The Impacts of Chronic Homelessness for Women

A report for the Northern Ireland Housing Executive

Fiona Boyle, Fiona Boyle Associates

With Professor Nicholas Pleace and Dr. Joanne Bretherton, Centre for Housing Policy, The University of York

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CONTENTS

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

SECTION 1 INTRODUCTION AND BACKGROUND – RESEARCH BACKGROUND, OBJECTIVES AND METHODOLOGY

Introduction

1.1 The NI Housing Executive (henceforth 'the Housing Executive') identified the need for Northern Ireland wide research on the theme of *The Impacts of Chronic Homelessness for Women.*

Research rationale and aims

1.2 The purpose of the research was to assist the Housing Executive in understanding the scale and impact of chronic homelessness on women whilst also identifying any additional gender specific issues that should be addressed in future action plans and service delivery both by the Housing Executive and wider service providers in the statutory and voluntary sectors. In particular the research aimed to understand the issues and challenges experienced by women who find themselves in chronic homelessness. The term chronic homelessness is defined at paragraphs 2.6 – 2.9.

1.3 The research was externally commissioned by the Housing Executive and undertaken by lead consultant, Fiona Boyle[1] with support from the Housing Executive via the Research Unit and the Homelessness Strategy & Policy Unit. In addition, specialist knowledge and expertise on homelessness policy and literature relating to chronic homelessness amongst women in the rest of the United Kingdom has been provided by Professor Nicholas Pleace and Dr Joanne Bretherton, Housing Centre, The University of York.

1.4 A Project Advisory Group (henceforth referred to as the PAG) was established for the research study. Membership of the PAG comprised:

- Maureen Kerr Housing Executive, Homelessness Strategy & Policy (Client)
- Karly Greene Housing Executive, Head of Research (until October 2020)
- Patrice Reilly Housing Executive, Research Unit (Project Leader)
- Brian O'Kane Housing Executive, Housing Solutions
- Alister Mawhinney Housing Executive, Supporting People
- Deirdre Coyle Health & Social Care Board
- Valerie Hayes Department of Justice/ NI Prison Service
- Meadhbha Monaghan Extern (Until May 2020)
- Kate Harrison Extern (From May 2020)

1.5 The agreed role of the PAG was to:

- Provide guidance to the research consultant in terms of methodology, data sources and key/emerging issues;
- Facilitate access for the research consultant to various data sets and consultation/feedback with relevant stakeholder groups including staff and service users;

Act as a sounding board to review key outputs including preliminary findings, test scenarios and the final report.**Research objectives**

[1] Principal consultant, Fiona Boyle Associates.

1.6 The key research objectives outlined in the research specification were as follows:

1. Analysis of the extent of chronic homelessness for women – profile, causes, key issues;
2. Analysis of challenges in delivering services to women who are experiencing chronic homelessness;
3. Analysis of the impact current services have on the cycle of chronic homelessness including women's experiences of those services;
4. Explore effective service delivery in other jurisdictions and interagency working opportunities to assist the needs of women experiencing chronic homelessness;
5. Explore methods for identifying the numbers of women experiencing chronic homelessness who do not engage with the Housing Executive (hidden homelessness).

Research methodology

1.7 The agreed research methodology was multi-faceted with three specific research areas and stages. These were as follows:

- **Research Area 1: Review of relevant literature and policy context**

This element of the research included a review of the relevant literature in Northern Ireland, Great Britain and internationally on the theme of chronic homelessness amongst women. In addition, this research area referenced current relevant legislation and policy in Northern Ireland; in particular the Housing (NI) Order 1988, the Homelessness Strategy NI 2017 – 2022 and the Chronic Homelessness Action Plan (2020). This element of the research also looked at the definition of chronic homelessness[2].

- **Research Area 2: Quantitative analysis of existing data**

This desk-based element of the research sought to identify, collect/collate and review available existing data in relation to women who are defined as chronic homeless. On the one hand this research area examined the direction of travel initiated by the Housing Executive to develop working counting mechanisms and to integrate this into the Housing Solutions Form. Whilst a new system was to have been in place from 1st April 2020 providing this new and additional data source, implementation of data collection was delayed because of covid-19. In the absence of tailored Housing Executive data specifically relating to women experiencing chronic homelessness, data from a range of external sources was analysed under this research theme, with a key focus on aiming to assess the level and nature of chronic homelessness amongst women in Northern Ireland.

- **Research Area 3: Primary Data collection**

Primary research was undertaken to establish the views and opinions of three groups of stakeholders – this comprised sectoral engagement through semi-structured interviews with eight key stakeholders/organisations, six temporary accommodation providers, 16 Housing Executive staff members and feedback from 24 women defined for the purposes of this research under the categorisation of chronic homeless. This latter group included current and past service users of temporary accommodation provision and those using external or other types of service, e.g. in prison,

[2] At the time of the research (2020 to early 2021) this definition was *available*, having been developed in full consultation and detailed discussion with the statutory and voluntary homeless sectors. However, because of covid-19 the definition had not yet been *operationalised* at the time of the research.

using Day Centres, using drop-in facilities. Appendix 1 provides a list of all stakeholder interviews including temporary accommodation providers, service providers and Housing Executive respondents. The research tools including external interview schedule, and profile/interview questions for women experiencing chronic homelessness are available on request from the NI Housing Executive Research Unit. It is important to note the use of the term 'service user' throughout this report. This denotes an individual who has experience of using services in terms of homelessness and the range of other supported related services e.g. health, mental health, addictions etc. 'Service user' is used as a broad term for all users of services, as well as the participants and respondents in this research. We recognise that there is a shift in terminology which increasingly refers to service users as 'experts by experience'.

1.8 The primary research fieldwork took place between August and December 2020. The research methodology was covered by guiding principles in terms of seeking access and obtaining views from service users who could be deemed to be vulnerable and/or have a chaotic lifestyle or display chaotic behaviour. Firstly, in line with standard practice the research consultant was Access NI checked. Secondly, the research approach, methods and tools were developed in line with Social Policy Association Guidelines on Research Ethics[3] and the general ethical principles for research with vulnerable groups[4] in Northern Ireland. Thirdly, the consultant's track record in research with vulnerable homeless clients enabled the fieldwork stage – and the relevant research briefing notes, invitation to interview/participation, research questionnaires and semi-structured interview schedules – to be adapted specifically for the needs and complexities of this group. For example, this included close attention to the wording of questions, in particular removing difficult language, jargon and also being cognisant of the fact that the research interview could potentially touch on current emotional issues and past or historical trauma. To respond to this the participant was provided with a Housing Executive contact (in order to check the validity of the research either in advance or during the research phase) and arrangements were put in place should the participant require or request follow-up support following the interview(s) or for a period of time after the research phase. In addition, service providers including temporary accommodation hostels and Day centres, were made aware that the service user may require additional support.

1.9 The internal Housing Executive interviewees were spread across the three Housing Executive Regions[5] and covered a range of staff levels and roles. In addition, the external stakeholders were based across Northern Ireland and included organisations representing a wide range of client groups relevant to the definition and categorisation of chronic homelessness including homelessness per se, mental health, addictions (drug or alcohol), street activity (including rough sleeping, street drinking and begging), violence and abuse, prison and offending and 'looked after' children and young people.

1.10 For the interviews with service users, particular consideration was given to informed consent, confidentiality, protection from harm and understanding of and agreement to the sharing of the research findings. Access to service users was organised via temporary accommodation and other service providers. In addition, an easy-to-understand written briefing was given to service users before they were asked whether they wished to participate in the research. Those who did participate

[3] www.social-policy.org.uk/downloads/SPA_code_ethics_jan09.pdf

[4] *Ethical Principles for Researching Vulnerable Groups (2003)* Paul Connolly, University of Ulster

[5] Belfast, South and North Regions.

were provided with contact details of Housing Executive personnel, should they wish to discuss any aspect of the interview or participation in the research process.

1.11 The main focus of the primary data collection was to explore the following themes and topics:

- Discussion of the profile, causes and key issues for women who are experiencing chronic homelessness. In particular including the nature, prevalence and characteristics of chronic homelessness amongst women;
- Identification of what temporary accommodation is currently being used by women categorised by chronic homelessness and how do they access/use it? What barriers or challenges do they encounter in accessing both temporary and permanent accommodation? What gender specific factors relate to tenancy retention and sustainment?
- Discussion of the challenges in delivering services to this group of women – what are the challenges? What services are currently available and accessible? What are the gaps, with specific reference to gender?
- Discussion on the impact of current services (models, availability and location) on the cycle of chronic homelessness for some women. What service factors perpetuate chronic homelessness for women? What impact in particular does serial placement have on homeless women? How does it affect movement into and sustainability of permanent accommodation? What are the factors that can enable successful halting of the cycle of chronic homelessness – in terms of identification of need, targeting of services, tailoring of services and effective follow-up and interventions, inter-agency work etc.
- Discussion on the risk and perpetuation factors – what is the balance between the root initial causal factors of chronic homelessness being the key factor versus the type and nature of service provision (if available) being the key risk to perpetuating this type of homelessness?
- Discussion on what the different groups of respondents feel would be the best way of minimising and eradicating chronic homelessness amongst women? This may be different types of accommodation or services, as well as suggestions around inter-agency working – who needs to work together to solve the problem?
- Discussion on mechanisms to identify hidden homelessness amongst women who have or may experience chronic homelessness, who do not engage with the Housing Executive.

Report Layout

1.12 **Section 2: Context – Relevant legislation and services in Northern Ireland** provides background context and historical information on the move towards recognising chronic homelessness in Northern Ireland and the shift towards measurement and responding to specific needs in this categorisation. In addition, this section references the overarching homelessness legislation. Finally, this section outlines the gender specific temporary accommodation and other services for homeless women (and in some cases for women experiencing chronic homelessness) provided directly by the Housing Executive and indirectly via Supporting People funding to external statutory and voluntary sector providers.

1.13 **Section 3: Literature Review – Chronic homelessness amongst women** explores the grey and academic literature relating to this topic. In addition, to widen out the perspective beyond Northern Ireland, this Section examines literature relating to chronic homelessness in women in the other UK

jurisdictions, the Republic of Ireland and worldwide. This section looks at a range of topics and themes including measurement or counting of chronic homelessness amongst women, the causes and profile characteristics, the range of typical homelessness journeys or experiences for this group, and reflections on their experiences within services. The Centre for Housing Policy provided this section.

1.14 Secondary data on homeless clients was provided by the Data Analytics Unit (the Housing Executive) as well as a number of statutory and voluntary sector providers who had interaction with this group (women experiencing chronic homelessness). This included Extern, the H&SC Board, the NI Prison Service, Depaul, Simon Community NI, Women's Aid, the Welcome Organisation and the Belfast Health Inclusion service. Data from these various sources was analysed for the time period 2015/16 – 2019/20[6]; some organisations were unable to provide for the full five years and provided whatever period of data that was available. This formed the basis of an initial examination of the profile of women experiencing chronic homelessness, using evidence based secondary data. This is covered in **Section 4: Research Findings – Incidence and profile of chronic homelessness in Northern Ireland amongst women.** The limitations of this wider secondary data are acknowledged in Section 4, including different collecting mechanisms, differing availability and robustness of data in different organisations and availability of information for different timescales.

1.15 Two sections outline the findings from the primary fieldwork. These are as follows:

Section 5 Research Findings – Feedback from stakeholders

Section 6 Research Findings – Feedback from women experiencing chronic homelessness

1.16 **Section 7: Chronic homelessness amongst women – Different responses** then provides feedback from stakeholders in the housing and homeless sectors, together with suggestions from the female service users in terms of what interventions and services would help to prevent and move chronic homeless women from a cycle of homelessness to a more settled and sustained permanent tenancy and/or interaction with appropriate services. This section looks at services in Great Britain and the Republic of Ireland. Similar to Section 3, the Centre for Housing Policy contributed to this section; and the research consultant also provided analysis of other models of good practice.

1.17 Finally **Section 8: Conclusions and recommendations** summarises the key findings and points from the research; in particular identifying learning from the research engagement, wider literature/data review and wider models of good practice. This section summarises the conclusions about direct service development and delivery for this client group and sector.

[6] This 5-year period was agreed by the PAG as a relevant time period to enable comparison over time and appropriate in terms of incorporating the period both before and after the introduction of Housing Solutions, as the mechanism to administer homelessness. The Housing Executive noted the following in relation to data provided – *To ensure consistency in presentation of the data and classification of offices this data is reflective of a live system and therefore the data will vary with figures previously published. The variation in data is a result of some cases having been back keyed, or where applicants have successfully appealed a decision, and this will cause a slight variation between the historical static snapshot data and the statistics provided at this point.*

SECTION 2 CONTEXT – RELEVANT LEGISLATION, POLICY AND CURRENT SERVICES IN NORTHERN IRELAND

Introduction

2.1 Women impacted by chronic homelessness fall under the Housing Executive's statutory duties in relation to homelessness. The primary legislation, the Housing (NI) Order 1988, established the definitions and the duties surrounding homelessness (homeless/threatened with homelessness, priority need and intentionality), making enquiries, temporary accommodation and decision letters[7]. The Housing (NI) Order 2003 amended the provisions of the 1988 Order, introducing changes to the definitions of homelessness and to the provisions regarding becoming homeless intentionally[8], and introduced the additional requirement on the Housing Executive to assess an applicant's eligibility for housing assistance.

Relevant Legislation

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

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

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

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

2.3 The Housing Executive has a statutory duty under the provisions of the Housing (NI) Order 1988, as amended, to investigate the circumstances of all applicants presenting as homeless. In carrying out its statutory duty to make enquiries into homelessness applications, the Housing Executive should consider whether or not the applicant is:

- Homeless/threatened with homelessness
- Eligible for homelessness assistance[9]
- In priority need[10]
- Unintentionally or intentionally homeless

2.4 Where an applicant meets all of the legislative criteria, the Housing Executive awards Full Duty Applicant status (FDA), and undertakes a housing need assessment, with the award of relevant points in line with the rules of the Housing Selection Scheme. Any household that meets the four tests outlined is therefore accepted as a FDA; the housing duty to them includes ensuring that accommodation is made available for the household as well as the provision of temporary accommodation where necessary with the protection of the household's furniture and possessions.

2.5 However, the focus of this research was chronic homelessness rather than more generic or wider homelessness. There is no specific statutory or legislative duty in relation to chronic homelessness, and while the duties and categorisation of priority need outlined are clearly relevant and applicable, they fall short in terms of providing clear parameters for defining and responding specifically to chronic homelessness. In addition, data in relation to homeless applicants/presenters and those accepted as being full duty applicants is collated and stored in relation to factors such as District council area, household type and reason for homelessness. There is no current mechanism to identify or record if someone falls into the category of chronic homelessness. As noted earlier, a counting mechanism had been planned for implementation from 1st April 2020, however this was delayed as a result of the impact of covid-19 on Housing Executive operations.

Defining chronic homelessness – developing a definition

2.6 Over the last 20 years there has been increasing recognition of a group (not gender specific) of individuals who remain within and/or come in and out of the revolving door of homelessness, together with the need to further define, identify and respond to such individuals (and groups of these individuals). For the purposes of this report this group are referred to as chronic homeless, with specific reference to the definition outlined at paragraphs 2.7 and 2.9. The history of chronic homelessness in Northern Ireland, from both a practice based and policy perspective is outlined in the remainder of this Section, whilst Section 3 provides a review of literature throughout the United Kingdom and further afield.

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

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

2.7 The Homelessness strategy 2017-22 set out a definition for chronic homelessness based on the one developed in the Crisis report (2010)[11]. The situation of chronic homelessness or being chronically homeless is defined as "a group of individuals with very pronounced and complex support needs who found it difficult to exit from homelessness."[12]

2.8 A further part of the response to chronic homelessness was the development of a Chronic Homelessness Action Plan (CHAP), published in January 2020, following a public consultation exercise. The CHAP focuses on the Housing Executive's commitment, set out in the current Homelessness strategy, *to develop appropriate responses to address the needs of the population in Northern Ireland experiencing chronic homelessness*[13]. The CHAP includes a number of objectives including the design of specific criteria for measuring chronic homelessness and the implementation of a range of support services to help people sustain their accommodation. The CHAP report also emphasised that the problem of chronic homelessness cannot fully be resolved through housing provision; that it requires collaborative working across the statutory, voluntary and community sectors. The full list of objectives is outlined in Appendix 2.

2.9 The definition of chronic homelessness was developed further in the CHAP report (see Appendix 3). This definition was developed through a process of consultation and detailed discussion across the homeless sector, and was finalised as part of the CHAP report. Whilst there had been plans to operationalise the definition from April 2020 including ongoing counting/measurement, these plans were put on hold because of covid-19. At the time of the research (2020 to early 2021) the definition had not been operationalised. The focus of the definition was broadly on ensuring that the needs of such individuals were identified, recognised and responded to, whilst on the other hand ensuring that criteria for inclusion in the definition would enable a form of measurement or counting of those experiencing chronic homelessness. The definition and criteria therefore outline that an individual can be said to be experiencing chronic homelessness if they meet **one** of the indicators listed:

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

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

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

[11] *A Review of Single Homelessness in the UK 2000 – 2010,* Anwen Jones and Nicholas Pleace, Crisis 2010.
[12] Op cit.
[13] *Chronic Homelessness Action Plan* (CHAP), January 2020, page 1.

Section 4 provides further information on how these indicators have been developed into criteria within the Housing Executive's Housing Solutions form so that Housing Advisors and Patch Managers can identify, assess and also record anyone that falls within the categorisation of chronic homelessness. It should be noted that because of covid-19 this approach was yet to be operationalised at the time of writing.

Developing an understanding of chronic homelessness – policy context

2.10 As part of this discussion it is interesting to reflect on the route navigated to come to this definition. Service providers and temporary accommodation providers have long been aware of a proportion of the homeless population who remained homeless over significant periods of time and/or who came back in and out of the homeless sector irrespective of the type and nature of previous or current service provision (both in terms of presenting as homeless to the Housing Executive and requiring Day centre or temporary accommodation or wider services. The latter includes soup kitchens/runs, physical health care, support services for those rough sleeping etc.). A key point noted by Lynne McMordie sums up the nature of chronic homelessness in Northern Ireland:

The existence of a sub-group within the Northern Ireland homeless population whose experience is marked by cyclical temporary accommodation placements, episodes of rough sleeping and other forms of homelessness…[14]

McMordie's study, *Chronic Homelessness and Temporary Accommodation Placement in Belfast*[15], examined the provision and design of temporary accommodation services in Belfast and its use by individuals who have experienced chronic homelessness. This study highlighted the complex needs of this grouping, their experience in terms of multiple placements and periods of rough sleeping, and their coping mechanisms to reduce the stresses of living in hostel accommodation, which further adds to placement failure and the perpetual nature of their homelessness.

