovery goals the choose to pursue.

# 7. Consumer Choice & Recovery Orientation

> *"Most Housing First services are provided in the client's natural environment (i.e., their home or local community). The service is time-unlimited in that it is offered for as long as a client needs that level of support. The pace of the programme and the experience of each client is individualised because clients can choose the type, frequency, and intensity of services. Progress and graduation from the programme occur at different times for each client."*
>
> *(Tsemberis, 2020, p. 20)*

As described in Section 4, in most regions, clients' preferences and needs were matched to features of available housing units, including location. Location is an important dimension of choice in housing, and to the extent possible, programmes do match clients to locations of their choice. This is not always possible, however, particularly in rural regions. In rural regions, matching clients to homes in locations of their choice continues to be a challenge:

One of the things…is the kind of funding model we have [was designed to serve a] very big, big county. We have worked in hubs, which is what we put in our tender at the beginning. But now we're finding that the hubs don't work. It is not where people want to be, and if you're going to give them their choice … of where they're going to be, they don't want to live [in a particular town] and we can't afford to go anywhere else…. In fairness, [what] we put in our tender … is to work off hubs, [meaning] basically we would work from the centre …and that works in [one county] because [clients] want to be in the main town. It does not work in [another county] because they do not want to be in [the town that serves as that hub]. They want to be in their area of origin. [NGO respondent]

One area in which client choice is challenging for case managers is in the early days of a tenancy, when a new client may feel vulnerable and alone in their new home. Visitors from hostels and the streets can put tenancies at risk. Although clients have finally obtained homes of their own, they have also left behind friends and acquaintances living in hostel accommodation or rough sleeping on the streets. When an individual moves into their home, they can experience ambivalent emotions analogous to survivors' guilt. Learning to "manage the door" so that visitors do exploit or manipulate clients or cause conflict with neighbours can take time and is even more challenging when the individual is living with an active alcohol or substance use problem. Acquaintances from hostels and streets may pressure the person to allow them into their homes in exchange for alcohol or other substances. For case managers, it can be difficult to maintain a client-led orientation when they feel their clients' choices are putting themselves and their tenancies at risk. This is a challenge even for experienced case managers. For case managers whose caseload includes many clients with intense support needs, for case managers who are less experienced in supporting people to manage their doors, and for case managers in regions where clients are highly geographically dispersed and resources are thin on the ground, it can prove even more challenging. For example, one team described the situation of an older woman with significant alcohol-related problems:

She has got a drinking problem and she'll openly tell you she's an alcoholic. …The problem is…this cycle where she's brought in by the guards to the hospital, then she gets admitted to psych, but psych just ultimately discharge her, and now she's back on the street drinking and it's just that cycle. There's nowhere [for her to go] … She's hanging around with the wrong people, like they give her alcohol, they give her other drugs, she thinks that's great… I checked the property this morning because like she's been letting people in and out, and if people do go in like, she doesn't have the capacity to tell them no or to leave or whatever. So, she is totally being taken advantage of. (HF team leader)

These types of situations demonstrate how case managers need external community-based resources to intensively engage with clients because they cannot do it alone. They need community partners who support the team by coordinating efforts to engage with clients in ways that align with HF principles and practice. Otherwise. when an individual and a tenancy are at risk, the attribution for failure can be misplaced onto the team, the programme, or the individual, rather than the system. As this team member concluded:

Yeah, it's very hard to find a positive. Like she's no living skills, she can't cook… Her personal hygiene is quite poor and um, it's alarming. It's quite bad to be honest. It's actually, I don't wanna be dramatic, but it's probably one of the worst [situations] I've seen over the past 10 years of working in this gig. I suppose just due to her age and her vulnerability and the fact that no one really seems to care. …And that's very, very frustrating. (HF team leader)

It is important to note that if this person was not engaged with HF, she would still be sleeping on the streets, rotating through emergency homeless services and A & E. It is useful to contrast this situation with a similar case in a different region, where the client has intensive support needs and depends on staff to take care of very basic activities of everyday living:

I suppose one person in particular… who is very high support…. we needed to put in special flooring because of incontinence issues and toileting management issues. He had never used appliances before. …A very, very high level of support. At the beginning everybody was kind of on board like, isn't this great? …As long as it's feasible to support them to the extent that they're in a flat, instead of sleeping rough, you're still achieving something. …It doesn't mean it's not working and it's time to call time on it. It means we are going to have to figure out how we bring in volunteers and resources [to] maintain an ongoing intensive level of support…. (HF manager)

Together, these examples illustrate the extreme end of HF clients' support needs, and they illustrate the HF principle that supports are individualised, intense, and open-ended. As the respondent in the second excerpt notes, not all cases are this intense, and with an adequately staffed HF team augmented with sufficient supportive community resources, individuals with high support needs can and do maintain independent private accommodation consistent with HF principles of separation of housing and services and client choice. Consistent with HF principles, this respondent noted the individualised nature of recovery trajectories. Not every individual's recovery journey will end at the same destination, and recovery is not on a timetable for anyone. HF ensures that each person has maximum autonomy and opportunity given their unique challenges and situation to find their way on their recovery journey on their timeline.

> *"Making choices about one's life, and experiencing the consequences of those choices, is fundamental to the process of learning and growth. Client choice – which translates into the experience of self-efficacy and self-determination – is a core principle of HF because it helps clients to develop a sense of mastery and wellbeing." – Tsemberis, 2020, p. 18*

Clients' choice regarding recovery goals are the heart of HF principles and values. Person-centred planning is used to identify clients' goals and capitalise on their individual strengths and resources. Case managers foster clients' self-determination over their everyday activities and respect their choices. Recovery refers to rehabilitation from alcohol and other drugs, reduction of mental health-related symptoms, and treatment for physical health problems. It also refers to personal growth, such as reclaiming old or developing new positive personal identities and relationships, as well as identifying and pursuing personal goals that give new meaning and purpose to life. Clients are not required to abstain from alcohol or other substances. Rather, the team uses assertive engagement and other creative techniques to work within a harm-reduction, client-centred approach to help them to reduce the negative effects of alcohol or substance use.

…It's nearly all drinkers we have at the moment…They have agreed for the team to -- from a harm reduction approach --buy their booze for them. That takes a lot of trust. So, so the trust is there with the team, the team discuss [with the client], you know, have you considered, would you consider, in an MI [motivational interviewing] consistent fashion the choices and options that are there, but by no means would be forcing anybody on an inappropriate recovery journey that they don't want to be on, but you can still be recovery-focused at the same time. (NGO manager)

The overall fidelity self-assessment score for the Recovery Orientation domain was 3.61 (out of 4.0) and ranged from 3.17 to 3.83. In comparison, the average score across the 10 sites in the multi-country study of HF fidelity was 3.7, and 3.5 for Ireland, for the equivalent domain "Service Philosophy". We heard many stories of staff members attempting to work with clients to reduce harm from alcohol and drug use, and we also heard stories from clients and team members about the range of approaches they used to promote both rehabilitation and growth-focused recovery. For example, we learned of case managers who

facilitated clients' interests in kayaking on the Liffey, gardening, attending the gym, learning to cook, reconnecting with their families, and going back to school. In one example, a case manager and their client went to play pool together to both have fun and help the client with their social anxiety:

Er no, I have, I have a case manager, and I go once a week with him. I've always, I love pool, I'm quite good at pool, so it's something that kind of yeah. Oh, I'm so sorry, I probably should clarify, I have crippling social anxiety, so that's what, that's… Without someone anyway, without someone, I've no family, I've no friends, so, it's just the case manager when he comes up to me. (HF client)

Importantly, however, most of our evaluation activities overlapped with physical restrictions associated with the Covid-19 pandemic. We were not able to visit teams, shadow them on home visits, review case notes, or otherwise gain first-hand experience of the extent to which services conducted person-centred planning, used motivational interviewing or other approaches intended to promote self-determination. We do, however, have indirect insight into some programmes' orientations to self-determination through our efforts to recruit clients to participate in the self-assessment questionnaires and interviews. Although HF clients are adults entitled to choose whether to participate in the evaluation and have their voice heard, several case managers expressed their reservations about their clients participating and told us that their clients were unable to do so. This pattern recurred often enough to raise questions about the extent to which clients or providers were making these decisions, although these incidents are anecdotal and therefore insufficient for drawing firm conclusions or generalisations about choice, autonomy, and self-determination.