2.11 As early as 2002, the need to examine homelessness services for those with more complex needs was noted in the first homelessness strategy *Making a Difference to People's Lives*[16]. For a period of time one key group within the list of indicators of chronic homelessness was the focus of much of this discussion – rough sleepers. Ongoing concerns, in particular relating to deaths of a number of individuals sleeping rough in Belfast city centre, resulted in the development of the *Belfast Area Rough Sleepers Strategy 2004 – 2006* and a number of Street Needs audits and Street counts. These in turn led to the formation and further development of a range of specialist services[17] designed to address the issue of rough sleeping. Discussion on rough sleeping again reached a height in May 2014 when the Welcome Organisation noted the death of at least five people sleeping rough in Belfast City Centre from the start of that year[18].

[14] Lynne McMordie, July 2018, *Chronic Homelessness and Temporary Accommodation Placement in Belfast,* Heriot Watt university, I-sphere, Oak Foundation.
[15] *Chronic Homelessness and Temporary Accommodation Placement in Belfast,* Lynne McMordie, Heriot Watt University, I-sphere, Oak Foundation, July 2018.
[16] *Making a Difference to People's Lives,* NI Housing Executive, 2002.
[17] Specialist services including the provision of day-time and night-time street outreach services in Belfast and three Day centres, providing support services for up to 175 vulnerable people.
[18] https://www.bbc.co.uk/news/uk-northern-ireland-27473466

The Belfast Street Needs Audit (2016)[19] was commissioned by the HE and delivered in partnership with the Welcome Centre, Depaul and Belfast City Centre Management. The Street Needs Audit examined street activity (begging and street drinking) and rough sleeping over a 12-week period. During this period a total of 361 different individuals were observed engaging in some sort of street activity on one or more occasions. 85% of these individuals were male, with 15% female.

More recently, street counts[20] in Belfast and Newry (2017/2018) identified a relatively low number of rough sleepers – eight in total. Counts in Belfast, Derry and Newry (November 2018) demonstrate an increased number of rough sleepers within these areas – 16, 13 and five respectively. The Housing Executive also used rough sleeper street estimates to identify the number of rough sleepers more widely in Northern Ireland, in conjunction with local partners, e.g. PSNI. A nil return was recorded for most areas, except for the Coleraine area where four rough sleepers were recorded.

The Homelessness Monitor: Northern Ireland 2016[21] highlighted concerns relating to chronic homelessness; in particular referencing that whilst rates of visible rough sleeping in Belfast remained low, there was concern about perceived increases in begging and street drinking. In addition, the NI Audit Office (NIAO) report[22] specifically mentioned needs in relation to those accessing health and social care services, those with additional health needs, those who have experienced domestic violence, ex-offenders, rough sleeping, and changes effected from welfare reform.

2.12 The current and previous homelessness strategies both reference chronic homelessness. An independent evaluation[23] of the 2012 - 2017 Homelessness strategy reviewed its 38 actions[24] and concluded that: *In pursuing prevention, service coordination and innovation, in areas such as Housing First, the Strategy was widely perceived as moving homelessness in the right directions. There have been some positive developments in preventing and reducing homelessness in Northern Ireland, achievements that have been delivered by most of the agencies, public, voluntary and charitable, that seek to tackle homelessness.* The evaluation also noted that progress in delivering actions had not always been rapid.

Particular reference was made to those who could be categorised as chronic homeless. The evaluation highlighted, for example, that whilst there was evidence of enhanced service coordination, issues remained in terms of delivering effective coordination for long term and recurrent homeless people with complex needs; in short, they were not always receiving a joined-up service. The evaluation of this strategy and the 5-year time period it covered also evidenced improved service delivery to a range of vulnerable clients including ex-offenders, those in rural settings, young people and victims of domestic violence.

Respondents in the evaluation of the 2012 – 2017 Homelessness Strategy highlighted that *higher need individuals with large amounts of wraparound* (multiple and complex) *needs are stuck in that revolving*

[19] Belfast Street Needs Audit, Northern Ireland Housing Executive, The Welcome Organisation and Depaul Belfast City Centre Management, Final Report January 2016
[20] *Tackling Rough Sleeping in Northern Ireland: Key facts and figures*, NIHE, February 2019
[21] Crisis, *The homelessness monitor: Northern Ireland 2016,* November 2016.
[22] NI Audit Office, Homelessness in Northern Ireland, Report by the Comptroller and Auditor General, 21 November 2017.
[23] *The Homelessness Strategy for Northern Ireland 2012 – 2017 An Evaluation,* Fiona Boyle and Nicholas Pleace 2017.
[24] These had been reprioritised in 2014 to focus on homelessness prevention.

door of hostels and services. Respondents also noted concern; *to try and help people who are chronic homeless, there is a lack of understanding amongst housing staff, the work that needs to be done with someone to transition them into permanent housing.*

Reprioritisation of this 5-year Homelessness Strategy in 2014 enabled targeted focus on a number of measures to address the most significant impact of homelessness, including for those falling into chronic or vulnerable categories. This included a focus on Housing Solutions and the development of the Common Assessment Framework (CAF), a Central Access Point (CAP) and Housing First, and put in place measures to support sustainable tenancies.

2.13 The Homelessness Strategy 2017 – 2022, *Ending Homelessness Together* (published April 2017) recognised the important role of other agencies in providing advice, assistance and support to prevent households reaching crisis point. The five strategic objectives outlined are to prioritise the prevention of homelessness, to secure suitable accommodation and appropriate support for homeless households, to further understand and address the complexities of chronic homelessness and to have the right delivery mechanisms, measurement and monitoring in place to oversee and deliver the strategy. Clearly the current Homelessness strategy[25], building on the learning from the previous strategy and the evaluation, now has chronic homelessness firmly embedded as one of the five key objectives[26]. Objective 3 is as follows:

To further understand and address the complexities of chronic homelessness across Northern Ireland.

Further detail in the strategy document provides background information on the thinking behind prioritising this theme within the overall homelessness strategy. The strategy sums this up by noting:

Chronic homelessness can often manifest itself as rough sleeping or other street activity and is perhaps the most severe and visible form of homelessness. This client group tends to have extremely complex needs making it difficult for them to sustain tenancies causing frequent, repeat cycles of homelessness and typically intermittent engagement with services and periods of non-engagement.

This strategy also recognised the categorisation used by The European Conference on Homelessness[27], specifying chronic homelessness as long-term users of emergency services, in particular rough sleepers.

2.14 A Chronic Homelessness Action Plan (CHAP) was consulted on in the first half of 2019, with an agreed version published in January 2020. The CHAP focuses on the Housing Executive's commitment, set out in the current Homelessness strategy, *to develop appropriate responses to address the needs of the population in Northern Ireland experiencing chronic homelessness[28].* The CHAP includes a number of objectives including the design of specific criteria for measuring chronic homelessness and the implementation of a range of support services to help people sustain their

[25] *The Homelessness Strategy 2017 – 2022, Ending Homelessness Together* (published April 2017)
[26] The five strategic objectives are to prioritise the prevention of homelessness, to secure suitable accommodation and appropriate support for homeless households, to further understand and address the complexities of chronic homelessness and to have the right delivery mechanisms, measurement and monitoring in place to oversee and deliver the strategy.
[27] *Homelessness and Housing Policies in Europe: Lessons from Research,* FEANTSA, 2010.
[28] *Chronic Homelessness Action Plan* (CHAP), January 2020, page 1.

accommodation. The CHAP report emphasised that the problem of chronic homelessness cannot fully be resolved through housing provision; that it requires collaborative working across the statutory, voluntary and community sectors. The full list of objectives is outlined in Appendix 2.

In terms of numbers, the CHAP report[29] noted that based on wider research[30] it would be expected that between 5 – 10% of the homeless population could be identified as experiencing chronic homelessness. Based on a total of 22,000 FDA registered with the Housing Executive at the end of December 2018, this report suggests – *it would not be unreasonable to assume between 1,100 – 2,200 of these individuals or households could be experiencing chronic homelessness.* However, there is recognition that the analytical basis for this estimation is relatively dated. Section 4 looks in more detail at the development of a classification and counting mechanism.

2.15 The Housing Solutions manual (date) also references chronic homeless as a specific group, when noting suitable sustainment activity for specific housing issues. For example, under the heading of chronic homelessness, reference is made to domestic violence, whereby a customer may not be able to continue in current living arrangements. Services are noted in this regard including the Sanctuary Scheme, Women's Aid, the Men's Advice line and Housing Executive staff supporting the customer to obtain an injunction or a Court Order.

Wider policy context

2.16 The discussion on chronic homelessness sits within a wider policy context in relation to both the right to housing, and rights and responsibilities in relation to homelessness. The Housing Strategy for Northern Ireland 2012 - 2017[31] noted the vision for everyone to have access to good quality housing at a reasonable cost. The strategy noted that *a home is at the heart of people's lives* and *good quality, reasonably-priced housing contributes significantly to creating a safe, healthy and prosperous society*[32].

2.17 The Common Selection Scheme (effective from November 2000, and also referred to as the Housing Selection Scheme) provides a common waiting list; representing a single gateway into social housing in Northern Ireland. The Common Selection Scheme consists of a set of rules which govern access, assessment and allocation to social housing; this is administered by the Housing Executive and adhered to by all participating social housing landlords. Eligible applicants receive 'points' based on their housing need, with regard to intimidation[33], insecurity of tenure, housing conditions and health and social wellbeing needs, and the points received determine their position on the waiting list. In the context of any discussion on homelessness it is important to note that FDA status attracts 70 points under the selection scheme[34]. When a dwelling becomes available, it is offered to the applicant with the highest number of points requiring that type of property. From 2016 onwards the Housing Executive has developed and now delivers Northern Ireland wide a Housing Solutions and Support

[29] *Chronic Homelessness Action Plan* (CHAP), January 2020, page 25.
[30] *Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization Results from the Analysis of Administrative Data,* Kuhn and Culhane, 1998.
[31] *Facing the Future: The Housing Strategy for Northern Ireland 2012-2017.* In the absence of a functioning Northern Ireland Assembly and Executive since January 2017, this strategy has not been superseded, and is deemed under civil service rules to continue.
[32] Department for Social Development (2015) *Facing the Future: Housing Strategy for Northern Ireland.* Belfast: DSD p.4 Available online at: www.communities-ni.gov.uk/sites/default/files/publications/dsd/facing-the-future-housing-strategy.pdf [Accessed 25 January 2019]
[33] I.e. at serious and imminent risk and in immediate need of rehousing (www.nihe.gov.uk/Housing-Help/Apply-for-a-home/How-we-assess-your-application)
[34] FDA status is the second highest point-scoring criterion; the highest is intimidation which is worth 200 points.

approach, the overall aim of which is to effectively engage with housing customers to understand their individual needs and explore their housing and support options by taking a 'case management' approach.

2.18 Another important plank of policy context was the Fundamental Review of Social Housing Allocations[35]. The Department for Communities (DfC) commenced work on this review in 2013; the overall aim is to produce a better range of solutions to meet housing need and in particular an improved system for the most vulnerable applicants to the Common Selection Scheme, including those who are homeless. The *Consultation on Proposals*[36] published by the Department for Communities in 2017 put forward a total of 20 proposals to make the allocations process more fair, transparent and effective for all. The findings of the consultation were reported in December 2020[37] with implications regarding homelessness services highlighted in recommendations 4 and 9.

2.19 The Supporting People programme was introduced in Northern Ireland in 2003. Its aim is *to commission housing support services aimed at improving the quality of life and independence of vulnerable people.* Again this is an important contextual factor when thinking about chronic homelessness. It should also be noted that a draft Supporting People Strategy for 2021-2024 is under consultation at the time of writing, including engagement with service users and stakeholders.

Current Services

2.20 This sub-section reviews the range and types of services including accommodation-based services available to women who are experiencing chronic homelessness. It should be noted that this is an overview for the purposes of this research project, and not a definitive or categorical assessment of all available services.

On the one hand this client group have access to the wide range of services available firstly to the total population (Table 1), and secondly to what can be categorised here as the general homeless population (Table 2). These are listed below and have been sub-divided using the criteria listed under the definition of chronic homelessness (see paragraph 2.7) with the exception of street activity. This by no means diminishes that many of the publicly and generically available services are not suitable for or accessed by women who are defined as chronic homeless, and that there may be significant regional variations in terms of service provision and availability. That being said, this approach to outline current available services recognises the continuum of need represented in all service users and the continuum of responding services. Appendix 4 provides a summary of temporary accommodation provision by Council area for the whole of Northern Ireland, broken down by different client groups and needs[38]. Where relevant some of these are referenced in the following tables.

[35] This was part of commitments set out in the Housing Strategy 2012 - 2017 and the draft Programme for Government (PFG)

[36] Department for Communities (2017) A *Fundamental Review of Social Housing Allocations* Belfast: DfC pp 111-114 Available online at: www.communities-ni.gov.uk/sites/default/files/consultations/communities/AW-041017%200641%20Housing%20Consultation%20Review%20of%20Social%20Housing%20Allocation.pdf [Accessed 05 February 2019].

[37] More information is available from the Department for Communities website

[38] Client groups and needs include young people, single homeless with support needs, homeless families with support needs, people with alcohol problems, offenders or people at risk of offending, women at risk of domestic violence and single homeless crisis accommodation services.

Table 1: Total population – Range of different types of provision and service

	Range of different types of provision and service[39]
Total population	**Accommodation** – different tenure (owner occupation, social rented and private rented) as well as supported accommodation and other institutions including prisons, residential/nursing homes, children's care homes etc. Support from Housing Executive, advice from Housing Rights and other agencies. Access to social housing via Common Selection Scheme and waiting list etc. Welfare benefits including Housing Benefit.
	Mental Health – generic GP services, with referral to wide range of mental health services including Community Psychiatric Nurse (CPN), community-based services and acute/residential services. This may include services provided by a psychiatrist, psychologist, social worker or a mental health nurse. In addition, services may be provided via the community/voluntary sector[40].
	Addictions – referral via GP to local dedicated drug and alcohol support services for people with drug and alcohol problems or addictions. Range of treatment and support services e.g. Health & Social Care Community Addiction services, services via range of community/voluntary sector organisations, and in-patient detox.
	Risk of violence/abuse – interaction with a range of services including PSNI, and specific abuse in terms of domestic violence e.g. Women's Aid, provision of refuge services – safe emergency accommodation and support to women and children escaping or at risk of domestic violence and abuse. Services such as the MARAC[41] process also contribute to the coordination of support and reduction of harm to high-risk domestic violence victims, together with the Sanctuary scheme[42].
	Prison/youth custody centres – Support to those leaving prison is provided via the NI Prison Service in the various parts of the prison estate – Maghaberry, Magilligan and Hydebank Wood. Probation NI provide community-based support, and community/voluntary organisations also provide services e.g. Extern, Start 360 etc.
	'Looked after' child – Young people leaving care (including from children's homes/units and in foster care) are provided with support from their Health & Social Care Trust.

[39] Information sources for this table include NI Direct - www.nidirect.gov.uk

[40] Service providers include NIAMH (NI Action for Mental Health), Praxis and Inspire Mental Health.

[41] MARAC – Multi-Agency Risk Assessment Conference.

[42] Sanctuary scheme which aims to enable households at risk of domestic violence to remain in their own homes and reduce repeat victimisation through the provision of enhanced security measures and support. The Housing Executive operates a Sanctuary Scheme.

Table 2: Homeless population – Range of different types of provision and service

	Range of different types of provision and service
Homeless population	**Accommodation and services** – Legislation and policy cover situations where an individual or family present as homeless. This is assessed via the Housing Solutions approach. There are a wide range of providers of temporary accommodation, floating support and wider support to assist a move into permanent accommodation. A full list of temporary accommodation providers and services is outlined at Appendix 4 by Council Area. These are outlined by type of accommodation provision and the range of needs and household types[43].In addition, Supporting People-funded Floating Support services are important in the prevention of homelessness and in sustaining tenancies. Supporting People highlighted the following in this regard: • Homecare Independent Living Floating support – a peripatetic homeless service for 'complex needs' clients living in the community. • NICRO, APAC service – floating support for individuals and families (including family members) guilty of or subject to anti-social behaviour. • Triangle Floating support – floating support for clients with drug related dependency in their own homes. • First Housing & Support services – floating support service plus provided street outreach in Londonderry. The annual financial investment in homelessness amounted to £39.6m in 2019/2020[44]. In terms of the generic homeless population a range of temporary accommodation services are relevant; these are for young people, single homeless people with support needs and homeless families with support needs. The Housing Executive note that as part of their statutory duty to homeless households they provided a total of 4,527 placements[45] in temporary accommodation[46] during 2019/20. One hostel, Regina Coeli House, in North Belfast provides 20 units of accommodation specifically for females. Foyle Valley House in Derry provides 14 units of accommodation specifically for females with alcohol problems. All other hostels are either mixed gender, or specifically for males. Details of women's refuges are noted later in this table.

[43] This includes accommodation provision under the following headings – single homeless with support needs, homeless families with support needs, young people (leaving care and at risk), women at risk of domestic violence, people with drug problems, people with alcohol problems, offenders or people at risk of offending.
[44] Temporary accommodation, homelessness services, voluntary sector funding, Supporting People, leased properties, the private rental sector access scheme and miscellaneous.
[45] These are total placements, not individuals – as applicants may have multiple placements during the period.
[46] Temporary accommodation includes NIHE hostels, voluntary sector hostels, private single lets, hotels and B&Bs and leased property.

	Mental Health	There are a number of funded schemes aimed at supporting homeless people with poor mental health and/or addictions. For example, Extern's Multi-disciplinary Homeless Support Team is Belfast based and works in conjunction with the NI Housing Executive and the Belfast Health & Social Care Trust to provide assistance, support and advocacy to homeless adults. This includes work in terms of diagnosed and undiagnosed mental health and substance misuse, and includes services such as the Street Injecting Support Service, the Needle Exchange Service and the Dual Diagnosis Street Team. Temporary accommodation provision for homeless people with alcohol problems is outlined in Appendix 4. The Drugs Accommodation Support Project (DASP) and the Ormeau Centre are based in Belfast and managed by Extern.
	Addictions	
	Risk of violence/abuse – Women's Aid refuges provide emergency accommodation to women on their own or those with children. There are 12 Women's Aid refuges across Northern Ireland. Temporary accommodation provision for women at risk of domestic violence is outlined in Appendix 4.	
	Prison/youth custody – A number of organisations work specifically with those leaving prison who were previously homeless or are at risk of homelessness. This includes the Housing Rights project – Beyond the gate. The NI Prison Service also works closely with prisoners on their resettlement pathways, and there is a protocol, produced by the Housing Executive in partnership with a range of agencies[47], for the management of the accommodation and related support needs of people in custody in Northern Ireland. Temporary accommodation provision for offenders or people at risk of offending is outlined in Appendix 4. This includes, for example, the MUST hostel in Cookstown.	
	'Looked after' child – A number of organisations work specifically with young people leaving care, with a particular focus on supported transition and the potential risks of homelessness. For example, MACs provide supported housing and floating support.	

[47] NI Prison Service, Probation Board NI, Housing Rights, NIACRO and supported by Council for the Homeless NI and NI Federation of Housing Associations.

2.21 In addition, there are a range of accommodation based and other services developed and targeted specifically for the chronic homeless population, irrespective of gender. These are outlined in table 3; again under the different headings relating to the criteria listed in the definition of chronic homelessness, and in addition including reference to street activity (rough sleeping, street drinking and begging).

Table 3: Chronic Homeless population – Range of different types of provision and service

	Range of different types of provision and service
Chronic homeless population	**Accommodation –** One specific model of accommodation, linked to service delivery, and focussed on those who are categorised as chronic homeless is the Housing First Model. This provision, supported by the Housing Executive and delivered by organisations including First Housing Aid & Support Services and Depaul , provides the service user with a permanent home in the community, with support for a wide range of needs including addiction, mental health issues, release from prison. Support is provided so the service user can remain in their own home. The model and provision were reviewed in 2016[48]. In addition, a number of Crash beds are provided for those deemed to be chronic homeless. These are included in Appendix 4, under the categorisation *single homeless crisis accommodation services*. There are 31 'crash beds' in Belfast – 21 for males and three for females provided by The Salvation Army at Centenary House Night Shelter and 10 for females provided by Welcome Organisation at Annsgate Crisis Accommodation Service.
	Mental Health – the Multi-disciplinary Homeless Support Team[49] outlined in Table 2 is also relevant to the chronic homeless population. In addition, Day Centres and drop-ins like that provided by the Welcome Organisation address mental health issues/concerns relating to chronic homeless service users. Belfast Inclusion Health service also works directly with this client group; this includes mental health but also physical health needs.
	Addictions – A number of hostels provide accommodation and support for homeless service users, whilst allowing them to maintain some level of drinking (not total abstinence). These include Stella Maris (Belfast)[50] and The House on the Wells (Derry)[51].

[48] *The Efficiency and Effectiveness of the Housing First Support Service piloted by Depaul in Belfast, Funded by Supporting People: An SROI Evaluation;* Final Report, June 2016, Fiona Boyle and John Palmer, with Salma Ahmed.

[49] This is available in the Belfast area and is not available Northern Ireland wide.

[50] Stella Maris (Managed by Depaul charity) opened in 2005. The project works on the dual principles of harm reduction and low threshold, encouraging service users to make more positive choices in relation to their addiction issues. The hostel provides accommodation for up to 23 long-term homeless street drinkers; who often have associated mental and general health issues and diminished life and living skills.

[51] The House in the Wells (Managed by Apex) offers accommodation to homeless men with addiction issues. The hostel has 14 bedrooms and 5 chalets, each accommodating two people. The model of support is one of harm reduction, where controlled drinking is permitted within the accommodation.

	Range of different types of provision and service
	Street Activity – A wide range of organisations, including the Welcome Organisation[52] noted earlier, provide opportunities for those involved in street activity to avail of services during the day-time e.g. a hot drink or meal, washing and laundry facilities. The Welcome Organisation also runs a Street Outreach team on the streets of greater Belfast from 7am to 2am every day of the year. Other community/voluntary organisations including a number of churches run regular street soup runs, particularly in Belfast. For example, Homeless Aware and the St Patrick's soup kitchen/run, and Haven Outreach. In addition, the Belfast Inclusion Health service offers outreach services to people living on the streets, including GP, nurse (in-reach and out-reach services) dental and podiatry services. The aim of this hub is to bring services out of the clinical setting and into the community and on the streets.
	Risk of violence/abuse – As above, nothing specific for service users defined as chronic homeless.
	Prison/youth custody – As above, nothing specific for service users defined as chronic homeless.
	'Looked after' child – As above, nothing specific for service users defined as chronic homeless.

[52] The Welcome Organisation Drop-in centre is open from 8am to 10pm 365 days per year and provides people affected by homelessness with free access to – hot meals, tea and coffee, showers, toilets, internet, laundry facilities, pool table, advice and health support. In addition, the Housing Executive funds two other Drop-in or Day Centres – The Link in Newtownards and Foyle Haven in Londonderry. Together these three facilities can provide support for up to 175 vulnerable people.

2.22 Finally, a small number of services and accommodation already exists for the female chronic homeless population. Table 4 provides a summary of these.

Table 4: Chronic Homeless Female population – Range of different types of provision and service

	Range of different types of provision and service
Chronic homeless female population	**Accommodation, mental health and addictions –** 'crash' beds – as noted in Table 3 there are a total of 31 'crash beds' in Belfast – 21 for males provided by The Salvation Army at Centenary House Night Shelter and 10 for females provided by Welcome Organisation at Annsgate Crisis Accommodation Service. In addition, other services such as the Needle Exchange Service, the Street Injecting Support Service and the Dual Diagnosis Street Team have already been noted. Floating support and Housing First services are also relevant for chronic homeless women.
	Street Activity - Nothing specific for women defined as chronic homeless. Wider services for those engaged in street activity noted in Table 3.
	Risk of violence/abuse – Nothing specific for women chronic homeless. Domestic violence and abuse accommodation and services noted in Table 3.
	Prison/youth custody – Nothing specific for women experiencing chronic homelessness.
	'Looked after' child – Nothing specific for women chronic homeless.

Tables 1 - 4 highlight that whilst there is some provision for those defined as chronic homeless, there is very little specifically developed or delivered for chronic homeless service users who are women. Other than a small amount of gender specific accommodation for chronic homeless women, the provision is negligible. In addition, tables 3 and 4 highlight that what provision there is for those in the chronic homeless category is Belfast centric, with virtually no services outside of the Greater Belfast area, other than, for example, some Day Centres, Floating Support and Housing First delivery. Attention on the terminology of chronic homelessness is clear from the CHAP report and the services outlined in tables 1 - 4, and some service provision has developed as a result of increased focus on chronic homelessness. However, when the information on provision summarised in this section is considered alongside the research findings set out in Sections 4, 5 and 6, it is abundantly clear that more needs to be done to strategically develop relevant and appropriate services for chronic homeless women, both in Belfast and throughout Northern Ireland.

A note on Covid 19, this research and the wider homelessness response

The period since March 2020 has been dominated by the impacts of and response to the covid 19 pandemic, which has affected every aspect of society. The purpose of this research was to consider and critically evaluate the services available for women experiencing chronic homelessness, and assess the number of women living in chronic homelessness. The impacts of Covid-19 are outside the remit of the report as the objectives were agreed in 2019 and the analysis was conducted on the available data at the time which was pre-pandemic (pre-April 2020). Similarly, service users reflected their homelessness experiences, which were primarily pre-pandemic.

The following provides a brief overview of how the Housing Executive, in partnership with other sectoral stakeholders, responded to the Covid-19 pandemic in relation to homelessness services:

A number of relevant agencies and stakeholders in Northern Ireland worked in partnership during the early stages of the pandemic to ensure that homelessness services in Northern Ireland continued to operate effectively and safely (AgendaNI, July 2020). The Housing Executive worked with homelessness sector service providers, the Department for Communities, Department of Health and Public Health Agency and received additional funding from DfC and subsequently for the Supporting People programme, to:

- Limit the transmission of the virus among those experiencing homelessness, including a commitment that no-one, including those with no recourse to public funds, would be sleeping on the streets;
- Review and reconfigure services, including night shelters, day services, and accommodation and floating support services, in light of public health advice; and
- Ensure the availability of adequate temporary accommodation: by 9 May, 2,884 households were in temporary accommodation placements across the region.

The measures put in place in March 2020 represented an emergency response to an unprecedented situation but, by the summer, an exit strategy and contingency plans for a possible second wave were being developed; these were being viewed as "an opportunity to 'reset' rather than 'revert'". (AgendaNI, July 2020) Homelessness sector charities echoed the need for an exit strategy and preparations for the 'new norm' (Viewdigital, 18 May 2020), given the expectation of a significant increase in demand for services due to the pandemic.

The Housing Executive launched a Homelessness Reset Plan (*The Way Home – Homelessness Response to Covid-19*) in November 2020 to consider the organisation's response to challenges in homelessness service delivery during the pandemic, and to consolidate all learning and insight gained from this experience that could enhance service delivery moving forward. Just as Covid-19 presented significant challenges to homelessness services, so too it accelerated change and promoted collaborative partnerships that have enhanced service delivery and should continue. It is the Housing Executive's view that the pandemic will have long-lasting impacts on homelessness, increasing demand for homeless services. For example, homelessness presentations due to loss of private rental accommodation and domestic abuse are predicted to increase. Similarly increasing unemployment, financial hardship and worsening mental health issues will impact homelessness services for some time to come. In response to the Homelessness Rest Plan, the Communities Minister (May 2021) confirmed an investment of £9 million to fully fund the Homelessness Reset Plan for the financial year 2021-22.

SECTION 3 LITERATURE REVIEW – CHRONIC HOMELESSNESS AMONGST WOMEN

Introduction

3.1 This chapter, provided by Professor Nicholas Pleace and Dr. Joanne Bretherton, Centre for Housing Policy, The University of York, explores the available evidence base on chronic homelessness among women in Great Britain (England, Scotland and Wales). The chapter begins with a discussion of the definition of chronic homelessness, before moving on to examine available research on chronically homeless women's characteristics and needs. Reference to available evidence on effective services for chronically homeless women by Professor Pleace and Dr. Bretherton is provided in Section 7.

International evidence and definitions

3.2 The concept of 'chronic' homelessness, defined in terms of both duration and repeated experience, is American[53] in origin, dating from some of the first systematic longitudinal analysis of patterns in homelessness conducted in the 1990s. The Federal government definition covers people who are living in 'places not meant for human habitation', a 'safe haven' (accommodation-based services for homeless people with severe mental illness), or in an emergency shelter for at least 12 months, or at least four separate occasions in the last three years, where that equals at least 12 months of homelessness[54]. Staying in institutional care for less than 90 days is not seen as constituting a break in homelessness and is included in the 12-month total. Finland, which also has programmes and strategies specifically targeted on what is termed 'long-term homelessness', defines this as meaning 'a person whose homelessness has lasted, or *threatens* to last, for over a year due to social or health reasons, or whose homelessness has been repeated during the past three years'[55].

3.3 Both terms mean the same thing, i.e. enduring homelessness, but as the long-term homeless population has very high rates of severe mental illness, problematic drug and alcohol use, limiting illness, disability and poor physical health, these terms are widely used as a shorthand for homeless people with high and complex needs. In Finland, the definition also encompasses people who are assessed as being *likely* to become long-term homeless because they have high and complex needs.
The international evidence base indicates that chronic homelessness can be a small element within overall homelessness, but this varies with the extent and nature of social protection systems and homelessness services and strategies. In contexts where homelessness can be triggered by poverty, including in-work poverty, chronic homelessness constitutes a *minority* of homeless people. An estimate of chronic homelessness in the USA suggested that it accounts for 10-15% of a total homeless population[56] of around 0.56 million at any one point[57]. Around one-third of chronically homeless people were women, i.e. 3-4.5% of the total homeless population.

[53] Culhane, D. (2018) *Chronic Homelessness: How has our understanding of chronic homelessness evolved?* The Center for Evidence-based Solutions to Homelessness http://www.evidenceonhomelessness.com/wp-content/uploads/2018/04/evidence-page-chronic-homelessness-April-2018.pdf
[54] https://files.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf
[55] Source: ARA https://www.ara.fi/en-us/
[56] Culhane, D. (2018) op. cit.
[57] 567,715 persons experienced homelessness on a single night in the USA according to the HUD Point-In-Time (PIT) count and Housing Inventory Count (HIC) conducted in January 2019 https://www.hudexchange.info/resource/5948/2019-ahar-part-1-pit-estimates-of-homelessness-in-the-us/

3.4 In countries where welfare, public health and social housing systems are at their most extensive, e.g. Scandinavian countries, homeless populations are small but tend to have higher rates of long-term homelessness. In Denmark, there are around 6,000 homeless people at any one point, in a country with 5.8 million people, but, within that population, there are high rates of long-term and repeated homelessness associated with high and complex support needs. These differences are thought to exist because very extensive welfare systems, which tend to be combined with well-resourced and integrated homelessness strategies, effectively prevent, and/or rapidly resolve, homelessness generated for economic and social reasons. However, there are a few people with very high and complex needs who 'fall through' extensive welfare and public health systems, becoming homeless[58]. Finland's strategy to reduce long-term homelessness developed because it was realised that the bulk of a small homeless population was long-term and repeatedly homeless people whose needs were not being met by existing service provision[59]. Across the economically developed world, the rates at which lone adult women experience homelessness, including living rough, have been increasing for the last 20 years, although most data suggest women are in the minority, at no more than 20-25% of homeless populations[60]. As is discussed elsewhere in the report, there are several reasons why this is likely to be an underestimate.

3.5 While only some countries have specialist programmes and services focused on long-term/chronic homelessness, many have services and programmes designed for homeless people with high and complex support needs and most chronically homeless people will also be in this group. Danish, Dutch and French Housing First programmes are designed to work with homeless people with high and complex needs[61], while other programmes and strategies are designed to work on chronic/long-term homelessness, including examples in Finland[62] and the USA. The people using these different services will, despite these differences in emphasis, share many characteristics, needs and experiences.

3.6 While there is evidence that severe mental illness or addiction can act as a *trigger* for long-term homelessness, there is also evidence that these conditions can *appear* among populations experiencing long-term homelessness, alongside marked deteriorations in physical health. Beyond this, sustained or repeated exposure to homelessness means that existing support needs are often exacerbated and that someone without high and complex needs before experiencing long-term homelessness is *likely* to develop such needs during homelessness[63]. From a policy costs perspective, the financial costs of solving long-term or chronic homelessness tend to increase, the longer it is experienced[64]. It is debatable, when talking about long-term and repeatedly homeless populations,

[58] Benjaminsen, L. and Andrade, S.B. (2015). Testing a typology of homelessness across welfare regimes: Shelter use in Denmark and the USA. *Housing Studies*, 30(6), pp.858-876.
[59] Pleace, N.; Knutagård, M.; Culhane, D.P. and Granfelt, R. (2016) The Strategic Response to Homelessness in Finland: Exploring Innovation and Coordination within a National Plan to Reduce and Prevent Homelessness in Nichols, N. and Doberstein, C. (eds) *Exploring Effective Systems Responses to Homelessness* Toronto: Canadian Observatory on Homelessness, pp. 426-442.
[60] Busch-Geertsema, V.; Benjaminsen, L.; Filipovič Hrast, M. and Pleace, N. (2014) *The Extent and Profile of Homelessness in European Member States: A Statistical Update* Brussels: FEANTSA. www.feantsaresearch.org/download/feantsa-studies_04-web2445115205382853398 1.pdf
[61] Pleace, N.; Baptista, I. and Knutagård, M. (2019) *Housing First in Europe: An Overview of Implementation, Strategy and Fidelity* Brussels: Housing First Hub Europe.
[62] Y Foundation (2017) A Home of Your Own – Housing First and ending Homelessness in Finland Helsinki: Y Foundation https://ysaatio.fi/en/housing-first-finland/a-home-of-your-own-handbook
[63] Culhane, D.P., Metraux, S., Byrne, T., Stino, M. and Bainbridge, J. (2013) The age structure of contemporary homelessness: Evidence and implications for public policy. *Analyses of Social Issues and Public Policy,* 13(1), pp.228-244.
[64] Pleace, N. and Culhane, D.P. (2016) *Better than cure? Testing the case for enhancing prevention of single homelessness in England* London: Crisis.

whether homelessness remains the primary concern, when multiple high support needs, including problematic drug use and addiction, are often present.

England, Scotland and Wales – Definitions

3.7 England, Scotland and Wales do not have working definitions of 'long-term' homelessness beyond local strategies and individual services. Housing First Scotland, intended for "people whose homelessness is experienced alongside other severe and multiple disadvantage"[65] is, effectively, also aimed at long-term and recurrently homeless people and most Housing First services in England and Wales have the same focus[66]. The national pilot programme for Housing First in England, in Merseyside, West Midlands and Manchester, has a different focus on people living rough, but this again includes long-term and recurrently homeless people[67]. Supported housing services, including floating support and accommodation-based services, are sometimes intended specifically for homeless people with high and complex needs and will work with a high proportion of people whose experience of homelessness is long-term or repeated. Lower intensity services commonly report a small number of people with complex needs who are in a 'revolving door' situation, i.e. making high use of homelessness services but never exiting homelessness on a sustained basis.

3.8 England, Scotland and Wales all identify populations of 'entrenched' rough sleepers, who have been on the streets on a sustained or recurrent basis as a policy priority, but do not tend to focus on people experiencing this form of homelessness for a set period[68]. Again, the line between duration and complex needs is very unclear, an 'entrenched' rough sleeper is defined as much in terms of being within a high cost, high risk element within the homeless population, as by the long duration of their homelessness[69].

How many women experience chronic homelessness?

3.9 Much of the research conducted on long-term homelessness has been focused primarily on rough sleeping and emergency shelter using men in North America, with rather less work in the UK and Europe. Criticisms have been directed at work which uses cross-sectional or 'snapshot' surveys of people on the street or in emergency services:

- There has been a broad tendency to note that women are present, that they constitute a minority, and then to not pursue much, or sometimes any, further analysis of how women might differ from men in terms of their needs, behaviour, characteristics and experiences[70].
- Studies have been criticised for not including long-term and repeatedly homeless people living in situations of hidden homelessness. There is growing evidence indicating that hidden homelessness may be disproportionately experienced by chronically homeless women, those women both tending to rely more heavily on informal support to keep a roof over their head

[65] www.housingfirst.scot
[66] Bretherton, J. and Pleace, N. (2015) *Housing First in England: An Evaluation of Nine Services* York: University of York.
[67] www.homeless.org.uk/connect/news/2018/may/09/government-launches-its-three-regional-housing-first-pilots
[68] Wilson, W. and Barton, C. (2020) *Rough Sleeping (England)* House of Commons Briefing Paper Number 02007, 9 April 2020 https://commonslibrary.parliament.uk/research-briefings/sn02007/
[69] Ibid.
[70] Bretherton, J. (2017) Reconsidering gender in homelessness. *European Journal of Homelessness* 11(1), pp. 1-21. www.feantsaresearch.org/download/feantsa-ejh-11-1_a1-v045913941269604492255.pdf

and avoiding services that have a working assumption that most lone homeless people are men[71].

- There is some evidence from North America, Ireland and the UK that cross-sectional studies (surveys conducted over a short period) tend to *oversample* long-term and recurrently homeless men, i.e. men with the most complex needs tend to be the ones who will be on the street, or using an emergency shelter or hostel, at any one point in time, so they are more likely to be present when data collection happens[72]. However, by not covering other aspects of homelessness (particularly hidden homelessness), cross-sectional research may have also *underestimated* the scale of chronic homelessness among women with high and complex needs.

3.10 Women, specifically lone adult women, were broadly assumed to not be present in significant numbers in the long-term and repeatedly homeless populations, so little effort was put into trying to understand and define the scope of chronic homelessness among women[73]. A longstanding assumption was that women experiencing homelessness often did so with their children, often as a consequence of (often violent or abusive) relationship breakdown, and that meant that domestic violence, child protection and welfare services - across the economically developed world - stopped many women becoming homeless. This was thought to be because systems to protect women against domestic violence and/or stop their child or children experiencing destitution also protected them. While the fact that lone women were being found in surveys and research on lone homeless adults, including long-term and repeatedly homeless women, has been repeatedly pointed out[74], the idea that women do not tend to become chronically homeless is still mainstream at the time of writing.