Interestingly, the pandemic was described as opening opportunities for clients to work on substance use recovery goals. For example, a case manager from Dublin described how Covid-19 acted as a catalyst for those seeking to access addictions services.

> It's a very different picture from Dublin to the regions…In Dublin, you have a plethora of services. I suppose one of the marked differences recently has been Covid-19 because …access to services and what services could do and how quickly they could do them [completely changed]. And while Covid has been very complicated and difficult to work through, I'm hoping that one of the positives to it, aside from the much better traffic, is going to be the access to services because people who were on waiting lists for methadone were assessed and were nearly on their methadone within days. Which you know, when you're dealing with addiction, somebody has the notion that they're going to do something in that moment, you nearly need to act on it in that moment to get the ball rolling. But to tell an addict that they have to wait for a month for an assessment and they're still not even going to be on it at that stage, it made it very complicated for us. (HF team leader)

As we emerge from the pandemic, it is important that teams have the resources they need to support and encourage recovery in more growth-related domains. It will be important going forward to ensure that clients emerge from pandemic lockdowns, integrate into their communities, assume positive roles and identities that are personally relevant and meaningful. One important growth-related recovery goal is to repair and re-establish relationships with family members and friends, where appropriate and desired. We learned of several instances in which clients reconnected with family members. For example:

> But as of recent, I met my mother. I think like two or three months ago. I'm in contact with her. I'm back in contact with my siblings [also]. (HF service user)

According to one service provider, another client re-established communication with his sister, whom he had not spoken to in years, and they began to talk by phone on a regular basis.

> In order to stabilise, in order to reach complete independent living, you have to create as many anchors in the community as possible. And one of them was, one of the guys, all he wanted to do, you know, every week the project worker facilitated a phone call to his sister in England. So, he was able to tell his sister [about his home] and she was able to tell him that she's proud of what he did and that he has his own home now. And like that's as important, that's even more important in some cases than anything else you can do…and like that's what he looked forward to every week. (HF team leader)

We want to end this section on recovery with three success stories that illustrate how working intensively through individualised, client-led services, HF teams in Ireland have created opportunities for

people with long histories of homelessness and very complex support needs to establish and maintain homes of their own:

We have one lady actually, who was street homeless for many years and she's now in her accommodation 18 months. So that's very exciting. Even, you know, it was such a process because even to the aspect of hygiene and using a shower and using electricity, because she would literally turn off the full fuse box and everything every day. Because [her] concept of electricity was like, 'oh my God, we need to save this. We need harbour this.' And so… going through all of those things with that person was…it was extraordinary, really. And now to see her like, relish in her home is just, it's a beautiful thing.

Some of these people would have gone from sleeping on the street or shared rooms in hostels, never having a home before and now they have their own place, their own kitchen...When I look at them, I don't see the people that were in the hostel, the heads were down they were always hiding in their room, grumpy. Now, they're standing tall and they're very proud of themselves and you can see it.

There's a guy… who's the longest in homeless accommodation. Who's 10 years in homeless accommodation and so he's completely institutionalised and …loves the communal environment, but when I went down to tell him he was getting the HF house, this is before Covid, he hugged me, so there was huge jubilation and a big party when he got into his home… So he gets on really well with the neighbours and they're trying to link him in with the local kind of community structure, difficult in Covid times 'cause there hasn't been a whole lot of activities happening but yeah, he's doing his best.

Taken together, HF teams demonstrated a strong commitment to delivering client-led, recovery-oriented supports. To the extent possible in a context of significant housing shortages and a pandemic, programmes do their best to offer clients choice over housing. Choice over location was more limited in rural regions because of the scarcity of one-bedroom units and clients' preference to live outside towns designated as 'hubs'. Case managers work intensely with clients when they move into their homes to protect them and their tenancies. Challenges around "managing the door" were often cited as issues case managers worked on with their clients in conjunction with efforts to reduce problematic alcohol and other drug use. Across all the regions we heard many examples of case managers helping clients towards recovery, whilst respecting the client's choice, autonomy, and self-determination in the process. We also heard of how the pandemic widened access to services for those seeking recovery from substance use and many instances where clients reconnected with family members. The excerpts from interviews included here highlight clients' success stories. They also illustrate HF teams' successes in housing individuals with histories of long-term homelessness and complex needs and promoting their recovery with an individualised, client-led practice that fosters choice, autonomy, and self-determination.

# 8. Programme Operations

> *This dimension [of fidelity] examines the day-to-day operation, organisation and discipline of the Housing First service. This includes assessing the appropriateness of frequency of contacts, how crisis is managed, quality of staff supervision, and client representation in the programme's decision-making process.* (Tsemberis, 2020, p. 93)

HF programmes provide supports to clients and are available around the clock to respond to crises. Case managers have non-treatment related contact with clients at an intensity that matches their needs. A minimum threshold of four meetings per month is the standard, but this can increase or decrease in frequency depending on clients' circumstances. A low client-staff ratio ensures that adequate contact hours are possible each week, and everyone on the team is familiar with the programme's clients so that in case of staffing changes, clients will be familiar and comfortable with all team members. Team members meet regularly to discuss, plan, and review clients' support needs. Staff receive supervision from a line manager with expertise in HF principles and practice. Clients are fully represented in programme operations and can provide their input on relevant policies. The average fidelity self-assessment score across all regions for the domain 'Programme Operations' was 3.10 (out of 4.0). Scores ranged from 2.86 to 3.43. In comparison, the average score across the 10 sites in the multi-country study of HF fidelity in the corresponding domain, "Programme Structure" was 3.5, and 3.0 for Ireland.

Home visits are a core element of the Programme Operations domain. When an individual moves into a home obtained through HF, the person is usually visited at least daily until they become comfortable establish a routine. Because most programmes were very new, many clients had not been in their homes for long when the evaluation began (but see footnote 5). All new clients were visited on at least a weekly basis. Some clients had significant support needs that required daily visits on an ongoing, open-ended basis. During the pandemic, where possible, these visits were managed remotely or outdoors. Findings demonstrated that even through the most restricted periods of the pandemic, the teams were able to effectively support their clients:

> In October we rolled out a virtual support service […] So, this service I suppose is twofold for us. It came in as a result of the pandemic and a way to support people without always being in physical proximity to them, but also it became absolutely invaluable to us in the regions. So, the virtual supports over three bases, there is a mental health worker, an addiction worker, and a nurse. Those three can link in with clients either virtually through video, through WhatsApp or FaceTime. Or just over a phone for people who maybe don't want to do video or don't have a smartphone. And that also allows for a similar situation with us, where if someone is in crisis and they need that immediate intervention, and we are all an hour or two hours away, that person is able to ring the virtual supports line or equally virtual supports can ring and link in with them. And then it allows us that time to get to that person. So that's been absolutely fantastic over the last few months, and it works really well. We have quite a high percentage of clients in the regions engaging in it. (NGO Stakeholder)

Most of the regions had a system in place through which clients could contact someone out of hours. In some regions, out of hours supports were provided by a 24-hour service at a congregate living facility. Teams operating in large geographical areas described challenges in being able to cover their territories and to be able to meet with their clients as frequently as they wanted to.