3.11 Criticism of the idea that women did not become chronically homeless at the same rates as men centres on evidence that women experience 'hidden' homelessness, i.e. staying in insecure housing or accommodation provided by family, friends and acquaintances for long periods[75]. Definitions of what constitutes homelessness vary and in some economically developed countries women in this position are defined as 'housed'. However, UK homelessness legislation, which differs across England, Wales, Scotland and Northern Ireland, does recognise some forms of hidden homelessness, as do the prevention-led systems now at the forefront of statutory responses in Wales and England.

3.12 Definitions of what constitutes 'hidden homelessness' start with situations where a woman does not have her own address and her own living space, to which she has an enforceable legal right. To be a woman's own living space, housing has to be under her control, and it has to be private, so she is not unwillingly sharing private living with others, because she has no alternative housing. Finally, her housing must be conducive to her health and wellbeing, it cannot be an environment in which she

[71] Pleace, N.; Bretherton, J. and Mayock, P. (2016) Long-term and Recurrent Homelessness Among Women, in Mayock, P. and Bretherton, J. (eds) *Women's Homelessness in Europe* London: Palgrave MacMillan pp. 209-223.
[72] O'Sullivan, E. (2020) *Reimagining Homelessness for Policy and Practice* Bristol: Policy Press.
[73] Bretherton, J. (2020) Women's Experiences of Homelessness: A Longitudinal Study. *Social Policy and Society*, 19(2), pp. 255-270 doi:10.1017/S1474746419000423; Pleace, N. (2016) Exclusion by Definition: The Under-representation of Women in European Homelessness Statistics in Mayock, P. and Bretherton, J. (eds) *Women's Homelessness in Europe* London: Palgrave MacMillan pp. 105-126.
[74] Baptista, I. (2010) 'Women and homelessness in Europe', in O'Sullivan, E., Busch-Geertsema, V., Quilgars, D. and Pleace, N. (eds.), *Homelessness Research in Europe*, Brussels: FEANTSA, pp. 163–86.
[75] Mayock, P., Sheridan, S. & Parker, S. (2015) "It's just like we're going around in circles and going back to the same thing ...": The dynamics of women's unresolved homelessness, *Housing Studies*, 30, (6), pp. 877 – 900; Bretherton, J. (2017) and (2020) op. cit.; Pleace, N.; Bretherton, J. and Mayock, P. (2016) op.cit.

is at risk, including risks of violence and abuse from other people either within or outside the household. A woman who is physically unsafe because of an abusive person in her home may have legal security of tenure (or it may be her home, but a perpetrator holds the tenancy), but she cannot live there, which makes her homeless. Chronic homelessness exists for women among long-term and repeatedly homeless populations, living rough and in homelessness services (including populations caught in a revolving door of using homelessness services repeatedly but not exiting homelessness) and women whose experience of hidden homelessness is sustained or recurrent.

3.13 Importantly, there is some evidence that lone adult women experiencing long-term and repeated hidden homelessness can have high and complex support needs. This means that women who are not experiencing chronic homelessness on the street or in emergency shelter/supported housing settings, but in other people's homes nevertheless share the high rates of severe mental illness, problematic drug and alcohol use, limiting illness, disability and poor physical health found in those populations[76].

What are the support needs of chronically homeless women?

3.14 The needs of women who seek assistance via homelessness legislation, and in Wales and England statutory preventative systems, run by English, Welsh and Scottish local authorities are recorded with varying levels of detail. Prior to the use of the H-CLIC dataset[77], which superseded the 'P1E' data[78], English data were headcounts, providing little beyond a broad breakdown of how many statutorily homeless households (owed main duty) were headed by women. However, some operational and development issues have delayed full roll out of the statistical reports from H-CLIC at the time of writing. HL1 data[79], collected on the Scottish statutory system, have always provided case-by-case data, which provides more detail, while the Scottish statutory system, which does not employ priority need in determining whether a main duty is owed, is more open than those in Wales and England. The Welsh homelessness statistics are less detailed. England, Scotland and Wales do not publish detailed analysis by gender of homeless applicants, those receiving preventative support nor those owed the main duty (or equivalent).

3.15 Aggregated data are available on who uses accommodation-based and floating support homelessness services funded via the (still existent) Supporting People programme in Wales[80], but data were never collected in Scotland and ceased to be collected in England when, as in Scotland, Supporting People was effectively abolished[81]. However, both detailed and broad statistical analysis of the use of emergency accommodation and housing related support services by women has not been conducted anywhere in Great Britain.

3.16 Another limitation in existing datasets, both in terms of local authority administrative data for the statutory systems and the data collected by services, is that Great Britain does not, in marked

[76] Pleace, N.; Bretherton, J. and Mayock, P. (2016) op. cit.
[77] https://www.gov.uk/government/collections/homelessness-statistics
[78] Quarterly 'P1E' forms were used to collect data from English local housing authorities on their responsibilities under homelessness legislation. The form also included a section on homelessness prevention and relief.
[79] HL1 is the homeless statutory statistical return to the Scottish Government submitted by each Local Authority, containing details regarding homelessness applications submitted locally.
[80] https://gov.wales/supporting-people-programme
[81] A budget nominally existed, but the ringfencing was removed alongside austerity measures, meaning that many local authorities in England ceased to have a Supporting People programme with a dedicated budget and centralised data collection on SP services in England was cut.

contrast to somewhere like Finland or the USA, have dedicated programmes, services or strategies aimed at 'chronic' homelessness. The absence of a strategic focus on 'chronic' homelessness means there is no imperative to collect data on this group, unlike say Finland[82] with municipality-level and national data on long-term homelessness, or the USA[83], which has detailed counts by administrative areas for federally funded homelessness services, individual states and nationally. Within individual services and sometimes at local authority level, more detailed data are being collected on homeless women who tend to have high and complex needs. However, alongside not being aggregated at national level, this is only indirect recording of information on women who are likely to be characterised by high rates of long-term and repeated homelessness, not data collection focused on chronic homelessness.

3.17 While statistical data are limited, there is an evidence base on women's experiences, needs and characteristics and their pathways through long-term homelessness[84], collected through qualitative social science[85], ethnographic studies[86] and research funded by homelessness charities[87]. This research shows the following:

- Very high prevalence of experience of domestic violence and abuse as a trigger for homelessness and as an experience that occurs while homeless. This includes some evidence of unwanted sexual partnerships in exchange for accommodation, although there is evidence that this is not by any means a universal experience.
- Severe mental illness, other mental health problems and a high prevalence of problematic drug and alcohol use (again, this is not a universal experience), linked to experience of multiple forms of stress and highly negative life experiences both preceding and during experience of homelessness. Many lone women experiencing long-term and recurrent homelessness are parents who do not have children with them; some have had children taken into care, others have children living with another relative.
- Poor physical health and limiting illness.
- Low levels of education, work experience and training, with economic dependence on (mostly male) partners being a trigger for homelessness when relationships broke down, including violent relationship breakdown.

3.18 Evidence from research on Housing First has sometimes indicated a higher than expected level of women among people whose homelessness is long-term, recurrent and linked to high and complex needs. Some of the initial work on Housing First for homeless women is also indicating that typical levels of support need among long-term and repeatedly homeless women, including those around

[82] www.ara.fi/en-US/Materials/Homelessness_reports
[83] https://files.hudexchange.info/resources/documents/2019-AHAR-Part-1.pdf
[84] Pleace, N.; Bretherton, J. and Mayock, P. (2016) op. cit.; Reeve, K. with Batty, E. (2011) *The hidden truth about homelessness: Experiences of single homelessness in England* London: Crisis
[85] Mayock, P. and Bretherton, J. (2016) *Women's Homelessness in Europe* London: Palgrave MacMillan.
[86] Menih, H. (2020) 'Come Night-time, It's a War Zone': Women's Experiences of Homelessness, Risk and Public Space, *The British Journal of Criminology*, azaa018, https://doi.org/10.1093/bjc/azaa018; Wardhaugh, J. (1999) The unaccommodated woman: Home, homelessness and identity. *The Sociological Review*, 47(1), pp.91-109.
[87] Reeve, K. (2018) Women and homelessness: putting gender back on the agenda. *People, Place and Policy Online*, 11(3), pp.165-174.

high rates of experience of abuse and violence, tend to be even *higher and more complex* than those for chronically homeless men[88].

3.19 Research has pointed out some flaws in common assumptions about the needs and characteristics of homeless women[89]. A key issue here is an assumption of what might be termed 'deviant' behaviour among homeless women. This is linked to widespread cultural assumptions that expect women to be in 'domestic' roles, i.e. always being a mother/partner/carer who forms the heart of cultural expectations around what constitutes a 'home'. Women outside the home, particularly on a long-term basis, can encounter an array of negative expectations about who they are and how they behave. Common assumptions being that women will, or have at some point, 'traded' sex for accommodation and have problematic drug and/or alcohol use[90], when these experiences are not universal. Negative stereotypes exist around chronic lone male homelessness as well, but research indicates chronically homeless women will often encounter harsher and more judgemental attitudes[91].

3.20 There is a wider discussion of the degree to which homeless people, including those experiencing long-term and recurrent homelessness, have agency, i.e. the degree to which they control their own lives and trajectories through homelessness. Research on homeless women, highlights differences around how homelessness is typically experienced. Women appear to rely on informal arrangements, i.e. enter forms of hidden homelessness more often than is the case for men, showing that women often exercise at least some control over what happens to them[92]. Hidden homelessness can mean entering arrangements that can be precarious or potentially dangerous, but women will also face potential risks within male-dominated congregate and communal services (or within such services that are women-only) and high risks from living rough[93].

An area that requires more research is the degree to which women are able to 'self-exit' from homelessness, as it is known that some people enter, experience and leave homelessness without necessarily drawing on services, including lone women and women with children. This is important because in better understanding how some women are able to leave homelessness, the *barriers* to leaving homelessness (which mean some women become chronically homelessness) can be better understood.

3.21 Research indicates that the barriers to self-exit from homelessness exist in three, interlinked forms[94]:

- The degree to which someone has *personal resources*, both in terms of their innate capacity, skills and knowledge and in terms of what financial resources they either have or are able to access.

[88] Quilgars, D. and Pleace, N. (2017*) The Threshold Housing First Pilot for Women with an Offending History: The First Two Years* York: University of York www.york.ac.uk/media/chp/documents/Threshold%20Housing%20First%20Evaluation%20Report%20-%20FINAL%20(14-3-18).pdf
[89] Bretherton, J. 2017 and 2020, op. cit.
[90] Bretherton, J. and Pleace, N. (2018) *Women and Rough Sleeping: A Critical Review of Current Research and Methodology* York: University of York http://eprints.whiterose.ac.uk/138075/
[91] Hansen-Löfstrand, C. and Quilgars, D. (2016) Cultural Images and Definitions of Homeless Women: Implications for Policy and Practice at the European Level in Mayock, P. and Bretherton, J. (eds) *Women's Homelessness in Europe* London: Palgrave MacMillan pp. 41-73.
[92] Bretherton, J. 2017 and 2020, op. cit.
[93] Bretherton, J. and Pleace, N. (2018) op. cit.
[94] Pleace, N. (2016) Researching Homelessness in Europe: Theoretical Perspectives *European Journal of Homelessness* 10(3), pp. 19-44.

- The degree to which someone has access to *informal support,* from family and friends, who can provide them with information, emotional support and practical help, such as helping someone put down a deposit to rent a flat.
- The degree to which there is effective access to *formal support* from mainstream welfare, public health, charitable and social housing services and whether and to what extent suitable support is available in respect of homelessness prevention, rapid rehousing systems, and supported housing and Housing First/housing led support where necessary.

3.22 The absence of any of these three creates a greater risk both of homelessness and that homelessness will be sustained. Once support is missing in two or all three of these areas, homelessness is both likely to *occur* and more likely to be *sustained*. Over time, the evidence suggests that exits from homelessness become more challenging in terms of the resources required and for people seeking to exit homelessness[95].

3.23 The research indicates that it is important to avoid discussing women's experiences of chronic homelessness simply in terms of vulnerabilities; women show their resilience and resources in, for example, keeping a roof over their head via friends or relatives, rather than having to live on the street or in emergency accommodation. While there are risks, the safety and the quality of their lives, the best *available* choice, for women may be arranging their own solutions to homelessness. While this is not gender specific, the evidence does suggest that women are using their own agency to create interim ways of minimising the risks of homelessness more frequently than is the case for men[96]. However, women may be at particular risk of *chronic* homelessness for several reasons:

- Trauma may undermine both mental and physical health and be associated with problematic drug and alcohol use. Domestic violence and abuse are triggers for women's homelessness at much higher rates than men. Across the UK, and throughout the economically developed world, women's homelessness is clearly associated with male violence and abuse[97]. Women may also become separated from their children, sometimes choosing to leave a child with relatives, sometimes having children taken into care. Risks of chronic homelessness may be exacerbated for several reasons, including the trauma and risks to mental wellbeing potentially undermining personal resources and, in addition, physical displacement – particularly the need to get away from perpetrators of violence and abuse – disrupting or severing access to both informal and formal support.
- Services exist for homeless women, both within the homelessness sector and in refuge and other service provision for women who are made, or who are at risk of becoming, homeless due to violence or abuse. However, emergency shelters, hostels and supported housing, alongside some preventative services, are often modelled on the assumption that homeless people with high and complex needs – and hence chronically homeless people – will be disproportionately male. Where services are, how they operate and the support they offer may make them male orientated, creating barriers for some homeless women[98]. A larger city in England, Scotland and Wales will have one or more dedicated domestic violence

[95] Pleace, N. and Culhane, D.P. (2016) op. cit.
[96] Bretherton, J. (2017) op. cit.
[97] Mayock, P.; Bretherton, J. and Baptista, I. (2016) Women's Homelessness and Domestic Violence:
(In)visible Interactions in Mayock, P. and Bretherton, J. (eds) *Women's Homelessness in Europe* London: Palgrave MacMillan pp. 127-154.
[98] Bretherton, J. and Pleace, N. (2018) op cit.

and/or supported housing services for homeless women, smaller and more rural places may not. Access to prevention, resettlement and tenancy sustainment support may be limited because the right forms of services do not exist at sufficient scale.

- There is evidence that lone homeless women and women heading one parent families with dependent children, can exhibit a tendency to 'exhaust' informal forms of support before seeking formal help from public/charitable services[99]. This can be because there is an expectation that they will be refused formal help, sometimes not knowing about the supports that are available, or there is reluctance to approach formal services because an informal arrangement seems to, or does, offer a better alternative than what might be available from formal services.
- While the data on this are not exact and also allowing that people will experience something in different ways, the available evidence indicates that homelessness does not need to be experienced for very long before it starts to significantly undermine wellbeing, socioeconomic integration and mental and physical health. Even what might seem a relatively short period of experiencing homelessness may be sufficient to make the likelihood of sustained or recurrent, 'chronic', homelessness much more likely. This was a key argument in making the case for enhancement of homelessness prevention and rapid-rehousing systems in England[100].

[99] Bretherton, J.; Benjaminsen, L. and Pleace, N. (2016) Women's Homelessness and Welfare States in Mayock, P. and Bretherton, J. (eds) *Women's Homelessness in Europe* London: Palgrave MacMillan pp. 75-102.
[100] Pleace, N. and Culhane, D.P. (2016) op. cit.

SECTION 4 RESEARCH FINDINGS – INCIDENCE AND PROFILE OF CHRONIC HOMELESSNESS AMONGST WOMEN IN NORTHERN IRELAND

Introduction

4.1 This section looks at the incidence and nature of chronic homelessness amongst women in Northern Ireland. It commences with an acknowledgement that counting mechanisms are as yet under-developed UK wide, and cannot adequately measure the full extent and nature of chronic homelessness amongst women. In the absence of a full capture of the incidence and nature of chronic homelessness amongst women, including which of the criteria in the agreed definition are most prevalent, it is difficult to adapt current services and plan new services to meet their needs.

The text in the next sub-section (paragraphs 4.2 – 4.4) was provided by Professor Nicholas Pleace and Dr. Joanne Bretherton, Centre for Housing Policy, The University of York.

Finding ways to count long-term homelessness among women

4.2 Counting women experiencing long-term and recurrent homelessness is challenging on multiple levels. For women who are experiencing living rough on a sustained or recurrent basis, there is evidence both that some will avoid male-dominated service environments in which they feel unsafe (as will some men) and that most will hide when living rough to avoid trouble (as will most men). Women in these situations will not be recorded in administrative data collected by services, nor in street counts[101].

4.3 It is inherently challenging to count people experiencing hidden homelessness. Research in Northern Ireland on the feasibility of adopting the European Typology of Homelessness (ETHOS) as a framework for counting the homeless population, reported that data were at their most limited when it came to estimating the numbers of homeless people living in situations of hidden homelessness. Existing surveys did not find them (numbers were too small) and, unless they were recorded by administrative systems in services, which depended on whether they contacted those services, there was no way of keeping track of a population who were characterised by mobility and not having their own address[102].

4.4 Women, including those experiencing chronic homelessness, tend to be missed by existing systems for counting homeless people for the following reasons[103]:

- Street counts of people living rough are inherently inaccurate[104], as they only cover some areas, at certain times, the population of people sleeping rough changes over time and people will seek shelter, or at least conceal themselves, if they are sleeping without a roof over their head.

[101] Pleace, N. (2016) op. cit.
[102] Pleace, N. and Bretherton, J. (2013) *Measuring Homelessness and Housing Exclusion in Northern Ireland: A test of the ETHOS typology* Belfast: Northern Ireland Housing Executive.
[103] Pleace, N. (2016) op. cit.
[104] But can be useful as indicators of whether there is a broad trend of increasing or decreasing levels of rough sleeping.

- Systems often do not record whether or not someone is long-term or recurrently homeless and domestic violence services will not always record whether a woman using them is in a situation of homelessness, whether short or long term.
- Women appear to be more likely to experience long-term or repeated homelessness in situations of hidden homelessness, which is challenging to count, meaning that there may be underrepresentation of the extent and nature of chronic homelessness among women. Homeless people in general are harder to find if they are not (visibly) living rough and/or using a homelessness housing service where they can be found and at which their details are recorded.

Incidence and profile of chronic homelessness amongst women in Northern Ireland

4.5 Accepting the lack of a coherent and robust counting mechanism of chronic homelessness, not least one by gender, as noted earlier by Pleace & Bretherton, this section now looks at what data exists in Northern Ireland with specific reference to the indicators outlined in the definition of chronic homelessness (Appendix 3). This approach helps to build up some understanding of numbers and incidence of chronic homelessness amongst women, and points towards the need to instigate a robust counting mechanism. It is worth highlighting again that this definition was developed as part of the CHAP and through a process of consultation and detailed discussion across the homeless sector. Whilst there had been plans to operationalise the definition from April 2020 including ongoing counting/measurement, these plans were put on hold because of covid-19. At the time of the research (2020 to early 2021) the definition had not been operationalised. In addition, reference is made at point 4.12 to the limitations of the available wider secondary data.

This section builds on the information noted at point 2.14, which referenced previous research which suggested that it would not be unreasonable to expect that between 5 and 10% of the homeless population could be categorised as experiencing chronic homelessness. Further estimates, as noted in Section 3, suggest that in some countries chronic homelessness can account for 10 – 15% of the total homeless population, e.g. USA.

Analysis of Data on homelessness amongst women – Housing Executive

4.6 Homelessness amongst women is not a new phenomenon in Northern Ireland. Women are well represented in the figures in terms of single females presenting (and being accepted as homeless) and within couples, pensioner households and homeless families. Table 5 indicates the trends in relation to single female presenters and acceptances in general (aged 16 – 17[105], 18 – 25 and 26 – 59) together with females aged 60+ in pensioner households[106]. Whilst the overall number of female presenters in these categories is lower than male presenters over the 5-year period being examined (e.g. 2015 – 2016: 4,310 female presenters compared to 7,108 males), it is also apparent that females are more highly represented than males in some household categories (e.g. singles aged 16 – 17 years and singles aged 60 plus). The number of females in these groupings is consistently higher throughout the time period.

[105] Data on 16 – 17-year-olds is also covered later in this section through data provided by the Health & Social Care Trusts.
[106] Current Housing Executive data analysis covers *households* rather than *individuals*. Therefore gender of head of household is reported for single households only.

4.7 Table 6 provides an overview of female presenters and acceptances over the time period for each of the three Housing Executive Regions – Belfast, South and North. This shows that the number of female presenters and acceptances was relatively similar across the three Regions; with Belfast Region indicating slightly more than the South Region and around 200 more presenters per year than the North Region. The acceptance level as 'full duty' applicants varied between 70% in Belfast and 73% in the South Region.

4.8 Tables 7 – 10 provide an analysis of the four age categories of female presenters by reason for homelessness, where this specifically inter-relates to one or more of the criteria listed in relation to chronic homelessness[107]. It should be noted that whilst some women's reason for homelessness correlates with these chronic homelessness factors or indicators, these women may not by default be chronic homeless. This is particularly important to emphasise given that the definition of chronic homelessness is based on an individual having more than one episode of homelessness in the last 12 months or multiple (3 or more) placements/exclusions from temporary accommodation during the last 12 months. This underlying basis for defining chronic homelessness then has the additional listed criteria, with the definition stating that two or more of these indicators should apply, for the person to be defined as in chronic homelessness.

In addition, there may be chronic homeless women presenting to the Housing Executive via a wide range of other reasons, who are not necessarily recorded as chronic homeless. The picture is further compounded by a wide number of other factors; not least that, as noted earlier by Pleace & Bretherton, many chronic homeless women do not present to the Housing Executive or other statutory/administrative systems and in some cases even if they do – irrespective of how comprehensive the Housing Solutions approach is – previous homeless experiences or the repeat nature of their homelessness may not be identified.

The data in tables 7 – 10 indicates a differential between younger and older females presenting as homeless in terms of their reasons for homelessness, with previously being in care as a reason more prevalent in the 16 – 17 and 18 – 25-year-old categories, and domestic violence as a reason for homelessness higher amongst the 26 – 59 and 60+ age categories.

[107] A number of caveats/notes are connected to table 7; these are also relevant to tables 8 – 10.

Table 5: Homeless presentations and acceptances by single female and by age, 2015 - 2020

Female presenters and acceptances	2015 – 2016		2016 – 2017		2017 – 2018		2018 – 2019		2019 - 2020	
	No of presenters	No of acceptances	No of presenters	No of acceptances	No of presenters	No of acceptances	No of presenters	No of acceptances	No of presenters	No of acceptances
Single females 16 – 17 years	160	94	122	74	106	56	89	53	90	44
Single females 18 – 25 years	1,388	775	1,365	816	1,274	799	1,250	828	1,195	776
Single females 26 – 59 years	1,821	1,164	1,842	1,238	1,749	1,220	1,873	1,351	1,722	1,198
Female 60+ years	940	778	980	842	1,020	866	1,032	898	946	818
Total	**4,309**	**2,811**	**4,309**	**2,970**	**4,149**	**2,941**	**4,244**	**3,130**	**3,953**	**2,836**

Source: NIHE Data Analytics Unit

Table 6: Homeless single and 60+ female presentations and acceptances by Housing Executive Region, 2016 - 2020[108]

Female presenters and acceptances	2016 – 2017		2017 – 2018		2018 – 2019		2019 - 2020	
	No of presenters	No of acceptances	No of presenters	No of acceptances	No of presenters	No of acceptances	No of presenters	No of acceptances
Belfast Region	1,560	1,065	1,468	1,046	1,496	1,084	1,399	982
South Region	1,461	1,072	1,364	989	1,437	1,075	1,349	988
North Region	1,288	833	1,317	906	1,311	971	1,205	866
Total	**4,309**	**2,970**	**4,149**	**2,941**	**4,244**	**3,130**	**3,953**	**2,836**

Source: NIHE Data Analytics Unit

[108] Prior to 2016 the Housing Executive regional administration units were Belfast, North East, South, South East and West.

Table 7: Homeless single female presentations, aged 16 – 17 years by reason for homelessness, 2015 - 2020

Reason for homelessness	Single female presenters, aged 16 – 17 years				
	2015 – 2016	2016 – 2017	2017 – 2018	2018 – 2019	2019 - 2020
Range of reasons[109]	140	106	94	76	69
Reasons relating to chronic homeless definition[110]					
Domestic violence[111]	2	2	2	4	4
Child ex care	17	12	10	9	17
Release from prison	-	-	-	-	-
Sexual abuse/violence	1	2	-	-	-
ANR –Mental Health[112]	-	-	-	-	-
Sub-total – presenters for 'chronic homeless' reasons	**20**	**16**	**12**	**11**	**21**
Grand Total – presenters in this category	**160**	**122**	**106**	**89**	**90**

Source: NIHE Data Analytics Unit

[109] These include the range of reasons noted as reason for homelessness – including loss of rented accommodation, relationship breakdown, breakdown of sharing/family dispute etc.
[110] The various categories relating to 'chronic homelessness' are outlined in the definition at Appendix 3. Factors such as addictions or street activity etc. are not recorded under any of the reasons for homelessness categories. Reference to mental health as a reason for homelessness – under Accommodation Not Reasonable (ANR) is only available in the data sets 2018 – 2019 and 2019 – 2020.
[111] In some years this category is referred to as battered partners/violence – 2016/2017 and 2017/2018.
[112] Only available from 2018 – 2019 onwards.

Table 8: Homeless single female presentations, aged 18 - 25 years by reason for homelessness, 2015 - 2020

Reason for homelessness	Single female presenters, aged 18 - 25 years				
	2015 – 2016	2016 – 2017	2017 – 2018	2018 – 2019	2019 - 2020
Range of reasons	1,291	1,237	1,158	1,094	1,028
Reasons relating to chronic homeless definition					
Domestic violence	66	76	78	98	100
Child ex care	23	31	22	22	33
Release from prison	1	4	3	1	2
Sexual abuse/violence	7	17	13	13	9
ANR –Mental Health	-	-	-	22	23
Sub-total – presenters for 'chronic homeless' reasons	**97**	**128**	**116**	**156**	**167**
Grand Total – presenters in this category	**1,388**	**1,365**	**1,274**	**1,250**	**1,195**

Source: NIHE Data Analytics Unit

Table 9: Homeless single female presentations, aged 26 - 59 years by reason for homelessness, 2015 – 2020

Reason for homelessness	Single female presenters, aged 26 - 59 years				
	2015 – 2016	2016 – 2017	2017 – 2018	2018 – 2019	2019 - 2020
Range of reasons	1,611	1,657	1,533	1,530	1,369
Reasons relating to chronic homeless definition					
Domestic violence	176	149	178	224	219
Child ex care	-	-	-	-	-
Release from prison	14	10	13	7	14
Sexual abuse/violence	20	26	25	30	17
ANR –Mental Health	-	-	-	82	103
Sub-total – presenters for 'chronic homeless' reasons	**210**	**185**	**216**	**343**	**353**
Grand Total – presenters in this category	**1,821**	**1,842**	**1,749**	**1,873**	**1,722**

Source: NIHE Data Analytics Unit

Table 10: Homeless female presentations, aged 60+ years by reason for homelessness, 2015 – 2020

Reason for homelessness	Single female presenters, aged 60+ years				
	2015 – 2016	2016 – 2017	2017 – 2018	2018 – 2019	2019 - 2020
Range of reasons	902	952	969	936	859
Reasons relating to chronic homeless definition					
Domestic violence	32	26	48	56	43
Child ex care	-	-	-	-	1
Release from prison	1	-	-	-	1
Sexual abuse/violence	4	2	3	1	-
ANR –Mental Health	1	-	-	39	44
Sub-total – presenters for 'chronic homeless' reasons	**38**	**28**	**51**	**96**	**87**
Grand Total – presenters in this category	**940**	**980**	**1,020**	**1,032**	**946**

Source: NIHE Data Analytics Unit

Analysis of Data on measured chronic homelessness amongst women – Housing Executive

4.9 As noted earlier a new counting mechanism in relation to chronic homelessness has been developed by the Housing Executive as part of the Chronic Homeless Action Plan (CHAP)[113]. This counting mechanism was designed to be incorporated at local area office level via the Housing Solutions teams, utilising prompts and guidance via the Housing Solutions form. Using an identified set of criteria, Housing Advisors would identify applicants who can be defined as chronic homeless under the definition and criteria listed in Appendix 3.

Unfortunately, these planned system changes were impacted by covid-19. The Housing Executive noted: *Whilst the consultation with staff had been completed and the changes were ready to go, it was felt that the adjustments that staff were having to make, e.g. working from home, changes to policy in relation to getting rough sleepers off the streets, new booking mechanisms for temporary accommodation etc. meant that to introduce a further change to the assessment mechanism without the opportunity to provide training and guidance was not the right thing at the right time.*

The overall purpose of this 'count', when it is implemented in due course, will be to both assess the scale of the problem and to then in turn inform the provision of effective and targeted interventions. For the purposes of this research study, and in the absence of Housing Executive data specifically on chronic homelessness and women it was therefore decided to pull together a picture of the level and nature of chronic homelessness amongst women from a range of different sources. This is examined in the rest of this Section.

Analysis of Data on repeat presentations – Housing Executive

4.10 One element of Housing Executive data that was available for analysis is an examination of the level of repeat presentation amongst single female presenters. This links directly to the definition of chronic homelessness, in terms of the initial categorisation, that is *an individual with more than one episode of homelessness in the last 12 months.* The Housing Executive have emphasised that counting and measuring 'repeat' homelessness is not without its difficulties[114].

4.11 Data on repeat presentation is available for the last three years (2017/18, 2018/19 and 2019/20). Table 11 indicates that for the most recent year (2019/20) there were a total of 253 female repeat presenters[115]; when compared to the total female presenters in that year, this indicates that around 6.4% of female presenters were 'repeat' presenters. Table 11 also highlights that this incidence level has increased slightly over the last three years.

Again, it is important to stress that repeat homelessness in itself does not mean an individual can be defined as chronic homeless. However, in cases where repeat homelessness is combined with the other criteria listed in the definition of chronic homelessness, these females could then be described

[113] *Chronic Homelessness Action Plan* (CHAP), January 2020

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

[115] The Housing Executive defines a repeat presenter as any household that had previously presented within 365 days of their current application.

as experiencing chronic homelessness. In the absence of a formalised count of chronic homelessness, at this point, this is one other indicator of the criteria relating to chronic homelessness, albeit that this should be treated with caution as per its limitations.

Table 11: Homeless single female repeat presentations – all age groups, 2017 - 2020

Year	2017 - 2018	2018 – 2019	2019 - 2020
Total presenters in year	4,149	4,244	3,953
Repeat presenters	215	218	253
Percentage repeat presenters by total presenters	5.2%	5.1%	6.4%

Source: NIHE Data Analytics Unit

Analysis of Data on chronic homelessness amongst women – Other providers

4.12 This section provides an overview of data collected and recorded by a number of other statutory and voluntary providers interconnecting with women who fall into the definition of chronic homeless under one or more of the criteria listed under the definition. Data on females has been obtained on the categories outlined overleaf. In addition, it should be noted that in some cases this relates to females that are categorised as homeless, whilst in other cases it relates to women who may be at risk of homelessness. The source of data is noted against the various criteria. In addition, three organisations – Depaul, Belfast Inclusion Health service and Simon Community NI provided broader data, across all six criteria, of females who had used their services, who they deemed to fall into the definition of chronic homeless. This is covered at the outset of this sub-section.

Other temporary accommodation providers, service providers and other groups working in the homeless sector also have databases relating to this client group. The data sources used for this analysis are indicative rather than definitive. It should be noted that each data set is kept differently for the purposes of each organisation and, in addition, there will be women recorded across a number of different services and over time. Clearly, whilst scanning this data gives us some insight, it cannot enable us to be definitive about the total number of chronic homeless women or their associated needs. From a research perspective it is important to note the limitations of this wider secondary data, including different collecting mechanisms, differing availability and robustness of data in different organisations and availability of information for different timescales. In addition, it is clear from the analysis that different providers have varying terminology in place and this again places a limitation on what can be discerned from the data. Whilst it is important to take these limitations into account, and without suggesting that this is any type of formalised count of chronic homelessness amongst women, this approach can provide indicative data and insight with which to make some analysis and conclusions about the incidence and nature of chronic homelessness amongst women in Northern Ireland.

Criteria	Description	Data Source
1	An individual with mental health problems	Extern
2	An individual with addictions e.g. drug or alcohol addictions	
3	An individual who has engaged in street activity, including rough sleeping, street drinking, begging within the last 3 months	The Welcome Organisation
4	An individual who has experienced or is at risk of violence/abuse (including domestic abuse) - risk to self, to others or from others	Covered earlier – NIHE data Also in this section - Women's Aid
5	An individual who has left prison or youth custody within the last 12 months	NI Prison Service
6	An individual who was defined as a 'looked after' child (residential and non -residential care)	Health & Social Care Board

Criteria 1 – 6 Data from Depaul, Belfast Inclusion Health service and Simon Community NI

4.13 Depaul undertook a full analysis of their records for the period September 2015 – September 2020, across eight of their services throughout Northern Ireland. During this 5-year period they noted that a total of 146 females, who used their services, could be categorised as chronic homeless. Table 12 shows distribution of these females by age. This indicates that many of the chronic homeless women who presented to Depaul were in the age bracket 20 to 59, with a slightly higher proportion in the 20 to 39 age groups. The highest levels of chronic homeless women received services at the Stella Maris hostel and in the Housing First services in Belfast and Derry, suggesting linkages to addictions and mental health problems.

Table 12: Service users by age and service, 2015 - 2020

Service	18 -19	20 – 29	30 – 39	40 – 49	50 – 59	60 – 69	70 plus	Total
Castlehill	-	13	4	5	-	-	-	22
Cloverhill	-	6	1	-	-	-	-	7
Harm Reduction FS[116]	-	-	-	1	3	1	-	5
Housing First – Belfast	-	3	9	4	7	4	-	27
Housing First – Derry	-	7	8	7	8	1	-	31
Family Services FS	-	-	4	2	1	-	-	7
Mater Dei	-	8	3	2	1	-	-	14
Stella Maris	-	2	10	6	13	2	-	33
Totals	0	39	39	27	33	8		146

Source: Depaul

[116] Service provided in Newry & Mourne, and Armagh & Dungannon.

4.14 Belfast Inclusion Health service works directly with females who are homeless or at risk of homelessness. Over the last three years (2018 – 2020) 400 referrals were made to this service. The level of referrals has increased year on year – with 86 in 2018, 133 in 2019 and 181 in 2020. In addition, the number of new contacts or reviews covering clinical work, health advice and promotion, and case planning has also increased – with 902 new contacts/reviews in 2018, 1,096 in 2019 and 1,311 in 2020. Based on the referral figures, it is clear that some of the women are multiple attendances and/or receive multiple interventions. The service provider noted: *We suggest that this is the more complex clients with poly drug misuse, injecting drug misuse and associated health related issues.* In addition, this service provider noted that in reviewing their records, they counted at least 55 females who would fall into the category of chronic homelessness.

Table 13 outlines the distribution of referrals by age, indicating high levels of females in the 20 – 39 age categories, with significant numbers also aged 40 – 60 years of age.

Table 13: Referrals by age, Belfast Inclusion Health service, 2018 - 2020

Year	18 -19	20 – 29	30 – 39	40 – 49	50 – 59	60 – 69	70 plus	Total
2018	0	34	24	12	13	3	0	86
2019	3	38	30	32	23	6	1	133
2020	12	53	51	28	22	14	1	181
Totals	15	125	105	72	58	23	2	400

Source: Belfast Inclusion Health service

Criteria 1 – 6 Data from Simon Community NI

4.15 Simon Community NI works with men and women who experience homelessness, including chronic homelessness, providing a range of services and temporary accommodation[117]. As part of this research SCNI reviewed the data collected when an individual is referred[118] to or presents to their services[119], for the period March 2018 – February 2020, with a particular focus on identifying the number of females that had presented as homeless to the Simon Community two or more times per year during this time period, and who also demonstrated one or more of the six criteria listed within the definition of chronic homelessness.

In total this exercise identified 73 women, over the course of this 2-year period, who had 'repeat' presented[120] as homeless and had one or more of these defining characteristics. Analysis is outlined in table 14.

[117] Temporary Accommodation for families, young people and single homeless. Floating support services to young people in Portadown and adults in Kilcooley, Bangor. Drug and alcohol outreach support services. Housing First service for young people. Transition Service for Separated Children. Crisis response and move on support services.

[118] Referrals can come from any source. Primary referral sources are NIHE, HSST, self-referrals, social workers, and professionals working in health and justice.

[119] The dataset was anonymised in terms of non-inclusion of names and any other identifying information.

[120] It is acknowledged that the term repeat presenter/presentation has different meanings across the statutory and voluntary sector. NIHE note that as part of their response to meeting their statutory duties, they may make more than one referral to/placement in temporary accommodation provision for individuals who present as homeless. In addition, the Housing Solutions & Support teams are aware of and record the number of temporary accommodation referrals and placements for each homeless presenter, rather than repeat homeless For voluntary providers repeat presentations generally mean that a person has come back to the provider within a measured space of time; generally one year.

Table 14: Homeless single female repeat presentations – all age groups Simon Community, 2018 - 2020

Number of presentations	Number
2 presentations	31
3 presentations	20
4 presentations	12
5 presentations	5
6 presentations	4
7 presentations	1
Total females who made repeat presentations, 2018-2020	73
Total females who presented more than once in a 12-month period, 2018-2020	***36***

Source: Simon Community NI

4.16 Whilst table 14 shows the level and number of repeat presentations amongst the group of 73 females who can be defined as 'repeat presenters' it is again important to emphasise that these females do not all necessarily fit the definition of chronic homelessness; for example, if the repeat presentation was more than 12 months apart, albeit that the individual was still defined as being 'previously known' by the service provider, they would not fall into the exact definition. Whilst not necessarily fulfilling the time-frame element in the definition of chronic homelessness, the repeated nature of presentations – in some cases, five, six or seven times – points to females who have not settled in the community on a long-term basis.