> Like we have a really good team. So, it's more just we're really under-resourced. Sometimes you just have to make choices as to what you see. The funny thing about [our county] is we [have a very big] urban-rural divide. You look at [the north], it's really urbanised. And then you could go down south and it's really ruralised, really disadvantaged, really deprived. There's such different kind of needs across the whole county as well. (HF Team member)

Case managers and NGO managers in more rural and geographical regions noted that the recommended caseloads are difficult to manage because the ratio of travel time to visit time is high. Although the ratio of clients to staff remains within the recommended guidelines of HF operations, large distances between clients' homes and high staff turnover make it challenging for teams to meet their goals

for home visits and to respond quickly in emergency situations. Some respondents worried that as their programmes grow, they will have a difficult time maintaining an adequate number of face-to-face meetings with their clients each month. For instance, one service provider stated that:

> The biggest issue is the rural thing. That has to be addressed. It is very much a sense that this is a model that was designed for the big cities, for Dublin and stuff like that and then just attempting to place it out into the rural counties without really taking into account that it's not, the model is the same, it's just that the resources needed to do it to that extent in rural areas is not the same. You need a smaller client to staff ratio. You need more funding for things like travel and things like that […] So, going forward I think that's the biggest issue for us I would suggest is the resources to be able to do it, HF in rural Ireland properly. Whether that is in [the county town] town or in a village thirty miles away, they deserve the same service. That takes more resources than we have at the moment. So that's our biggest block going forward, I would suggest. (HF team member)

High rates of case manager turnover were frequently described by both team members and clients and was a concern mentioned by respondents across the regions by staff and clients. Clients described how difficult and frustrating it is for them to repeatedly build relationships and trust with new case managers (See Section 11 below). When we asked participants what they liked least about HF and what they would change, a large majority said 'nothing', but the second most frequent category of response referred to case manager turnover. The reasons for high rates of turnover are unknown, and could vary across the regions, but should be explored and addressed, because case manager retention is vital to building and maintaining client trust and for preserving important organisational knowledge.

Client representation in programme operations should include peer advocacy and input into operations and policies. As described below in Section 11, HF clients have strong desires to "pay it forward" and pursue further education and training to learn how to support similar others on their own recovery journeys. HF clients, with their insight, wisdom, and experience, are valuable resources not only to other HF clients, but also to the teams themselves. As Tsemberis (2020) described it:

> The HF programme has its origins in a profound commitment to peer support. The programme was developed out of a client-directed drop-in centre where half the staff was comprised of peer support. There were several reasons for hiring people with lived experience: the programme valued direct input from programme participants, peers fostered strong engagement and empathy skills, and it ensured the ongoing inclusion of the client perspective in programme design, operation and governance. Hiring peer support staff was also intended to reduce the boundaries between professional staff and programme participants. Finally, hiring peer specialists created a third voice in the service sector community: a body of participants with a perspective and a unique voice. Peer support staff could interpret the participants' experiences for the professional staff and explain the intentions of professional staff to the participants, simultaneously serving as role models for both groups. (Tsemberis, 2020, p. 79).

At this stage of the implementation, however, there is very little peer representation in programme operations. One HF team in one of the rural regions has added a part-time voluntary peer support worker to their team. This respondent's description of the peer support worker and his relationship to other clients and to the team aptly reflects Tsemberis's description of this role:

> A very articulate and intelligent man… he has a great way with people and ...he is also very conscious of his story. …He is also not shy in telling the rest of us that we are talking through our behinds, if he thinks that we are. He is very articulate, a very soft, gentle man. Really, really very well suited to the role. Well able to advocate for [other clients] and indeed for himself…The lads react very well to him… it is also good for them because they know him … as somebody who was in the hostel with them, as another service user of it. You know, to see that he has had his journey and that there is a road out of it. (NGO manager)

For the rest of the regions, however, inclusion of peer workers and client representation in programme operations is mostly aspirational and something they plan to incorporate into their programmes.

> I think maybe a bit of peer support and like, you know, the long-term rough sleepers who are now housed and doing well, having them coming out and talking about it I think will help you know. So that is [peer support] something that [we] are working on at the minute, that peer support element because that will be crucial to [making it the] norm, you know and to accepting that. Okay, rough sleepers are rough sleepers but if we bring them into the community we could do great things for them, and they can integrate into the community seamlessly, not seamlessly in some cases, but you know, at the end of the day, you know they're human beings. They have issues and we'll help them deal with those issues so that

> they can integrate into the community and live a normal life, as normal as possible. You know, so I think that peer support is the bit that we're working on at the minute that's missing. That only comes with time anyway. (NGO manager)

HF teams meet frequently to discuss clients' cases and develop individualised care plans. Teams in more geographically dispersed regions used platforms like Microsoft Teams, Zoom, and Whatsapp to meet and discuss cases. These platforms were crucial tools for supporting clients during the restrictive periods of the pandemic. Across the interviews and focus groups, team members and stakeholders described the creative ways in which they stayed connected, shared important information about clients, and supported one another. Case managers absorb a substantial amount of vicarious trauma shared with them by their clients, and their work is very difficult, which can lead to burnout and turnover. Case managers who described their teams as cohesive and supportive also talked with passion about their commitment to their work and their clients. This passion and commitment are vital to clients' engagement with HF and their recovery from homelessness.

Across the regions, HF teams demonstrated good fidelity in programme operations. All teams have close contact and communication with their clients that intensifies and relaxes in response to clients' needs. Teams in most regions, especially the most recently formed teams, exceed the recommended three or four visits per week, because their clients have not been in their homes for very long. In contrast, in Dublin, some clients have been with HF for years now, and they are living independent lives with minimal contact with their case managers. Although it may not be an outcome for all or even many HF clients, graduation from the programme is an important goal for some. When graduations do occur, clients will stay in their own homes and receive services they need from community-based resources. As programmes mature, it will be important for them to develop, strengthen, and expand client representation as peer advocates, on committees and governing bodies. In rural areas, client-to-staff ratios must factor in large geographical regions with highly dispersed clients. Greater understanding of the causes of case manager turnover is needed to improve retention.

# 9. Clients' Experiences of HF, Recovery, and Well-being

The clients' self-report questionnaire included a broad range of indicators of how clients are doing and how they experience the services they receive (see Table 9.1). In this section we contextualize average scores obtained from NHFIE clients with comparisons to previously published findings from three sources: The Dublin HF Demonstration Evaluation (Greenwood, 2014), the Canadian HF trial, *At Home/Chez Soi,* and the Clients Study arm of Homeless as Unfairness (Home_EU), in which data were collected from homeless services users – both HF and Treatment as Usual (TAU) -- in eight European Countries. We do not have data from all three sources for every measure against which to benchmark our findings. We searched the HF literature for additional reports of scores on these measures and included the ones that we found in this section. Variations in reporting methods required us to perform some transformations on the data we extracted from these publications.[6]

**Housing and Services**

*Housing Quality.*[7] Housing quality (Toro et al., 1997) is a 6-item measure on which participants rate aspects of their housing 1 = *very bad* to 5 = *very good.* The average score for the **NHFIE sample = 4.43.** The average scores for two assessments obtained for Home_EU were HF = 4.10 and TAU = 3.48 (Greenwood et al., 2021). Within the Home_EU sample, the average score for Irish participants at Time 1 was HF = 4.49 and TAU = 2.92. In the Canadian HF Trial of At Home/*Chez Soi* (Aubry et. al, 2015), across four assessments the average score for HF was 4.02, and the average for TAU (Treatment as Usual) was 3.66.

*Consumer Choice.* With this 15-item measure (Srebnik et al., 1995), participants rate their choice over housing and services on a scale from 1 = *no choice* and 5 = *completely my choice.* The average score for participants in the **NHFIE sample = 4.5.** Scores reported from Home_EU were HF = 4.33 and TAU = 2.88. For the Irish Home_EU subsample at Time 1, HF = 4.5 and TAU = 2.76. At the 12-month assessment in the Dublin HF Demonstration, the average choice score was 4.24 for the HF group and 2.67 for the comparison group. In another study of 45 HF participants in Lisbon, Portugal, perceived choice was assessed with a modified choice measure (Martins, Ornelas, & Silva, 2016), and the average score was 3.99.

*Housing Programme Choice.* We assessed satisfaction with choice over specific aspects of housing with a measure included in the Canadian At Home/Chez Soi HF trial. This measure consists of five items that assess satisfaction with, for example, affordability, satisfaction with contact and availability of case manager. Items are rated on a scale from 1 = *Very Dissatisfied* to 5 = *Very Satisfied*. **For the NHFIE sample, the average score was 4.4**, corresponding to an average assessment between 'Satisfied' and 'Very Satisfied'. We could not locate any published scores to contextualize this finding.