4.17 Further analysis of the data relating to these 73 individuals showed that in 36 cases the female had presented more than once in a 12-month period, thus fulfilling the definition of chronic homelessness - *an individual with more than one episode of homelessness in the last 12 months.* This further analysis provides a better estimation of the number of females presenting to Simon Community services that could be defined as experiencing chronic homelessness.

In addition, analysis of the data relating to the 73 females who made repeat presentations provides a clear picture on the type and nature of their needs. This is outlined in table 15, which shows that a total of 240 needs were recorded; at least two 'needs' were recorded for each presenter, each time they presented. Their recorded needs were consistent in some cases (across their multiple presentations) whilst for other individuals their needs varied at different points and in some cases at each point of presentation. Simon Community noted that the individual's needs assessment would evolve over time, so that the figures in table 15 should be considered as a base level at point of entry/presentation.

Table 15: Homeless single female repeat presentations – all age groups, Simon Community, 2018 – 2020 – Type and Nature of Needs

Type of need	Needs recorded No	Needs Recorded %
Mental health	61	25%
Addiction[121]	59	25%
Engaged in street activity	9	4%
Experienced or at risk of violence or abuse	48	20%
Left prison or youth custody within last 12 months	57	24%
Defined as a 'looked after' child	6	3%
Total needs recorded (Base = 73 individuals who made repeat presentations) [122]	**240**	**100%**

Source: Simon Community NI

4.18 Table 16 provides an overview of the needs recorded for the 36 individuals who had presented more than once in any one year. Tables 15 and 16 both indicate that the highest levels of recorded need – which correlate directly with Criteria 1 and 2 of the definition of chronic homelessness – relate to mental health and addiction. Table 16 indicates that Criteria 4 and 5 of the definition of chronic homelessness, relating to experience or risk of violence/abuse (including domestic abuse) and leaving prison or youth custody, are both significant factors of need for those repeatedly presenting as homeless to the Simon Community.

Table 16: Homeless single female repeat presentation within any one year, Simon Community, 2015 – 2020 – Type and nature of needs

Type of need	Needs recorded No	Needs recorded %
Mental health	33	26%
Addiction	30	23%
Engaged in street activity	6	5%
Experienced or at risk of violence or abuse	26	20%
Left prison or youth custody within last 12 months	30	23%
Defined as a 'looked after' child	4	3%
Unknown	0	0
Total needs recorded (Base = 36 individuals who presented more than once *in a 12-month period*)	**129**	**100%**

Source: Simon Community NI

[121] Addiction covers alcohol and drug/substance addiction and polydrug use. Where drug use was recorded separately this has been incorporated into this heading.

[122] The total needs recorded was calculated by presentation – at least two needs were recorded per presentation, and some females had up to seven presentations during the five-year period.

The next number of sub-sections look at data from external providers, in relation to each of the six criteria.

Criteria 1 and 2 Individuals with mental health problem and/or addictions

4.19 Extern works closely with women who experience homelessness, including chronic homelessness, providing a range of services and temporary accommodation[123]. As part of this research Extern reviewed the data collected when an individual is referred[124] to or presents to their services[125], for the period 2015 – 2020, with a particular focus on identifying the number of females that had presented as homeless to Extern services two or more times during this five-year time period, and who also had a mental health problem (criteria 1) and/or an addiction (criteria 2).

In total this exercise identified 82 women, over the course of this 5-year period, who had 'repeat'[126] presented as homeless and had one or both of the other defining characteristics. These women were defined as being 'previously known' to Extern services, and therefore fulfilled some of the criteria (numbers 1 and 2) in the classification of chronic homelessness. Analysis is outlined in tables 17 - 19.

Extern noted that this figure is undoubtedly an under-count of the number of women that could be defined as chronic homeless under the definition that interact with their services. They noted that in relation to women who engage with their street outreach teams – the Street Injecting Support Service, Needle Exchange Service and the Dual Diagnosis Street Team – Extern are unable to collect and collate person specific information at a lower level, because of client confidentiality and the nature of the work. If available this data would reflect a more in-depth picture of female chronic homelessness.

[123] Extern services relevant to women experiencing chronic homelessness include the Multi-Disciplinary Homeless Support Team, a social work/ mental health worker team providing support to individuals who are homeless/ at risk of homelessness and experience multi-complex needs. The model of service delivery is assertive outreach and is high tolerance, low threshold in ethos. The principles of harm reduction are utilised as are various social work interventions including linking service users with statutory agencies which are often difficult to access due to the chaotic nature of the client group. The Ormeau Centre provides temporary accommodation for individuals who have complex needs and who require temporary accommodation. It also provides support to people who inject drugs within the context of harm reduction and overdose management including intensive support planning from a specialist staff team. Support provided in both services is intensive and client led.
Extern also operates two hostels which accommodate those who require temporary accommodation and who are engaged with Criminal Justice services. Extern are also lead partner/involved partner in the following – Street Injecting Support Service, Needle Exchange Service and the Dual Diagnosis Street Team. Further detail of all of these services was provided in Section 2.
[124] Referrals are made by a range of statutory and voluntary sector organisations including health professionals, hospital, hostels, NI Housing Executive, Social Services, voluntary agencies, the Welcome organisation and self/family referrals.
[125] The dataset was anonymised in terms of names and any other identifying information.
[126] As per footnote 116 - it is acknowledged that the term repeat presenter/presentation has different meanings across the statutory and voluntary sector. NIHE note that as part of their response to meeting their statutory duties, they may make more than one referral to/placement in temporary accommodation provision for individuals who present as homeless. In addition, the Housing Solutions & Support teams are aware of and record the number of temporary accommodation referrals and placements for each homeless presenter, rather than repeat homeless presentations. For voluntary providers repeat presentations generally mean that a person has come back to the provider within a measured space of time; generally one year.

Table 17: Homeless single female repeat presentations – all age groups, Extern, 2015 - 2020

Number of presentations	Number
2 presentations	41
3 presentations	22
4 presentations	10
5 presentations	6
6 presentations	1
7 presentations	2
Total females who made repeat presentations, 2015-2020	**82**

Total females who presented more than once in a 12-month period, 2015-2020	***49***

Source: Extern

4.20 Whilst table 17 shows the level and number of repeat presentations amongst the group of 82 females who can be defined as 'repeat presenters' it is again important to emphasise that these females do not all necessarily fit the definition of chronic homelessness; for example, if the repeat presentation was more than 12 months apart, albeit that the individual was still defined as being 'previously known' by the service provider, they would not fall into the exact definition. Whilst not necessarily fulfilling the time-frame element in the definition of chronic homelessness, the repeated nature of presentations – in some cases, five, six or seven times – points to females who have not settled in the community on a long-term basis. The definition as currently framed in the CHAP potentially misses this important element – of females presenting in different services (statutory and voluntary) over a longer period of time.

4.21 Further analysis of the data relating to these 82 individuals showed that in 49 cases the female had presented more than once in a 12-month period, thus fulfilling the definition of chronic homelessness - *an individual with more than one episode of homelessness in the last 12 months.* This is likely to be a significant underestimation because the dataset provided details by year of presentation, and it was not possible to calculate timescales between years, only within an actual year. This further analysis provides a better estimation of the number of females presenting to Extern services that could be defined as experiencing chronic homelessness.

In addition, analysis of the data relating to the 82 females who made repeat presentation, provides a clear picture on the type and nature of their needs. This is outlined in table 18, which shows that a total of 478 needs were recorded; two 'needs' or required programmes of care were recorded for each presenter, each time they presented. Their recorded needs were consistent in some cases (across their multiple presentations) whilst for other individuals their needs varied at different points and in some cases at each point of presentation.

Table 18: Homeless single female repeat presentations – all age groups, Extern, 2015 – 2020 – Type and nature of needs

Type of need	Needs recorded No	Needs recorded %
Mental health	227	47%
Addiction[127]	145	30%
Physical health	52	11%
Family & Child Care[128]	25	5%
Learning Disability	5	1%
Offender	4	/
Unknown	20	4%
Total needs recorded (Base = 82 individuals who made repeat presentations, 2015-2020)[129]	**478**	**100%**

Source: Extern

4.22 Table 19 provides an overview of the needs recorded for the 49 individuals who had presented more than once in any one year. For ease of analysis this records the two needs identified at their first point of presentation. Tables 18 and 19 both indicate that the highest levels of recorded need – which correlate directly with Criteria 1 and 2 of the definition of chronic homelessness – relate to mental health and addiction. This points towards a situation where many presenters are likely to have both mental health problems and an addiction, thus requiring dual diagnosis services. This theme is noted in Section 5, Feedback from stakeholders.

Table 19: Homeless single female repeat presentation within any one year, Extern, 2015 – 2020 – Type and nature of needs

Type of need	Needs recorded No	Needs recorded %
Mental health	47	48%
Addiction	29	30%
Physical health	8	8%
Family & Child Care	4	4%
Learning Disability	1	1%
Offender	1	1%
Unknown	8	8%
Total needs recorded (Base = 49 individuals who presented more than once *in a 12-month period, 2015-2020*)	**98**	**100%**

Source: Extern

4.23 This dataset also included age of presenter (at first presentation and then thereafter). Table 20 provides analysis of age for the 82 female presenters in the full data set. For this analysis age was taken to be at first presentation. Interestingly, this shows that the majority of female presenters were

[127] Addiction covers alcohol and drug/substance addiction and polydrug use. Where drug use was recorded separately this has been incorporated into this heading.
[128] In these cases an identified need in relation to family and child care meant that the individual had children in care, children on the Child Protection register or children with involvement in Social Services.
[129] The total needs recorded was calculated by presentation – two needs were recorded per presentation, and some females had up to seven presentations during the five-year period.

aged 35 and under (69%). In addition, the average age of all individuals was 32 years old. This dispels any myth around chronic homelessness being associated with older age groups, in particular amongst women. This age profile is not dissimilar to that of the 2016 Belfast Street Needs Audit, which recorded an average age of 36 years and noted that 20% of individuals engaging in street activity were 25 years old or younger[130].

Table 20: Homeless single female repeat presentations, by age Extern, 2015 - 2020

Age	Number	Percentage
18 – 25	23	28%
26 – 35	34	41%
36 – 45	15	18%
46 – 55	7	9%
56 – 65	2	2%
65 plus	1	1%
Total recorded	**82**	**100%**[131]

Source: Extern

Criteria 3 Individuals engaging in street activity

4.24 Datasets covering homelessness amongst women with direct reference to street activity, including rough sleeping, street drinking and begging include sector-wide rough sleeping audits and data held by the Welcome Organisation.

A street activity audit in 2015 (published 2016), undertaken by Depaul and the Welcome Organisation on behalf of the Housing Executive, found that 361 individuals engaged in 'street activities' including drinking, begging or sleeping overnight, over the 12-week period of the audit. As noted in Section 2 of this report, the gender breakdown was recorded as 85% male and 15% female.

The most recent street counts (November 2018)[132] identified a total of 38 rough sleepers across Northern Ireland. Sixteen were identified in Belfast, 13 in Londonderry and five in Newry via the street counts. A further four were identified in Coleraine, via street estimates. However, a gender breakdown of these counts is not available.

The Welcome Organisation provided an analysis of the women they have worked with over the last three years (April 2017 – March 2020). They noted that their services are not 'stand-alone' and that it is not unusual for individuals to avail of a number of their services, depending on the nature and level of their need, within any one year. When assessing their client group against the chronic homeless definition they also noted a number of the criteria for which they did not collect information or where it was not recorded in a way that it could be extracted from the database for analysis purposes. The three criteria which this related to were: an individual who has experienced

[130] Of the 361 individuals encountered in the 2016 Audit, 211 were willing to divulge their age. This audit found a 85/15% gender split between males and females.
[131] Figures may not tally to 100% due to rounding.
[132] Information provided by the Housing Executive.

or is at risk of violence/abuse; an individual who has left prison or young offenders within the last 12 months; and an individual who was defined as a 'looked after' child. They concluded that the absence of this information in their calculations means that this is in effect an underestimation of the number of chronic homeless women using their services. Table 21 provides an analysis of the number of female clients using each of the four services referenced by the Welcome Organisation – Annsgate Crash facility (women-only), Outreach project, Drop-in facility and the Floating Support service.

Table 21: Total number of female clients across all services, Welcome Organisation, 2017 - 2020

Service	2017 – 2018	2018 - 2019	2019 - 2020
Annsgate Crash Facility	153	155	173
Outreach project	103	232	223
Drop-in Facility	262	276	299
Floating Support service	Not available[133]	53	51
Total recorded – individual women[134]	**287**	**330**	**359**

Source: The Welcome Organisation

Table 22 then provides the Welcome Organisation's analysis of the number of women who they had determined could be defined as chronic homeless (with direct reference to the definition) and those women they had worked with who had street activity as part of their criteria in meeting the definition. The Welcome Organisation noted that they believed these numbers were an underestimation of the total number of women who were chronic homeless.

Table 22: Total number of chronic homeless female clients across all services and those with street activity, Welcome Organisation, 2017 - 2020

Service	2017 – 2018	2018 - 2019	2019 - 2020
Total number of women worked with	287	330	359
Number of women that could be defined as chronic homeless	43	66	62
Number of women that engaged in street activity	33	57	57

Source: The Welcome Organisation

This data firstly demonstrates that the number of chronic homeless women that the Welcome Organisation has worked with in the last three years has increased by about one third (from 43 in 2017 – 2018 to 62 in 2019 – 2020). The Welcome Organisation reviewed the individual names of clients over the three-year period and concluded that there was a total of 100 chronic homeless women during that time period. This exercise indicated that chronic homeless women had presented to the organisation on more than one occasion in the 3-year timescale.

[133] The method of data recording for Floating Support in this year did not enable extraction of this information.
[134] Total figure recorded is the total number of women worked with throughout the Welcome Organisation in one year. As clients can avail of more than one service, this is not a total of all users for each service, rather the total of unique users across the organisation.

In addition, it is interesting to note that the vast majority of chronic homeless women that the Welcome Organisation had worked with in the 3-year period 2017 – 2020, had street activity as part of their chronic homelessness. This appears to have increased over the last 3 years, both in actual numbers and as a proportion of chronic homelessness.

Similar to the Extern data, this dataset also included analysis of the women deemed to be chronic homeless by age. This is outlined in table 23 and indicates that the majority of chronic homeless women that the Welcome Organisation work with are aged 18 – 24 and 25 – 34 years old. Similar to the Extern data the majority of female chronic homeless clients were aged 35 and under (65% in 2017 – 28, 67% in 2018 – 19 and 74% in 2019 – 2020).

Table 23: Female chronic homeless clients, by age, The Welcome Organisation, 2017 - 2020

Age	2017 – 2018	2018 – 2019	2019 - 2020
18 – 24	15	18	17
25 – 34	13	26	29
35 – 44	8	13	13
45 – 54	5	6	0
55 – 64	1	3	3
65 - 74	1	0	0
Total recorded	**43**	**66**	**62**

Source: The Welcome Organisation

Criteria 4 Individuals who have experienced or are at risk of violence and abuse

4.25 As noted earlier, Housing Executive data indicates the level of female presenters that present under the reason for homelessness – domestic violence. Analysis of the most recent year (2019 – 2020) shows that for the total of 3,953 single presenters across all age groups, 366 gave domestic abuse and violence as their reason for homelessness (9%).

However, there is no further mechanism to relate this 'presenting' information to whether the individual can be deemed 'chronic' homeless; that is under the definition that they have presented more than once in the last 12 months and also fulfil at least one more of the listed criteria.

4.26 Data from Women's Aid provides an indication of the number of women they have worked with on an annual basis, both in their refuges[135] and in their Floating Support services. However, Women's Aid also noted that it was difficult to extract data against the criteria listed in the chronic homelessness definition; for example, it was difficult to extract specific information on individual women in relation to mental health or addictions. Data relating to separate outreach support was also provided but has not been included; Women's Aid noted that this was calculated in slightly different ways within the 5-year period and therefore may not be directly comparable.

The data in table 24 relates to all women who stayed in the refuges and/or who accessed Floating Support, who were homeless or threatened with homelessness. As noted, there is no mechanism by which to extract or extrapolate how many of these women could be deemed to be chronic homeless under the definition.

Table 24: Total number of female clients staying in refuges and/or accessing Floating Support Services, Women's Aid, 2014 - 2029

Service	2014 - 2015	2015 - 2016	2016 – 2017	2017 – 2018	2018 - 2019
Total number of women who stayed in refuge[136]	932	738	710	717	654
Total number of women who could not access refuge as it was full	439	267	245	258	381
Total number of women using Floating Support services[137]	3,567	4,220	4,643	4,563	5,095

Source: Women's Aid

[135] Women's Aid has a total of 13 refuges across Northern Ireland.
[136] In addition, children also stayed in refuges. The totals were 689 (2014 – 15), 520 (2015 – 16), 568 (2016 – 17), 485 (2017 – 18) and 421 (2018 – 19).
[137] In addition, children were part of the household receiving Floating Support Services. The totals were 4,186 (2014 – 15), 5,482 (2015 – 16), 5,420 (2016 – 17), 4,949 (2017 – 18) and 4,889 (2018 – 19).

Criteria 5 Individuals who have left prison or youth custody centre

4.27 The NI Prison Service provided data on the number of females in the prison population as of 1st February 2020; a total of 81 females out of the total prison population in Northern Ireland of 1,566 (around 5% of the prison population). Females are accommodated at Hydebank Wood, whilst males are accommodated in three parts of the prison estate[138]. In thinking about whether these females may appear in chronic homeless figures, on release from prison or in the subsequent period, it is important to consider what numbers will be released from prison and over what time period. Of the 81 females in prison[139] in Northern Ireland, 37 had been remanded in custody. Of the 44 sentenced prisoners, six were serving a life sentence. For the remaining 38 prisoners, 27 had an earliest date of release in 2020, nine in 2021 and two in 2022.

Table 25 indicates a significant number of those in custody also experience two of the other criteria noted under chronic homelessness – mental health and addictions.

A total of 32% of individuals in custody in Northern Ireland were recorded[140] with the health marker 'mental health': 466 males (31% of the male prison population) and 39 females (48% of the female prison population). Despite the low base of females it is still interesting to note the higher proportionate level of 'mental health' as a factor amongst females in prison, compared to males.

A further health marker, 'addictions', shows that 51% of the prison population were recorded with the marker 'addictions' – this was 52% for male prisoners (771 in total) and lower for females – 38% (31).

Table 25: Analysis of NI prison population (1st Feb 2020) by gender, and by mental health and addictions

Prison establishment	1st February 2020		
	Total population	With 'mental health' marker	With 'addictions' marker
Maghaberry – males	928	297	497
Magilligan - males	465	127	236
Hydebank Wood – young males	92	42	38
Hydebank Wood - Females	81	39	31
Total	**1,566**	**505**	**802**

Source: PRISM

[138] HMP Maghaberry, HMP Magilligan and Hydebank Wood.
[139] Data breakdown accurate as of 19th June 2020.
[140] Medical markers are collected at committal during the initial healthcare assessment which is completed by the South Eastern HSC Trust.

A further interesting note can be made in relation to the cyclical nature of homelessness, and the link between release from prison and chronic homelessness. Of the Prisoner Needs Profiles completed[141] during 2019, a total of 21% of individuals responded that they were either in hostel accommodation or homeless/roofless prior to custody. Interestingly the proportion was 20% for males, but higher for females – 33%. On a similar note, 29% of respondents to this profile noted that they had no accommodation to go to on release from prison; again, this was higher for females at 34%, and 29% for males.

Criteria 6 Individuals defined as a 'Looked after' child

4.28 Under the definition of chronic homelessness one of the additional indicators or criteria relates to an individual who was defined as a 'looked after' child (residential and non -residential care). There are joint arrangements between the NI Housing Executive and the Health & Social Care Trusts.[142] This protocol results in reciprocal arrangements when a young person presents as homeless, for example with the HSC Trust in some cases making an immediate telephone call to the NI Housing Executive to request temporary accommodation, whilst in other cases making a written referral using standard forms. The figures in table 26 point to the number of young people presenting as homeless, but again in the absence of additional information on previous homeless experiences or the repeat nature of their homelessness no firm conclusion can be made as to whether any of these females could be categorised as experiencing chronic homelessness. It should be noted that the data in the last column is for six months only (April – September 2019).

Table 26: Annual number of young people (aged 16 and 17) recorded as homeless by Health & Social Care Trusts, NI wide, 2015 - 2020

Health & Social Care Trusts – NI wide data	Number of young people presenting				
	April 2015 – March 2016	April 2016 – March 2017	April 2017 – March 2018	April 2018 – March 2019	April 2019 – Sept 2019
Males aged 16 years	18	27	13	19	10
Males aged 17 years	76	54	41	36	21
Females aged 16 years	26	23	16	22	6
Females aged 17 years	75	56	57	46	29
Total	**195**	**160**	**127**	**123**	**66**

Source: Health & Social Care Board

[141] The Prisoner Needs Profile (PNP) should be completed within 30 working days of committal for sentenced prisoners. During 2019 there were 352 female committals to Hydebank Wood relating to 249 specific individuals. During 2019 around 36% of female committals completed a PNP (89 individuals); this compared to 52% of male committals.

[142] *Meeting the Accommodation and Support Needs of 16 – 21-year-olds: Regional Good Practice Guidance agreed by the NI Housing Executive and the Health & Social Care Trusts.* December 2014, Revised Version. It should be noted that this document is under review.

Concluding comments on the measurement of chronic homelessness amongst women

4.29 A number of conclusions can be drawn from the analysis of data relating to females who are within the various statutory and voluntary sector homeless systems, and fulfil some or all of the elements of the definition of chronic homelessness. Again it is important to acknowledge the limitations of this analysis. Firstly, the impact of covid-19 on the planned operationalisation of the chronic homeless definition by the Housing Executive undoubtedly meant there was a gap in available data from this statutory source. However, this gap could not have been foreseen at the point of commissioning this piece of research. Secondly, the documented limitations of the wider secondary data included in this analysis, ranging from different collecting mechanisms, differing availability and robustness of data in different organisations and availability of information for different timescales. Furthermore the use of different terminology and definitions impacts the robustness of secondary data sources.

Whilst taking these limitations into account, it is still possible to make a number of concluding comments on the data analysis. Firstly, there are high numbers of single females presenting as homeless to the NI Housing Executive. Data on re-presenting or repeat presenting suggests that between 5 – 6% of female presenters each year have previously presented to the Housing Executive in the last 12 months[143]. This figure points to a reoccurrence of homelessness for a not insignificant number of women, between 215 and 253 each year over the last three years. Interestingly this figure of 5 or 6% coincides with that suggested by earlier research[144] which concluded that between 5 and 10% of any homeless population could be identified as experiencing chronic homelessness. However, in this analysis we have looked more closely at specific groupings – that is females, and females who are repeat presenters, rather than the overall generic homeless population.

Secondly, whilst the proposed mechanism to record and collate data relating to chronic homelessness is not yet in place, indications from Housing Executive data on the reason for homelessness amongst single female presenters suggest that those in the younger age categories (16 – 17 and 18 – 25 years) tend to note being in care/care background as their reason for homelessness, whilst domestic violence is a key reason for homeless amongst the 26 – 59 and 60+ age categories. This correlates with the analysis provided by Pleace and Bretherton at paragraph 3.17, which noted a very high prevalence and interconnection between chronic homelessness and experience of domestic violence/abuse.

Thirdly, data from the wider statutory and voluntary sector points to women who have experienced homelessness who have a wide and varied number of additional issues; loss of accommodation or lack of stability of tenancy or breakdown of a tenancy may be the reason why they present to a service, but generally they are coming with a significant number of other issues. This is particularly highlighted by the data shared by the Simon Community, Extern, the Welcome Organisation and the NI Prison Service. Mental health and addiction are prevalent. Other factors are often associated with the chaotic nature of these women's lives and the complexity of additional issues including physical health issues and lack of access to children or involvement with statutory services in terms of child protection. Again, the Northern Ireland data examined in this section, paints a similar picture to that provided by Pleace and Bretherton in paragraph 3.17; in particular the significance of mental health issues,

[143] The repeat presentation data sets are specifically related to a presentation within 365 days of the previous presentation.

[144] *Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization Results from the Analysis of Administrative Data,* Kuhn and Culhane, 1998.

addictions, interconnections to separation from children or involvement of Social Services with children and physical health problems.

A fourth point is the age range most frequently associated with chronic homelessness amongst women. A number of data sources (Depaul, Belfast Inclusion Health Service, Extern and the Welcome Organisation) point to a higher incidence amongst those aged 20 – 39, with not insignificant numbers in the 40 – 59 age brackets. This concurs with the Housing Executive data examined at the outset of this section.

A final conclusion to draw from the data relates to the estimated numbers of women that fall into the category of chronic homelessness. It is difficult to form a definitive conclusion given the different mechanisms for record keeping and the varying time periods covered. That said, it is worth highlighting here the figures suggested by a number of providers, albeit with various caveats:

- The NIHE data suggests around 250 female repeat presenters per year;
- Depaul noted a total of 146 females over a 5-year period who could be defined as chronic homeless, indicating an average of 29 chronic homeless women per year in or using their services;
- Over a 2-year period Belfast Inclusion Health service noted around 55 females in the chronic homeless category; suggesting an average of 27 – 28 per year;
- Simon Community NI noted 36 cases of chronic homeless women over a 2-year period; averaging 18 per year;
- Extern identified 82 chronic homeless women over a 5-year period; an average of 16 per year;
- The Welcome organisation identified an average of 57 chronic homeless women per year over a 3-year period.

The overall conclusion of this section is that there are pockets of record-keeping and data, all well intentioned and focussed on their client group and services. But critically, this is not enough to make a full, robust and comprehensive analysis of the level and nature of chronic homelessness amongst women in Northern Ireland. Furthermore, all of the current record-keeping systems have been developed for individual organisations' own purposes; and they are not linked or readily available or shared across the sector. One fundamental drawback of this is that whilst some knowledge helps to feed into project and service development (normally for the organisation in question), there is no mechanism to share the rich seam of data that undoubtedly exists. And most importantly this does not assist in ensuring joined-up working across the sector, for the ultimate benefit of the women themselves. Nonetheless, this exercise suggests that in any one year, upwards of 50 chronic homeless women are using a variety of temporary accommodation and other services.

It is important to bear in mind that the use of multiple data sets can result in over-counting; taking into account that some women in the category of chronic homeless may be service users and therefore counted in data sets by each organisation; with no recourse to cross-referencing or checking. In addition, the use of slightly different definitions and recording approaches in different organisations results in data which is not directly comparable. That being said, the opportunity to view criteria listed under a definition of homelessness from the viewpoint of different service providers is helpful, and can only add to the body of data and evidence. This is particularly helpful when looking, for example, at data regularly collected and collated by the NI Prison Service; specifically, the opportunity

to cross-reference time in custody with other factors such as mental health, addictions, prior homelessness and likelihood of homelessness occurring on release. Whilst the female prison population is small, the complexity of their needs highlights the necessity of focussing on particular groupings of vulnerable females.

As noted, an overarching flaw of the current situation is that there is no way of knowing whether it is the same women being counted on multiple occasions by different organisations – there is no mechanism to establish the level of overlap or to record data onto a common or shared system. This makes planning for now difficult and planning for the future uncoordinated and individualistic. That being said, examining available amalgamated records has enabled some insight into the level and scale of the problem.

This data analysis has also thrown up some question marks about the definition of chronic homelessness itself. The data provided by Extern, for instance, very clearly highlights females presenting as homeless over a period of a number of years on, for example, two or three occasions, but that these occasions were more than one year apart; this automatically knocks them out of the chronic homeless figures, and yet these women remain in the cycle of homelessness. Whilst these women may not be repeat homeless (within the narrow time period of 12 months) or been excluded from a hostel or multiple (3 or more) placements (again within a very narrow time period of 12 months), the cyclical nature of their homelessness connected to a wide range of factors (many of which are on the chronic homelessness list) should be examined within a wider reference framework and timescales relating to chronic homelessness. The definition as currently framed in the CHAP report potentially misses this important element – of females presenting in different services (statutory and voluntary) over a longer period of time, and not within the exact timescales and criteria covered in the definition.

The nature and coverage of the definition of chronic homelessness is covered in more detail in stakeholder feedback in Section 5. In addition, it is important to note even at this point that the Housing Executive recognises that the criteria outlined in the definition caused debate within the sector, and as a result an action was included in the CHAP report to review the criteria after one year of use, with particular reference to its robustness and whether it needs to be adapted.

Finally, and perhaps the most important point in relation to data collection and collation - chronic homelessness, by its very nature, does not always interconnect with services that collect and collate data in this area. Many women who could potentially be defined as being chronic homeless may not therefore be part of the measurement framework or interacting with all or any of the services and organisations that record numbers and profile information. In addition, as with any self-reporting, there may be significant under representation of certain groups of chronic homeless women.
Whilst these points confirm much of what was already known about the measurement and knowledge base relating to chronic homelessness, they further emphasise three of the specific objectives arising from the CHAP. These are as follows:

Objective 1 *Design specific criteria for measuring chronic homelessness to identify existing and emerging needs to inform the development of appropriate responses to address and prevent chronic homelessness.*

Objective 2 *Develop mechanisms across agencies for early identification of those who are at risk of homelessness or chronic homelessness and implement preventative measures as appropriate.*
Objective 7 *Promote interagency cooperation to address chronic homelessness and ensure mechanisms are in place to implement and oversee the CHAP.*

Whilst the proposed counting mechanism to be introduced by the Housing Executive was delayed in implementation by covid-19, it is perhaps timely to review whether the approach and associated tools will fully capture all the data required; and most importantly whether data relating to individuals can be shared across the relevant organisations working directly with women who experience chronic homelessness.

SECTION 5 RESEARCH FINDINGS – FEEDBACK FROM STAKEHOLDERS

Introduction

5.1 This section provides an analysis of stakeholder feedback on the topic of chronic homelessness and women. A full list of interviewees is outlined in Appendix 1. As a result of covid-19 restrictions all interviews were conducted by phone and notes/tape recordings transcribed for the purpose of analysis. A total of 14 Housing Executive personnel and 11 representatives from five temporary accommodation/service providers and three stakeholder organisations participated in the interviews.

5.2 This section provides analysis for both internal and external stakeholders under each heading. Quotes are provided in *italics* with the source of the quote in brackets – INT for internal (Housing Executive) stakeholder and EXT for external stakeholder. This analysis is qualitative in nature and follows the topics and themes in the research objectives and tasks as follows:

- The extent of chronic homelessness for women – profile, causes and key issues
- The challenges of delivering services to women who are chronically homeless
- The impact of current services on the cycle of chronic homelessness
- Exploration of the numbers of women experiencing chronic homelessness who do not engage with the Housing Executive

The final research objective and task (Suggestions of more effective service delivery to assist and meet the needs of women experiencing chronic homelessness) is examined in more detail in Section 7.

The extent of chronic homelessness for women

Extent

5.3 Whilst internal and external stakeholders had varied views on the number of chronic homeless women, in many cases based on their own geographical location and sphere of work, there was consensus on the following points in terms of quantifying the extent of chronic homelessness:

- The extent of chronic homelessness amongst women has been increasing, in particular in the last 3 – 5 years;
- In real terms there is a higher level of chronic homelessness amongst men. However, respondents suggested that the proportion of women has been increasing. Some suggested 70% men and 30% women whilst others suggested more of an even split; again, others suggested that it was still a predominantly male occurrence.
- The numbers of chronic homeless people are highest in city areas (respondents from Derry and Belfast); however, whilst numbers are smaller in more rural areas there was still reference to this existing. Housing Advisors in these areas suggested that chronic homelessness would only account for 5 – 10% (at most) of their caseload. The percentage of caseload in cities was deemed to be higher (more around 20%). One Housing Advisor in a more rural setting noted: *it's not a huge number of chronic homeless in our area. I could probably call to mind the names of a handful of people – 5 or 10 cases at the most.* (INT)

5.4 In thinking about quantifying the extent, respondents pointed to what would be the starting point for any 'official' measurement of chronic homelessness amongst women, namely the agreed definition. It was recognised that considerable work had gone into developing and agreeing the definition, as part of the consultation process for the development of the CHAP report. Feedback from interviewees indicated a high level of awareness of the topic of chronic homelessness, including the actual definition and how someone would be defined as being 'chronic homeless'; that is, what filters and criteria they have to meet to be defined as being chronic homeless. In the most basic form respondents suggested that chronic homelessness was repeat homelessness, interspersed at times with short periods of settled accommodation or status, together with at least two of the criteria noted in the definition.

Housing Advisors referenced a number of factors. Firstly, that using the Housing Solutions approach had resulted in them being more aware of (a) the number and level of multiple placement breakdowns and (b) the level of repeat homelessness, with them noting that they were seeing the same people coming back to them time and time again. Secondly, they noted that whilst chronic homelessness is not as widespread as what they referred to as 'normal' homelessness, nevertheless they noted spending a higher proportion of their time on chronic cases, in particular dealing with a wide range of complex factors on which many of them said they had limited knowledge or training .

A greater proportion of my caseload would be 'normal' homeless – but a greater proportion of my time would be spent on the chronic (homeless) – it just dominates a lot more of your time – it's very disproportionate. You just don't know when you're going to have a re-presenter – and it just takes over your day. By the time you get to the bottom of things and eventually get them placed somewhere. (INT)

In discussing what chronic homelessness covers in relation to women, there were different viewpoints in terms of whether this included women with children who have repeat periods of homelessness due to relationship breakdown or domestic violence. On the one hand some respondents referred to this as family breakdown where the applicant would be more likely to get priority need and Full Duty Applicant status because of dependent children in comparison to single female applicants. And on the other hand, it was also recognised that these women do also meet the chronic homeless criteria. For the most part this report examines the situation in relation to chronic homelessness amongst single women or women not currently with their children.

One of the most insightful discussions with internal and external stakeholders centred around whether the definition (as developed from the Crisis definition, 2010 and confirmed in the Housing Executive CHAP report, 2019) has got the balance right between what constitutes chronic homelessness and what, as referred to earlier by Housing Advisors, is 'normal' homelessness. This discussion was at times linked to the discussion about counting chronic homelessness (see end of Section 5) and by other respondents it was linked to their comments on the filters and criteria which embody the definition. There was widespread comment that the definition, as it stands is too wide. Respondents noted their opinion that too many homeless presenters will be deemed, under the definition, as falling into the chronic category by virtue of the fact that they have presented more than once in a 12-month period, or indeed that they have had three of more placements during the year. Some respondents noted that these were not uncommon occurrences, but did not by default mean

that someone was chronic homeless. Furthermore, when the six criteria were added in, respondents suggested that many of their 'normal' homeless clients would meet at least two, if not more, of these criteria[145].

Those who felt the definition was too wide were concerned that hundreds (and possibly thousands) of individuals would be defined as chronic homeless, whilst other respondents were concerned that in so doing, the 'count' would not get to focus on those they referred to as very chronic homeless or chronic complex cases. A number of stakeholders suggested numbers of very chronic homeless women. These ranged between 50 and 100 cases in Belfast, around 30 cases in Derry/Londonderry and fewer numbers elsewhere in Northern Ireland. These estimates concur broadly with the findings of Section 4 in terms of the likely number of chronic homeless women in Northern Ireland.

Profile

5.5 Based on some of the previous discussion, Internal and external stakeholders suggested that there are at least two age groupings of chronic homeless women: firstly those aged 35 plus, although it was noted that this is a much smaller and more residual grouping, and, secondly, a massively increasing group of those aged from 17 to 30 or 35. This younger age group was viewed as being linked to increased drug activity and also young people coming out of the care system.

Causes of and reasons for chronic homelessness – individual basis

5.6 There was universal consensus across all respondents (including internal Housing Executive personnel and external stakeholders) in terms of the person specific reasons and factors resulting in females moving into chronic homelessness. The reasons identified are outlined below, and relate to factors identified in individual women or across groups of women, rather than structural or systemic factors which are examined in detail later in this section. Quotes are provided for illustrative purposes.

- First and foremost, the woman's additional needs. This is examined in more detail under the six criteria provided in the definition.

- Other contributory factors in a woman's life were noted including early life difficulties, childhood homelessness, attachment issues, dysfunctional family, trauma and being in the care system, and loss of a child/children. There was also reference to high levels of women who either have diagnosed learning disability or could be described as vulnerable. These form additional triggers or events together with the criteria outlined in the definition of chronic homelessness. Generational homelessness was also noted as a recurring factor.

[145] The NIHE responded to this point by noting the following: *The training and guidance that are currently in development address these points as did the consultation with Belfast and Ballymena staff who assisted in the development of the guidance. Unfortunately due to Covid-19 all staff have not had the benefit of training and guidance and therefore, will be looking at the criteria in a more definitive way. The guidance will acknowledge that some clients will meet the criteria but will not be considered to be chronically homeless and that some will not meet the criteria but will be chronically homeless. In all of this, the expertise of the assessor will be called into play and the system will allow the assessor to add an explanatory note where they assess the status to be different from what the tick boxes would indicate. The example given here is cited specifically in the guidance – i.e. a family could be placed in an emergency situation in a B&B, moved to a hostel and then on to a single let. While this may tick the box of multiple placements, the housing advisor will have the facility to tick "no" when asked if chronic homeless and add an explanatory note as to why.*

I see it all the time, I see it very strongly that so much of this comes from attachment issues – from birth, from disordered families and poor attachment issues from when they were young. And I do think you could trace everything back to early childhood. (INT)

- The lack of ability or capacity in the woman to support herself, thus leading to a perpetual and repetitive cycle revolving between hostels, prison, the streets and other services was highlighted.

  My understanding of chronic homelessness would be homelessness of a repetitive nature, where the women may not have the ability to support themselves in terms of the longevity of temporary accommodation or even in hostel accommodation. They just aren't able to cope and they do need support to be able to do that. (INT)

- The lack of support the woman had received both before presenting and even when she has been deemed to be 'homeless' was viewed as a further cause of chronic homelessness.