*Working alliance.* The Working Alliance Inventory – Participant Version (Horvath et al., 1989) consists of 13 items rated from 1 = *never* to 7 = *always* and assesses the participants' perception of the quality of their collaboration with their case manager. For participants in the **NHFIE sample, the average score was 5.9**. The average score across two time points observed in the Home_EU sample was HF = 5.82 and TAU = 5.27. For the Irish subsample, the average was HF = 6.37 and TAU = 5.78.

*Service Satisfaction.* A 10-item version of Core Service Satisfaction Scale (Adair et al., 2005) assessed satisfaction with services on a scale from 1 = *Terrible* to 5 = *Delighted*. The average score on this measure for participants in the **NHFIE was 4.52**. Although we could not find published data for homeless services users, we did find a report of scores from a sample of persons with severe mental illness engaged with

[6] Articles reporting findings from At Home/Chez Soi report averages of participants' sum scores for each measure. To facilitate comparisons, we converted averaged sums to an averaged mean by dividing by the number of items in a given measure. So, for example, averaged sum scores for the RAS were divided by 22 and averaged sum scores for psychological community integration were divided by 4. Decisions regarding transformations were made in consultation with one of the lead evaluators from At Home/*Chez Soi*.

[7] These items were rated on a scale from 1 = Very Bad to 4 = Very Good in both the Home_EU study and the IHFNE. Raw scores were multiplied by 1.25 to convert them to the five-point scale used in At Home/*Chez Soi.*

community mental health services in Canada (Adair et al., 2005). The average of quartile scores reported in this article was 3.89.

**Mental Health and Well-being**

*Psychiatric symptoms.* Psychiatric symptoms were measured with the Colorado Symptom Index (CSI; Shern, et al., 1994). This measure consists of 14 items that assess the frequency of psychiatric symptoms during the past month, from 0 = *not at all in the past month* to 4 = *at least every day*. The average score for **NHFIE participants was 1.63.** In comparison, findings from At Home/*Chez Soi* averaged across three assessments yielded a score of 1.57 for the HF group and 1.66 for the TAU group. At the 12-month assessment in the Dublin HF Evaluation, the average score for HF was 1.12 and the average comparison group score was 2.03. The average scores obtained for the entire Home_EU sample countries were HF = 1.77 and TAU = 2.10. For the Irish Home_EU sample, HF = 1.91 and TAU = 2.35. Further, Greenwood and Manning (2017) reported an average CSI score of 1.91 for Irish residents of long-term homeless accommodation.

*Recovery.* The Recovery Assessment Scale (RAS; Corrigan et al., 2004) measures recovery as *personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination by symptoms.* Participants rate items on a scale from 1 = *strongly disagree* to 5 = *strongly agree*. In the **NHFIE, participants' average RAS score was 4.0.** For participants in the Dublin HF demonstration, the average score at the 12-month assessment was 4.26 and the average score for the comparison group was 3.86 (Greenwood, 2014). Across two time points, Aubry and colleagues (2019) reported a subset of findings from the Moncton site of the At Home /*Chez Soi* trial, with HF = 3.75 and TAU = 3.60. Across two assessments obtained for Home_EU, the average scores were HF = 4.09 and TAU = 3.89. For the Irish sample, HF = 4.21, and TAU = 4.04.

*Mastery.* 'Mastery' refers to self-determination and is measured with a seven-item scale (Pearlin & Schooler, 1978) with 1 = *Strongly disagree* and 4 = *Strongly agree*. The mastery scale assesses the extent to which an individual feels they have control over their outcomes and is believed to be one of the key psychological mechanisms through which choice over services aids recovery from homelessness. Participants in the **NHFIE scored, on average, 3.00** on the mastery scale. At the 12-month assessment period for participants in the Dublin HF Demonstration Evaluation, the average mastery score was 3.36, and the average comparison group score was also 3.36. Among individuals in long-term homeless accommodation in Ireland (Greenwood & Manning, 2017), participants' mastery scores were 2.82, and among another sample of residents of long-term accommodation in Ireland, the average mastery score was 3.22.

*Community Integration (Psychological).* The psychological integration subscale of the Community Integration Measure (Aubry & Myner, 1996) assesses the extent to which participants feel connectedness and belongingness with their community with four items on a scale from 1 = *Strongly disagree* to 5 = *strongly agree*. The average score for participants in the **NHFIE was 3.6.** The 12-month assessment scores from the Dublin HF Demonstration Evaluation were 3.56 for the HF group and 3.26 for the comparison group. Among the Irish participants in long-term homeless accommodation the average mastery score was 3.73 (Greenwood & Manning, 2017). Averaged across two time points (baseline and 12-24 months) Aubry et al. (2019) reported psychological integration averages for participants in the Moncton site of the At Home / *Chez Soi* trial, HF = 2.74 and TAU = 2.65.

*Community Integration (Physical)*. This subscale of the Community Integration Measure (Aubry & Myner, 1996) assesses whether participants engaged in any of 7 different community-based activities, such as attending a religious or spiritual service or sporting event, visiting the library or a café, in the past 30 days. The average score for participants in the **NHFIE was 1.30**. It is important to remember that these data were collected during severe lockdown periods during the Covid-19 pandemic. Aubry and colleagues

(2019) reported the level of physical integration for participants in the Moncton site of the At Home / Chez Soi trial, HF = 1.92 and TAU = 1.91.

*Quality of Life.* Because the service user self-report questionnaire was already long, we chose to include two single items to assess quality of life. We made this choice based on evidence that single item measures are as effective as more lengthy measures of QOL (Jovanović & Lazić, 2018). We asked participants in the NHFIE to rate their overall quality of life and their satisfaction with their life as a while on a scale from 1 = *Very dissatisfied* to 10 = *Very satisfied,* and the average score for **NHFIE participants was 6.55**. Patterson et al. (2013) reported longitudinal findings of changes in QoL for the Vancouver site of the At Home/Chez Soi trial. For the item that measures global QoL on a scale from 1 = *Terrible* to 7 = *Delighted*, the HF (both ACT and ICM groups) average score was 4.43 and the average TAU score was 4.16.

Finally, we created new items to assess the extent to which participants felt that their everyday activities were limited by their physical health, mental health, and substance use in the past 30 days. Each item was rated on a scale from 1 = *Never* to 5 = *Always*. For all three items, average scores for **NHFIE participants** were below the midpoint (See Table 10.1), indicating their everyday activities were never to rarely limited by physical health (*M* = 1.8), AOD (*M* = 1.6), or mental health problems (*M* = 2.1).

**Table 9.1 Key Outcome Measures from Clients' Questionnaire**

| Measure | Scale Anchors | | Mean | SD |
|---|---|---|---|---|
| Housing Programme Choice | 1 = Very dissatisfied | 5 = Satisfied | 4.4 | 0.6 |
| Housing Quality – Toro et al. | 1 = Very bad | 5 = Very good | 4.43 | .64 |
| Choice (Srebnik et. al) | 1 = No choice | 5 = Completely my choice | 4.5 | 0.5 |
| Working Alliance | 1 = Never | 7 = Always | 5.9 | 1.2 |
| Satisfaction with Services | 1=Terrible | 5 = Delighted | 4.5 | 0.8 |
| Psychiatric symptoms | 0 = not at all in the past month | 4 = at least every day | 1.63 | 0.64 |
| Recovery | 1 = strongly disagree | 5 = strongly agree | 4.0 | 0.6 |
| Mastery | 1=Not at all my choice | 5 = completely my choice | 3.00 | 0.50 |
| Community Integration (Psychological) | 1 = strongly disagree | 5 = strongly agree | 3.6 | 0.8 |
| Community Integration (Physical) | 7 community-based activities | 0 = No, 1 = Yes | Mean = 1.30<br>Range = 0 – 5 | 1.22 |
| Quality of Life | 1 = Very dissatisfied | 10 = Very satisfied | 6.55 | 2.07 |
| Activity limited by physical health (past 30 days) | 1 = Never | 5 = Always | 1.8 | 1.2 |
| Limited by AOD (past 30 days) | 1 = Never | 5 = Always | 1.6 | 1.1 |
| Limited by mental health (past 30 days) | 1 = Never | 5 = Always | 2.1 | 1.4 |

Taken together, these patterns demonstrate that participants in the National HF Implementation Evaluation are like findings obtained from other samples in Ireland and in other countries. These data are further indications that the Irish HF implementation is achieving its aims for housing and supporting adults who have lived significant portions of their lives in homeless situations. Going forward, these data can serve as a benchmark for monitoring clients' outcomes over time.

## 10. Social Connections & Meaningful Activity

We sought to understand clients' experiences of social connection after they moved into their new homes. The transition from congregate living to living independently can be associated with increased loneliness and isolation, and it is a period where existing friendships and acquaintances can undermine successful tenancies. It is important that clients develop trust in their case managers and that they build an effective working alliance together (Sandu et al., 2021; Stergiopolous et al., 2014). Much previous research has focused on loneliness and isolation because of moving from congregate to private accommodation (e.g., Ferreiro et al., 2021), and so it is important to understand how teams support their clients to minimize and cope with these experiences. To do so, we interviewed 15 individuals who had participated in the clients' self-assessment questionnaire (See Section 4): six women and nine men, ranging in age from 21 – 65 years old. These interviews were completed during extreme physical distancing restrictions intended to control spread of Covid-19, and so our findings are shaped by that context. Participants were asked to talk about relationships with case managers, family, friends, and neighbours.

Across the interviews, clients described positive relationships with their case managers. They expressed deep appreciation for case managers who were described as "helpful", "efficient", and going "above and beyond" their responsibilities to support them. Supportive case managers helped their clients feel as if they matter and they can make positive changes in their lives. For example:

Yeah, I think if I'd had her when I was younger… I think I would have had a better life. Yeah, it's just she's there to listen to me and chat like and it's like, you know what I mean? It's just like someone's keeping a record and I get to look at myself from another angle…

Case managers were described as going "out of their way" to provide clients with social support to ease the loneliness of living alone and the isolation experienced in the pandemic. One participant described how, even though she lives alone, she does not feel lonely because of her connection with her case manager:

She's been good company in that way as well because I'm just a single person, and support to know that there's someone there if I want to call, we call each other, you know? Like she, she's more like a friend at this point than a support worker.

Living alone can be lonely, especially in a new location; however, clients described case managers' support as both constant and unconditional, providing both comfort and reassurance. Case managers were frequently described as important members of clients' social networks. For one man, who was "*put out on the streets on my 18th birthday*", his relationship to his key worker relieved loneliness and loss:

[My case manager] dug the foundations in the groundwork because I come from a background of having no parents and being in care since I was two. He's [case manager] helped me a lot.

Many clients described the supports they receive from their case managers as essential to their recovery, with many saying something like, "I wouldn't be where I am without thanks to them". However, when case managers are the sole or primary source of social support and connection, staffing changes can be upsetting, especially when it happens frequently. Some participants remarked they were "getting sick of getting new case managers", and others said they were hesitant to connect to another new case manager. One person noted how difficult it was to trust and rely on someone only to see them leave after a short period of time:

But when you get attached to someone, you know what I mean? So, I was getting a few coming up to me and they were bleeding great like one or two girls were very good and would do anything for me, you know what I mean? They were only there for…I thought they were going to be there for two years but after six months, they'd have to go somewhere else.

Trust is fundamental to the client-case manager relationship, and disruptions can undermine recovery. Clients need to talk about difficult and private situations, to share stories that might be difficult and painful, to be able to ask for and receive the services they need. The case manager may be the most or one of the most important relationships in the clients' social network, especially in the early days of a

tenancy. A third reason this relationship is so important is that case managers can be extremely effective in supporting clients to navigate more difficult relationships with acquaintances, friends, and family.

Most interviewees described how relationships forged on the streets and in emergency accommodation were both valued and fraught. As mentioned in Section 3, learning to manage changes in these relationships, and to effectively "manage the door" is essential for maintaining a new tenancy. It is not surprising that clients hold onto relationships made during periods of homelessness and that they would want to help acquaintances still living in homeless situations. At the same time, most participants recognised the need to avoid certain old relationships. As one client said, "*if you don't want to keep your place, you'll let people in*". When acquaintances are actively using alcohol or other drugs, it can interfere with clients' efforts toward harm reduction and mental health recovery:

Well, it's just about being able to stay away from everyone and you know, just being on my own, having my own space, and taking pride in it. And it also helps my mental health, like I don't feel suicidal as much anymore.

HF clients have good insight into the problems created by relationships with others whose activities, including active substance use, can undermine both their tenancies and their recovery. It is not easy to negotiate these relationships, so clients may choose to end them, do things by themselves, and keep their own company. Clients reported that they know where to obtain help (from case managers) when they need it and found both comfort and security in everyday solitary activities and routines, like having a cup of tea or walking their dog. As one woman said, "If I want a relationship, I can have a relationship". Thus, at least for some HF clients, alone does not mean lonely, and the experience of privacy and solitude is highly valued. The void left when friendships and other relationships are ended are filled by new connections, first and foremost with case managers. Phone calls and visits from case managers were highly valued by clients. Importantly, effective case managers also help clients manage their door and negotiate relationships with individuals whom they know from the streets and congregate homeless accommodation.

From the safety and security of their own homes, HF tenants can plan and choose when and how to reconnect with family members. Several participants told us of reconnections with their parents, siblings, children, nieces, and nephews. Case managers are important sources of support and reassurance when these attempts are unsuccessful. Attempts to repair fractured relationships with family members can be difficult and disappointing, however, so it is important that clients have case managers who are engaged with the process and can support them if their efforts are rebuffed.

It's only in the last six weeks that I met them again... I said to her, "Do you mind if I dropped up?" and she said, "I'm not ready for that", and I said, "That's fine" and I said, "Look it when you're ready, I'll be there".

Clients may not wish to repair old relationships or establish new ones. One important source of connection for individuals in HF is a companion animal. Companion animals not only relieve loneliness, but they also provide important opportunities to matter to and be responsible for another being (Prilleltensky, 2020). Companion animals, especially dogs, are an important means through which clients can establish a daily routine, which many described as highly valued. For example, one client described how their companion animal provides structure and purpose to everyday life:

He [the dog] gets me up and out and stops me from isolating and stuff, but he has to be walked three times a day so that gets me out for fresh air and once I'm out I'm fine. I don't mind going back out then again... I tell people he's an emotional support dog.

The continuous contact and support provided by a companion animal keeps participants active, provides them reasons to leave the house and interact with the outside world. With a dog, the person is never completely alone or isolated. A dog also facilitates community integration and connection with neighbours. One client described how his dog is always there to stop him from feeling lonely:

Yeah, and my dog. I sat him down here with me now and he goes for walks with me all the time. He's great company down here when I don't have the grandkids, I have the grandkids at weekend.

Another client spoke of how, during the height of the Covid-19 pandemic, she dealt with isolation by getting a companion animal: "You know how I coped? I got a dog!" In a time where face-to-face contact with others, including case managers, was restricted, a pet was constant in participants' lives and was described as an important source of connection and well-being.

Loneliness and isolation are often experienced by individuals who move to a new neighbourhood, whether they have a history of homelessness or not. Given the interpersonal difficulties that individuals with long histories of homelessness have typically experienced, a core component of case managers' roles is to encourage and empower clients to build positive, trusting relationships by supporting them to repair broken ties, make new friends, and integrate into their communities. This is important because clients' case managers can become their most important relationship. However, relationships with case managers may end if the case manager leaves their post. Moreover, relationships with case managers are mostly unidirectional. Certainly, case managers develop deep affection for their clients, but the relationship is a professional one, and it is not equal status or reciprocal. Our most satisfying and rewarding relationships, the ones that contribute to our well-being, are bidirectional and allow individuals to experience opportunities to both give and receive (e.g., Antonucci, 1985; Crocker et al., 2017). Companion animals can fill an important gap in social connection and support created by the experience of long-term homelessness (O'Shaughnessy et. al, 2021), but opportunities to develop mutual, reciprocal relationships with significant human others is fundamental to well-being and supporting clients to develop and nurture these relationships is an important responsibility of the case manager role.

Contemporary conceptualisations of well-being focus on two dimensions: pleasurable experiences and actualising experiences of meaningful activity and connection with others (Seligman, 2018). We sought to understand clients' well-being by gaining insight into their everyday activities, personal goals, and hopes for the future. To do so, we completed an additional 10 client interviews with six men and four women aged 23 – 65 (average age = 40). Again, it is important to remember that these interviews were conducted mostly on the phone and during pandemic lockdowns, so we may have obtained different responses if individuals had more opportunities for a broader range of social activities, both informal and formal.

Many clients expressed pleasure in the activities of everyday life associated with maintaining a home, such as making the bed in the morning and cooking meals. They also told us they were engaged in a wide range of hobbies and leisure activities including gardening, camping, fishing, and carpentry. Consistent with our findings regarding social connectiveness and spending time alone, most clients mentioned pleasure in solitary activities, such as this person who described his love of camping this way:

I go off camping a lot, d'ya know em, I'm a loner, I don't really like other people's company a lot of the time. So, I like going off camping off on me own and stuff like that ya know. As I said, a lot of people just annoy me, d'ya know what I mean, they just, they're all looking for something so, I just keep to meself to meself. Oh, I love it, everything about it yeh, I have loads of camping gear in there, d'ya know what I mean, anything you could possibly think of to go camping I have it there. Like, just going up, going up to the woods with all the stuff that I have, yeh and I could survive up there for weeks if I wanted.

Because of the pandemic lockdown, a lot of activities were in the home, especially watching television and reading.

Ah yeah I read a lot of books, now, yeah there's times when I've been in the middle of a book, I look at the clock and five hours have gone by ya know, and I'm like no way you wouldn't expect that.

Others described social activities such as playing pool, football, and soccer, or taking cooking and gardening workshops alongside others. Some said they engaged in these activities with their case managers, such as one participant who enjoys playing pool but also struggles with significant social anxiety.

Being able to engage in activities that one finds pleasurable is important to well-being. Meaningful and purposeful activity are important to human flourishing because they satisfy needs for competence, relatedness, and self-acceptance (Diener et al, 2010). Participants described many different activities and aspirations for achieving well-being in these domains. For example, participants described ambitions to

help others, accomplish personal goals, and deepen their spirituality. Some focused on their own personal growth in terms of managing addiction, improving relationships, and meditating. One participant was actively involved in a peer support group for individuals who experience auditory and visual hallucinations. This group also provides workshops for first responders to help them understand how to help and protect individuals experiencing psychotic episodes:

It's basically just we meet up every Thursday and we talk about hearing voices. Like about the voices we hear and I'm the facilitator there for the last…. Three years. So yes, yeah…. And I work sometimes with Mental Health Ireland. What we do is we train Guards, first responders, ambulance men about how to actually deal with someone who has paranoid schizophrenia, rather than treating them all as they're all the same… We show them that … there's a spectrum of paranoid schizophrenia, you know? Yeah, that's what I do, so that's what I do in my spare time.

HF clients have many aspirational goals for personally meaningful and purposeful activities. These include further education, learning a trade, going back to work, working on their recovery goals (including managing substance use and mental health problems), travel, and working on valued relationships. Many recalled occupations they held in the past, both paid and unpaid. One client had worked as a carpenter, for example, and hoped to return to similar work. Several were waiting for physical distancing regulations to relax to begin new roles, such as a volunteer in a charity shop or as an employee in a gym.

The most frequently cited goal, however, was to pursue further education. One participant wanted to complete secondary school, one aspired to learn Arabic, and another has a passion for astrophysics. Some participants wanted to learn a trade such as driving a delivery truck, but most wanted to return to education so they could work in the helping professions. Several wanted to study social care so that they could support others, for example, adolescents struggling with addiction. One wanted to study emergency medicine. Most linked these interests to a desire to "pay it forward". For example:

I'll tell you what I want to do. When I was in the hostels. You know some of the people that were there made a big difference for me, yeah, so I probably would go do social care or psychiatric nurse.

Many clients said they would like to travel and see the world, with aspirations ranging from swimming with the whales to travelling Route 66 to walking the Camino. Personal development through health and exercise, through continued work on recovery from problem-related alcohol or other drug use, and through developing personal insights and self-knowledge were mentioned by several participants as their most important goals. One person expressed a desire to become healthy and happy for their kids:

…basically get me life back on track the way I want to get it on track, ya know leave a legacy for me kids, and just be happy and healthy in meself again ya know that kind of way, just like mind, body, soul d'ya know, not like having to worry about this that or the other, and is this going to go away or is that going to go away, d'ya know, that's it like just to, just to be happy in meself.

We wanted to know what clients hoped for and how they envisioned their futures. Several expressed hope for independence, mostly defined as continued stability and security in a home of their own. Others hoped to continue their journeys of recovery from substance use, while others aspired to repair relationships with. Together, their responses illustrate hopes for positive connections with others, for safety and security, and personal accomplishment, health, and well-being. For example:

Right, five years from now, oh my God (laughs). Um I want to finish me college and then I'd like to actually help people that have been through the same situation that I have been through, d'ya know and give back, basically d'ya know as well…as you know, rebuild relationships.

Since moving into their homes, HF clients have embarked on individualised paths to recovery. They find pleasure in the activities of everyday life, especially making and maintaining a home and hobbies and other activities that are personally meaningful to them. Their activities and aspirations are those believed to be integral to a well-lived life: health and well-being, positive relationships, engagement in pleasurable occupation, and personal accomplishment. Although our analysis of participants' responses to our questions may not represent all HF clients' experiences, they do give us some insight into their everyday lives, hopes and dreams. As one client said, she is ready to turn the page and start the next chapter of her life:

Yeah, I'm very resilient, I'm like a little warrior. Um, I've been through a lot, a hell of a lot, and d'ya know, it's kind of just stepping forward to something else I prefer, something else that is going to be, like a new chapter …of me life, basically.

As noted above, satisfying social relationships provide opportunities to give support as well as receive it. The finding that so many clients described, in one way or another, express a drive to support and help others is instructive. First, HF clients may talk about the importance of self-reliance and being on their own, but they also have a need to reach out to and matter to others in reciprocal, meaningful ways. "Mattering" refers to feeling like one has value, whether to self, others, work, or community (Prilleltensky, 2020, p. 16). Mattering is a building block of a meaningful and satisfying, purposeful life. HF clients have much to offer others and need opportunities to capitalise on their strengths, experiences, and wisdom forged through experiences of homelessness. Across the evaluation, we observed that opportunities to participate in HF programmes as peer support workers or in other meaningful roles were not yet available, even though this is a key component of a HF programme with high fidelity. We suggest that programmes should prioritise the mobilisation of resources necessary to support clients into peer support roles and into other valued roles in the programme. Clients with lived experience have much to offer and being able to contribute to their wisdom and experience will be mutually beneficial to the programme and to themselves.

# 11. Acknowledgements and Limitations

The evaluation team would like to acknowledge the significant time and information that HF clients, case managers, team leaders, programme managers and stakeholders provided to us. We particularly want to highlight the contributions of clients and case managers. Many case managers made substantial time investments in the evaluation: they facilitated our access to HF clients for questionnaires and interviews, who completed provider assessments for their clients, completed the fidelity self-assessment for their team, and participated in focus groups and individual interviews. Clients generously shared their time, information, and personal stories with the evaluation team members. Team leaders and programme managers willingly and enthusiastically spoke with us about the work they do in their regions, sometimes on more than one occasion, sometimes for two or three hours at a time. Because of their support for the evaluation, we were able to collate a wealth of information from a wide range of sources and have confidence in the conclusions we drew from the findings. Nevertheless, as with all evaluations, there are some aspects of the timing, context, and approach that readers should take into consideration while assessing our findings and inferences, which we explain further in this section.

**Covid-19 Pandemic**

Covid-19 affected every aspect of the evaluation, mostly in negative ways, although there were also some positive consequences. The most substantive consequence was that we could not visit the HF programmes and met face-to-face with only a few HF clients. We would like to have visited the teams, attended their meetings, and joined them on home visits. We would like to have administered questionnaires and interviews in person with all HF client participants so that we could experience the joy of someone showing us their new home. Interviews and focus groups with service providers and stakeholders were all conducted online. Data collection with clients was almost entirely over the phone. Near the end of 2021, however, before the omicron infections surged, our evaluation team was able to visit the Dublin, Mideast, and Northeast programmes. Teams in these regions facilitated questionnaire data collection with several clients, and in doing so, chauffeured us across large regions. Through this experience we obtained glimpses of how small teams navigate large geographical regions, and this provided us with some insights that we included in this report.

**Sampling approaches**

We were able to obtain self-report questionnaire data from 143 clients from across all nine regions, but we do not know how representative this sample is. We were not able to obtain a list of clients in each region and directly invite them to participate. Rather, we recruited indirectly, via case managers acting as gatekeepers. Because we administered questionnaires and interviews with clients over the phone, we also had to rely on case managers to explain the evaluation, what was being asked of clients, and obtain voluntary informed consent for us, activities that fell outside the case managers' already heavy and often intense role responsibilities. Case managers used their own individual judgement to decide which clients to tell about the evaluation and ask to participate. Case managers' choices about who to approach may have been shaped by their individual beliefs about the evaluation and their clients' ability to participate. All HF tenants had a right to have their voice heard in the evaluation, and we encouraged case managers to let participants talk to us first and then decide whether to participate. However, some case managers expressed strong reservations about whether some of their clients could or should participate in this evaluation. Consequently, clients with high support needs and those who may have been more dissatisfied with their HF services may be underrepresented in this sample. Thus, while the evaluation team intensively engaged with HF teams in all nine regions to recruit as many HF tenants as possible and let them choose whether to participate after they spoke to us, we recognise that our findings may be shaped by our sample characteristics.

**Fidelity Assessments**

Fidelity was self-assessed by team members using a standardised tool that measures the extent to which the programme functions in accordance with five key ingredients of HF practice (See Tsemberis, 2020). We followed these self-assessments with focus groups with team members to consensualise the scores and then took the consensualised scores to focus groups with stakeholders to discuss enablers in areas of high fidelity and barriers or challenges in areas of low fidelity. The primary advantage to this approach within the context of a large and multi-pronged nationwide evaluation is that it is quick and easy, and it returns trustworthy findings that can provide a snapshot of how and why programme is operating as it is, at a given time. Another advantage is that a team can use this tool themselves to monitor the programme and look out for fluctuations in fidelity over time, for example in relation to staffing, organisational, and structural changes. The primary disadvantages to relying only on self-assessments are the very human motivation to be seen and assessed in a positive light and the competitive funding environment that motivates individuals and organisations to put their best face forward. The evaluation team assured HF teams that our aim was not to catch them out on areas of low fidelity, but rather to help them identify areas of higher and lower fidelity so they could capitalise on strengths and address areas in need of improvement or development. Nevertheless, it may be that this approach to fidelity assessment is not sufficient for capturing areas of lower fidelity. Our fidelity assessments would have been enriched by site visits, case notes reviews, focus groups with HF tenants, and importantly, shadowing case managers on home visits. That said, we are confident in our findings that the HF programmes in all nine regions are operating with a high degree of fidelity to the HF model and are staffed with team members and managers who are highly committed to improving in areas of lower fidelity and maintaining areas of higher fidelity. We recommend that future evaluations include the full complement of case review, site visits, and meetings with staff and clients.

**Programme Implementation and Interagency Coordination**

With few exceptions, we had wide open access to team members, managers, and stakeholders and we were able to amass a large amount of information about how the programmes learned to work together to deliver HF in their regions. In each region, we were able to talk to representatives of local authorities, the HSE, and NGOs. The NGOs are most widely represented among service providers and stakeholders and given the relatively greater representation of the NGOs compared to local authorities and the HSE, it could be that the inferences we drew were skewed toward NGO experiences, and that we may have drawn different, or differently nuanced inferences with a different pattern of representation from the LA, NGO, and HSE in each region. Our experiences, however, across the board, both within and across regions, were of honest, thoughtful reflection and description of both successes and challenges, facilitators, and blocks.

The evaluation was not designed to identify “workarounds” to overcoming challenges to linking clients with services, but it is important to note that we have heard, anecdotally, about some workarounds, especially in the case of brokering models, that have been implemented since the Covid-19 pandemic and to recognize that certain developments have taken place. For example, one new development is the establishment of client consent protocols between Mental Health Teams and Case Managers. Mental Health Teams secure the HF clients consent specifically to contact the case managers about their upcoming appointments. This workaround was described by one informant as alleviating some of the pressures associated with keeping clients engaged with support services. Further, this informant noted that these small tweaks in practice can have significant impact for those implementing HF with the brokering services delivery model.

# 12. Recommendations and Conclusions

Based on evidence obtained from clients, team members, managers, and stakeholders, we offer the following ten recommendations for the future development and expansion of HF across the nine CHO regions. These recommendations arise from an overall appraisal of a highly successful and remarkable, cutting-edge and innovative approach to national implementation of HF that can serve as a model for effectively implementing HF in other national contexts with histories of seemingly intractable, yet solvable, chronic homelessness.

## Recommendations

1. *Sustain commitment to HF at local, regional, and national levels.* There is a substantial evidence base that HF can and does end long-term homelessness for individuals who have complex support needs in urban, suburban, and rural regions across Ireland. Beliefs about the ability of this group of individuals to live independently have shifted, and now stakeholders across the nation are involved in delivering this important service. This is co-occurring, however, with the context of a broader national housing crisis overlaid with the humanitarian crisis of the war in Ukraine. To-date, over 33,000 Ukrainian refugees have arrived in Ireland and need homes. The situation is complex and the need for housing is acutely high. We urge politicians, policymakers, voluntary and statutory bodies to sustain their commitment to the resourcing, development, and expansion of HF within and across the CHO regions during these incredibly difficult times and beyond.

2. *Address gaps in housing unit availability with a flexible approach tailored to regional contexts.* Despite the challenges posed by the requirement to source one-bedroom properties for clients across the regions, the teams have been able to meet their targets. Concerns about an adequate supply of one-bedroom units were raised in every region, however. The historical decisions by housing developers and related statutory bodies to not invest in one-bedroom properties, especially in rural and sparsely populated regions, were flagged as some reasons for the one-bedroom shortage. To scale out HF programmes and increase the number of clients housed in the regions, HF programmes must be able source to an adequate number of housing units. Until adequate one-bedroom housing is built, policy "workarounds" must be created to meet the need. HF programmes can only expand when there is adequate housing stock. In the light of the progress made during the national rollout of this model, it is recommended that National HF Committee review the HF housing unit guidelines and identify flexible solutions tailored to the housing demands in each region so that move-ins are not delayed because one-bedroom units are not available.

3. *Develop standardised procedures for eligibility, nominations, and intake.* The evidence suggests that all regions have developed approaches to screening and intake that effectively identify individuals who are in most need of HF services. In the next stage of scaling up and scaling out HF nationally, it is recommended that representatives from the nine regions work with the National HF Committee to develop a set of standardised yet flexible procedures to determine level of need at programme intake, while allowing for regional differences in client demographics and support needs.

4. *Increase availability of specialist supports for HF clients.* We obtained consistent and robust evidence that HF teams effectively support clients using harm-reduction, client-led, non-coercive approaches. GP and addictions services are widely available, and it appears that many clients are currently engaged with necessary treatment or have completed treatment. However, there needs to be an effort to move away from the term 'behavioural' in relation to clients' support needs, because it is stigmatising and it conflates several issues that need to be dealt with separately, such as diagnosis and access to services. It is recommended that the HSE engages with the HF community of practice to clarify the available treatment and support services for this population and how they can be most effectively accessed. Reasons for long waiting lists for OT and dental services should be investigated and addressed. Regarding psychotherapeutic care, the Stepped Model of Mental Health

Care, provided by an assertive outreach team, is an innovative model being piloted in Dublin and that could improve pathways and access to mental health care.

5. *Deliver training to professionals in the needs of clients with significant histories of homelessness.* Because most HF clients have histories of traumatic experiences, we recommend that all professionals who deliver treatment or supports to HF clients receive training in trauma informed care and develop competencies in creating psychologically informed environments.

6. *Increase availability and accessibility of treatment for dual diagnoses.* All HF programmes across the regions serve clients who have dual or multiple diagnoses of addictions and mental health problems (either psychiatric or psychological or both). Timely access to psychological supports and for dual diagnoses is essential for effective case management with HF clients. These services are more accessible in urban and more populated areas, and for clients whose teams are multidisciplinary or have in-house services. Wider access to dual diagnosis treatment is needed in many regions, however, and in these regions, stronger links to multidisciplinary health and psychiatric services would improve accessibility. For example, the new mental health clinical programme for dual diagnoses could be used to create important pathways to dual diagnosis treatment for HF clients. Moreover, the introduction of dual diagnosis treatment resources in regions where it is not yet available would not only benefit HF clients but also others who have not experienced homelessness but have unmet treatment needs in this area. We recommend dual diagnosis supports be made available in all CHO regions.

7. *Resource and increase clients' involvement in programme operations.* We recommend that programmes prioritise and incorporate clients' involvement in their programme operations and development plans. It is clear from our conversations with HF clients that many of them are eager to contribute in these ways. This will require additional resources that could be drawn from existing programmes such as mental health recovery education programmes and self-care programmes. In some regions, intentional peer support workers and citizen peer support programmes are available, and HF teams could access them. We recommend that teams receive adequate resourcing and supports to integrate individuals with lived experience into programme operations and create adequate links to relevant community resources to promote and enhance peer support services available to HF clients.

8. *Reassess staffing and resource needs in geographically dispersed regions.* Concerns about working in large, rural areas were raised by staff working in those contexts. As teams scale up their operations, those working in large geographical regions will need higher staff-to-client ratios than standard recommendations. Consultations with experienced rural HF programmes such as HF Vermont may offer important learning around creative approaches to providing effective supports in large, sparsely populated regions.

9. *Investigate and address sources of high case manager turnover.* Concerns about high case manager turnover were expressed to us by staff and clients. Trust between client and case manager is paramount to achieving the outcomes targeted for HF clients. It is recommended that reasons for high staff turnover are identified and addressed. Staff must receive effective training, supervision, and support in the HF paradigm to ensure job satisfaction, minimise burnout, and increase retention.

10. *Implement a schedule of routine fidelity assessments in each region.* Regular fidelity assessments are necessary, if not sufficient, for preventing programme dilution and drift. We recommend that each region engage in regular fidelity self-assessments to monitor their practice and ensure that services are delivered in line with the Pathways HF model. A regular schedule of external fidelity assessments that include site visits, case note reviews, focus groups with clients and staff, and shadowing, will ensure that programmes are able to recognize and affirm their achievements while they also stay alert to blocks to fidelity. Regular programme review will identify gaps and blocks and

will help to ensure that programmes operate to their best ability to support clients in their homes and on their recovery journeys.

## Conclusions

The National HF Committee has succeeded in implementing HF across Ireland, in urban, suburban, and rural areas. In some regions, the concept of HF was new, and represented a cultural shift in the way homelessness was addressed in their communities. Individuals previously believed to be unable to live independently are, with the support and encouragement of HF case managers, successfully maintaining homes of their own. Hearts and minds have been changed by the achievements of the HF teams and their clients. Across the regions, HF teams support clients in their homes in ways that promote self-determination, tenancy sustainment, and recovery. Housing retention rates are high, and fidelity scores are also high. When clients are rehoused, it is usually to promote tenancy sustainment with a move to more suitable accommodation or a preferred location, or because of a hospital stay or prison term. In these latter instances, the teams continue to engage with clients and help them find new homes when they are discharged. Taken together, findings from the evaluation indicate that the National HF Implementation has achieved its primary goals in each of the nine regions: HF programmes have been successfully implemented, vulnerable individuals with substantial histories of rough sleeping and emergency accommodation are getting housed, staying housed, and receiving choice-driven and individualised care to support them on their recovery journeys. Through continued local, regional, and national investment and support, continued expansion of HF could reverse enduring and intractable long-term homelessness in Ireland.

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# Appendices

**Appendix I**


## A Harmonised Definition of Homelessness for Statistical Purposes

Sometimes referred to as ETHOS 'Light', this is a version of the ETHOS typology developed in the context of a 2007 European Commission study: *Measurement of Homelessness at European Union Level*. It is a harmonised definition of homelessness for statistical purposes. It is a pragmatic tool for the development of homelessness data collection, rather than a conceptual and operational definition to be used for a range of policy and practice purposes.

| OPERATIONAL CATEGORY | | LIVING SITUATION | | DEFINITION |
|---|---|---|---|---|
| 1 | People living rough | 1 | Public spaces / external spaces | Living in the streets or public spaces without a shelter that can be defined as living quarters |
| 2 | People in emergency accommodation | 2 | Overnight shelters | People with no place of usual residence who move frequently between various types of accommodation |
| 3 | People living in accommodation for the homeless | 3<br>4<br>5<br>6 | Homeless hostels<br>Temporary accommodation<br>Transitional supported accommodation<br>Women's shelters or refuge accommodation | Where the period of stay is time-limited and no long-term housing is provided |
| 4 | People living in institutions | 7<br>8 | Health care institutions<br>Penal institutions | Stay longer than needed due to lack of housing<br>No housing available prior to release |
| 5 | People living in non-conventional dwellings due to lack of housing | 9<br>10<br>11 | Mobile homes<br>Non-conventional buildings<br>Temporary structures | Where the accommodation is used due to a lack of housing and is not the person's usual place of residence |
| 6 | Homeless people living temporarily in conventional housing with family and friends (due to lack of housing) | 12 | Conventional housing, but not the person's usual place of residence | Where the accommodation is used due to a lack of housing and is not the person's usual place of residence |

## Appendix II: Health Conditions

| Health condition | Number | Percent | Health condition | Number | Percent |
|---|---|---|---|---|---|
| Dental problems | 77 | 54 | Liver disease other than hepatitis | 11 | 8 |
| Back problems | 42 | 29 | Hepatitis C | 10 | 7 |
| Asthma | 41 | 29 | Diabetes | 10 | 7 |
| Migraines | 40 | 28 | HIV/AID | 8 | 6 |
| Other | 35 | 24 | Effects of stroke | 8 | 6 |
| Arthritis | 32 | 22 | Thyroid condition | 7 | 5 |
| Epilepsy or seizures | 30 | 21 | Tuberculosis | 6 | 4 |
| Foot problems | 23 | 16 | Heart disease | 4 | 3 |
| Skin problems | 23 | 16 | Cancer | 4 | 3 |
| Inability to hold urine | 18 | 13 | Dementia/Alzheimer's | 2 | 1 |
| High blood pressure | 17 | 12 | Pregnant | 2 | 1 |
| Anaemia | 17 | 12 | STD-other | 1 | 1 |
| Stomach ulcer | 14 | 10 | Lice, scabies, bed bugs | 1 | 1 |
| Bowel problems | 13 | 9 | Gynaecological problems | 1 | 1 |
| Chronic bronchitis/emphysema | 12 | 8 | Hepatitis B | 0 | 0 |
| Kidney or bladder | 12 | 8 | | | |