- Another factor was that even where support is available, in many cases a lack of engagement by the woman means that their homelessness becomes chronic or embedded. This was often linked to lack of trust and/or poor previous experience with service provision.

  They have trust issues for a reason. You can always trace things back to their past, where they've had awful experiences – then they think people are out to get them or that they will do bad things to them. And then they become confrontational and defensive.

- The fact that providing a house or temporary accommodation does not deal with the primary causes/reasons for the chronic and chaotic state was noted as one of the most significant causal factors. The key obstacle here was deemed to be that the woman had experienced past trauma which had never been fully or adequately dealt with.

- The unsuitability of many of the placements was seen as a key contributor to repeat homelessness. Housing Executive personnel noted that they can only place where there is space and availability. This is covered in more detail under reasons for placement breakdowns (section 5.8) and perceived unsuitability of temporary accommodation in the heading relating to the impact of current services on the cycle of chronic homelessness (section 5.10).

Key Issues

5.7 For the purposes of this analysis the key issues have been examined in relation to six criteria listed in the chronic homeless definition. The definition notes that the individual must present with two or more of the listed criteria. Stakeholders emphasised the interconnection between all of these factors – poor mental health leading to addictions (or vice versa), sex work resulting from drug activity, criminal activity as a result of needing funds for alcohol or drugs etc.

Mental health

Internal and external respondents suggested that all chronic homeless clients have some level of mental health problem – from anxiety/depression through to more complex cases; one respondent said – *it's almost universal*. (EXT) Some respondents thought most were undiagnosed whilst others

felt there was a relatively high level of diagnosis. In terms of this criteria linked to mental health a lack of support in general was noted, including long waiting lists, time-limited services, incompatibility if client moves between Trust areas (back to bottom of queue), and general lack of services in the community to help someone with mental health issues.

Addictions

Respondents noted that this reason had increased significantly amongst female presenters in general – with an indication that the biggest proportion of this is in relation to drugs rather than alcohol. Drugs noted included cannabis and prescription drugs – with a small increase in younger women using heroin. Stakeholders also noted that mental health and addictions were the most prevalent of the six factors; noting that in many cases mental health/psychosis was as a result of drug-taking.

We've noticed a difference between young women and young men. The men are using heroin and occasionally street begging but using heroin in a safer way. Whereas young women are taking it to oblivion. (EXT)

Street Activity

Internal and external stakeholders noted that this was more predominant in cities – Derry and Belfast – in terms of street drinking and rough sleeping. Specific reference was made to sex work related primarily to drug activity.

I think we're finding women with multiple traumas, women who are caught in a trap. Who are actually in the midst of a chronic addiction. And actually, they don't have any future plan – and they are stuck in a trap around sexual exploitation and sexual violence. And actually, they've gone so far down the line that they may not have any other form of support – than the people who are acting as their pimps. And if you look at their behaviours – which is very high energy – almost like an addiction in itself and its very damaging. (EXT)

Abuse/violence

Stakeholders noted that this has increased as a reason for homelessness and as an additional or contributory factor in other cases in the last 3 – 5 years, and in particular under lockdown because of covid-19. Reference was made to abuse and violence as a background factor in many chronic homeless women's lives, although this was not always the primary reason for homelessness

The things that people tell us are usually huge things about abuse now or in the past – repetitive experiences of rape. (INT)

We have women that have experienced multiple childhood trauma, adverse childhood experience and who then move into volatile relationships. I see this as a key theme and it's a worrying theme. These women have been assaulted and sexually assaulted. (EXT)

Prison

Numbers of chronic homeless women linked to leaving or having been in prison appeared to be one of the lower criteria based on the feedback from Housing Advisors. However, external stakeholders noted this as a significant part of the homeless cycle for this group of women. Particular points were

noted in relation to timing of release dates from prison, advance information for release planning, issues relating to retention of tenancy/placement whilst in prison and also issues around benefits.

We find that a lot of females are engaged in petty crime, rather than serious or violent crime, and they get short and sporadic sentences. Which makes it even more difficult to hold down a tenancy if you're constantly in and out of custody.

Leaving and after care

Respondents suggested this is a massive factor; firstly, in many of the young women they are currently seeing, who have had repeated placement breakdowns and secondly as a background factor in some of the older chronic homeless women.

The challenges of delivering services to women who are chronically homeless

5.8 This sub-section examines respondents' feedback on difficulties and challenges experienced by both statutory and voluntary sector providers in response to women who are chronically homeless. Reference was made earlier to factors relating to hidden homeless; where clearly service provision of any type is difficult if it cannot be targeted to those most in need.

Feedback indicated that delivering services to this grouping of women is particularly difficult for two main reasons. Firstly, that because of the repeat nature of the homelessness the same women keep coming back through the service, and length and nature of stay and service involvement is often brief and punctuated by the woman going to other services or becoming 'hidden' again within the cycle. Secondly, for those women where some length of service provision is achieved the same difficulty frequently arises because their placement (accommodation) or service (floating support) or attendance (Day centre or drop-in) is brought to a close as a result of non-adherence or breaking rules, unacceptable and challenging behaviours, criminal activity etc. Both these factors together mean that there is only a limited period of time or window of opportunity to work with the woman, and given the extent and chronic nature of her needs this is wholly inadequate in length and opportunity.

One Housing Advisor commented as follows:
Services are always time-limited and if you give them a Floating Support worker or community mental health worker, they'll work with them for so many weeks…then they discharge them. Everyone wants to move them on and get them off their books…there is pressure on all services and it results in having to keep everyone moving, but no-one is actually getting enough support. They're getting a bit of everything but because they (the chronic homeless woman) *move as well you'll find a Trust will say – oh, they're not ours, we don't work with them anymore… so they'll make a referral somewhere else - then they're onto a new waiting list and you start again with a new support worker that they've no relationship with, there's no trust there…there's no consistency. You're just moving people around – and generating more work. Nothing is ever seen through to a conclusion.* (INT)

This picture of frenetic movement both within the homeless sector and between different sectors (homeless, prisons, leaving care system) as well as rough sleeping and other informal networks (sofa surfing, squats etc.) highlights the chaotic lifestyle of this grouping. In addition, it brings into sharp focus the challenges for service providers.

A number of key challenges were identified by external service providers including:

- Limited or inadequate information about the individual;
- Challenges in dealing with the range of other non-housing related factors including mental health and addictions;
- Multiple placement breakdown (outlined in more detail below)
- Multiple and cyclical moves (outlined in more detail below)

Reason for placement breakdown

5.8 A number of different factors were noted by respondents in terms of the reasons for placement breakdown and/or tenancy breakdown amongst chronic homeless women:

- In the case of tenancies, they may be asked to leave or given notice to quit or they may also simply 'abandon' the tenancy because they are not coping and because their lives are too chaotic etc;
- Violence and aggression to other residents and/or to staff/management;
- Not adhering to rules and regulations – e.g. taking drugs in hostel, bringing other people into B&B room etc. They are unable to keep the rules, which are too restrictive for their lifestyle and behaviours;
- They frequently seek out similar people – this then leads to placement breakdown – through relationships formed which then are chaotic, violent and break down;
- They often do not know how to live with the people around them, be that in a hostel or B&B or in the community; as a result there are high levels of anti-social behaviour, partying and general nuisance attracting people from the same homeless/addiction circuit who then cause noise and problems. It was suggested that the PSNI and other emergency services are as a result in attendance at hostel setting;
- Inability to cope (even with support), together with the fact that their needs are so high and unless these needs are addressed temporary placements (never mind settled tenancies) are not possible or sustainable;
- Age is a factor (and associated contributory factors) – the higher levels of young females in the system at present with no previous settled life or experience of what a home should be;
- Placement breakdown – because the placement was unsuitable to the person's needs and/or capacity – from the outset;
- Low threshold of some providers (hostel and Floating Support), meaning there is a mismatch between provision and individual;
- Overall non-engagement – with the requirements of being a tenant, with the responsibilities of keeping accommodation, of being in a hostel and uptake of their support services.

Number of moves and cyclical nature of chronic homelessness; barriers to getting out of chronic homelessness

5.9 Housing Executive respondents pointed to the level of placement breakdown and the number of times some clients came back to them on a repeated basis; numbers of up to eight moves for one chronic homeless woman were not unusual. The cyclical nature of these women's situation was highlighted; going between hostels (and other temporary accommodation), tenancies and also

high levels of sofa surfing and staying with friends etc. In general, this was the pattern, rather than having any length of time settled in one place.

As noted earlier, all respondents suggested that for chronic homeless women their behaviour and past history is contributing to the cycle of moves through permanent and temporary accommodation (see above – reasons for placement breakdown). They effectively place themselves into a position where some providers do not want to take them back in (accommodation) or provide a service (floating support). Whilst some of this may be to do with threshold levels, the reality is that the type and nature of client behaviour is chaotic and, in some cases, extreme, and it is not safe for them (or the other residents, clients or staff) to have them back into certain settings or receiving the service.

External stakeholders held the view that the system and how it is managed by the Housing Executive in reality contributes to the number of moves as they move people between temporary accommodation settings, in particular in relation to getting someone moved on from B&B which is expensive. It was noted that this in itself is very disruptive for these individuals, adding to their difficulties and not providing a longer term settled period.

The cycle of chronic homelessness has been facilitated by providers. (EXT)

All stakeholders noted that the lack of move-on accommodation, and its accessibility and affordability, were further contributing factors for multiple moves. In particular, the length of wait for any offer of social housing and the lack of deposit or finances for the private rented sector were referenced.

Consensus across internal and external stakeholders indicated that the nub of the issue is that trying to solve a more engrained problem through provision of housing (or temporary accommodation) is not what is needed for this particular client group. Interviewees pointed to the need to comprehensively deal with the individual's presenting issues and the additional other factors in their life including mental health and/or addictions in order to make a move into settled housing successful. There were mixed views in terms of whether this should be done prior to rehousing or alongside rehousing (Housing First model). This is examined in more detail in Section 7.

The impact of current services on the cycle of chronic homelessness

5.10 This sub-section examines the impact of current services, as contributors to this cycle of chronic homelessness. This includes temporary accommodation provision and support services, and also examines other wider provision and systems. In addition, this sub-section examines the impact of chronic homelessness on the women themselves.

Respondents noted that the overall response or strategy with this group was not working, mainly because it is embedded in a traditional response to 'normal' homelessness, and for all the reasons identified in terms of multiple needs and chaotic lifestyles such a response is both insufficient and not specifically targeted at these women. In making such comments respondents were in no way minimising the targeted work undertaken by some organisations with chronic homeless women in terms of for example, Day centres, crash beds and the Housing First model.

Temporary Accommodation options

5.11 As noted earlier, stakeholders pointed to the fact that there were limited options, particularly in some areas, when it came to trying to place someone to whom the Housing Executive had a homelessness duty, and where the Housing Advisor had identified that the individual was chronic homeless. Discussion centred on what options the Housing Executive had in terms of temporary accommodation or emergency hostels, single lets and B&Bs. In addition, external stakeholders made a number of broad points about the suitability of temporary or non-standard accommodation for those defined as chronic homeless.

- Housing Advisors said that it was becoming increasingly difficult and time-consuming when trying to place someone. This is partially due to a lack of accommodation options, but in many cases, because the woman has been previously placed and the placement had broken down, and the provider (and other providers) will not take them again.

- Housing Advisors noted that there is a lack of female only accommodation. Whilst Housing Advisors throughout Northern Ireland knew about the Regina Coeli hostel and Annsgate Crash facility and had in many cases tried to place a client there, they noted that (a) it was often at capacity and they could not get a place, (b) they felt Belfast clients had priority e.g. for Annsgate – and they were kept waiting all day in order to see if they could avail of a place and (c) they felt it was not always in the woman's best interests to move out of their area, even for a short period of time. In addition, (d) some respondents felt Annsgate was not necessarily the best type of environment for the type of women they were trying to place, and (e) there was consensus that Regina Coeli hostel would not accept or be the best option for women with needs in terms of mental health or addictions.

- Housing Advisors in some Areas noted that they had no or only one option in terms of a hostel (in the main mixed gender or linked to a different need e.g. Probation hostel). There were concerns about getting a place (often at capacity) and putting women into a largely male environment. Reference was made to the vulnerability of these women and how they were easily led into situations and relationships with men in the hostels and also other influences including alcohol and drugs. In addition, reference was made to incidents and allegations of sexual assault. Positive comments were made about hostels in terms of the level of support, the fact that they kept going with a person (rather than asked to leave at the first incident), and the opportunity to use it as a stepping stone to learn skills etc.

  I think in hostels where there is a multitude of people going in there, it's not suitable for everybody. The people that are there don't always have the mindset to do better…or to improve their lives – there are 'bad' influences in there. There's also people they've met before so there could be relationship problems as well. (INT)

- Housing Advisors noted that Women's Aid refuges provided female accommodation for a specific reason linked to domestic abuse or violence, and as a result this was not an option for all chronic homeless women where this criterion did not feature in their background. Whilst Housing Advisors felt there was a good network of Women's Aid refuges, they did highlight areas where there seemed to be a lack of capacity or space, and where there was no coverage at all.

- Housing Advisors in some areas said they had virtually no access to single lets for single homeless women, albeit that they were concerned that placing a very vulnerable woman in a single let, even with some level of support put in, was not always a good starting point for a sustainable placement, and that many of these chronic homeless women were not tenancy ready or able to cope/maintain a single let. For those in single lets the duration of placements was noted, given the lack of permanent move-on accommodation, with reference made to some individuals being in single lets for up to 10 years. There were mixed comments on the standard and location of single lets, with some respondents noting that these were meant to be fully furnished/equipped and often in relatively poor locations – lack of transport, away from family and friends etc. Again, respondents felt this was not always the best placement for a woman experiencing chronic homelessness.

- Whilst Housing Advisors noted that a B&B placement was their only option in a significant number of cases, there were similar comments (to hostels and single lets) about having to place someone at a long distance from their known area and any family/friends support they had, the high cost of taxis/transport, the fact that this was largely a one-night placement – and that the next morning they had to start again with the bed bureau – to try and move the person closer back to their area.

External stakeholders made similar comments about temporary accommodation options, with some further specific commentary on nature and availability. Placing chronic homeless women into mixed gender and particular hostels was referenced.

Specific reference was made to the female only Regina Coeli hostel in Belfast. *Our understanding would be that Regina Coeli don't take complex cases or have the ability to manage the needs and challenges that come with complex needs… their rules are not practical for women with mental health problems or addictions.* (ENT)

It was acknowledged that mixed gender hostels can be appropriate for some females, but this is rarely the case for very chronic and chaotic homeless women.

What we have is temporary accommodation that everyone is put in to – so then it's the management of a population with multiple needs….one of the challenges is that if you have someone coming who has been clean for 4 or 5 weeks, coming into somewhere there is access to drugs. We are working with a vulnerable population and actually there is nowhere for them to go to have a complete clean stay. So, we need to think about differentiating our resource – and for the higher end need, bringing in health and other departments. (EXT)

In addition, external stakeholders noted that the lack of what they deem to be safe and suitable provision means that in many cases females return to or move on to unsafe and unsuitable settings e.g. they move back to the setting where they were abused, they move into another abusive relationship. *They'll say – forget it, I'll sort myself out and then they're going back to somewhere which isn't suitable.* (EXT)

Overall, the lack of a female only hostel or provision aimed specifically at this group was noted. This was deemed as essential, as a separate option to Women's Aid provision, crash facilities and low threshold female provision. In addition, the lack of any female provision outside of Belfast and Derry was highlighted.

Support Services

5.12 While there were generally positive comments about the nature of Floating Support services, there was concern that they were difficult to access in some areas, that they stopped after a relatively short period of time (time-limited, after which the tenancy failed quite quickly) and that some providers would not take clients on again because of their past behaviours.

However, external and internal stakeholders noted significant concerns about what they perceived to be a lack of support from Social Services and mental health teams. Housing Advisors felt they (and the Housing Executive) were being left with clients, essentially to house them, but with very limited access to or offers of support for the clients from the type of service(s) they need, firstly to stabilise them and secondly to enable them to live independently. A further difficulty was highlighted for these women in terms of achieving continuity of service. Firstly, they very often do not engage and therefore fall back to the bottom of any lists again. Secondly, because they are moving around a lot (in some cases because temporary accommodation placements are in another HSC Trust area) they are moving on and off lists and service provision. This lack of stability was noted by external stakeholders as one of the key factors in trying to work with chronic homeless women.

The need for increased dual diagnosis services was also mentioned by external stakeholders. The fact that statutory services for mental health and addictions require the homeless person to be sober/drug free in order for a mental health assessment to take place was noted, alongside the acknowledgement that this is difficult, and indeed unachievable for the vast majority of the chronic homeless population. The need for dual diagnosis is covered in more detail in paragraph 5.14, which examines the need to count or assess the level and nature of chronic homelessness.

Impact of chronic homelessness on women

5.13 Respondents were asked what impact chronic homelessness has had on the women they have worked with – either as a Housing Executive client or within temporary accommodation or other services. This element of the interview was the most emotive and impactful as respondents recounted the significant impact this 'lifestyle' has had on these women.

One external stakeholder put this bluntly in describing what the final impact is for many of these women, referencing research[146] which indicates that life expectancy for homeless people is at least 30 years less than the general population, and even lower for homeless *women*, whose average age of death is 43 years. Whilst there is no specific data on this in Northern Ireland, it frames a question around the lost years that chronic homeless women may not experience. Another external stakeholder responded in a similar way - *Well one of the consequences of this is death – I can't underestimate the lives that have been lost for women in relation to this.* (EXT)

[146] *Homelessness: A Silent Killer* (2011), Crisis. This study investigated homeless mortality in England for the period 2001 – 2009. It found that the average age of death of a homeless person is 47 years old and even lower for a homeless woman at age 43, compared to 77 for the general population. It is acknowledged that this data is now out of date, and refers to England rather than Northern Ireland.

Respondents noted that invariably each time they see a particular chronic homeless woman there has been a deterioration in their physical and mental health. This was particularly visible in terms of their physical appearance – lack of self-care, dirty and smelly clothing which had been worn for a number of weeks, missing teeth etc.

They look quite poorly – they're very aged – they don't look their age. They look a lot older. They would be quite scruffy like around their hands with black fingers and nails. They are wearing clothes that they've been given from somewhere – so don't fit them. They would also have no teeth – their teeth have fallen out. And their hair is quite rough – they just look really bad. (INT)

If you've dealt with someone over the years – over time you can just see it in their appearance. You just know that life is not good for them – their physical appearance and even their mental appearance – how they present themselves mentally. Takes a big toll on how they present themselves – every time you see them, they're worse. (INT)

Physically it ages women. Some of our women here are in their 50s and 60s but they look like they're in their 80s – through falls, black eyes, head injuries – causing more brain injuries. They look unkempt a lot of the time, even with the support here. They still have that look about them of a 'drinker.' (EXT)

A very sad wee picture. She ticked all the boxes (of chronic homelessness) within two years of leaving care. Self-harming, violent tendencies – when she was about 23 you would have thought she looked 60. She abused everything – you name it, if she could have got her hands on it – aerosols, every drug, drink. A very sad life story – and this is because of the length of time these people experience those things. They age very rapidly – their physical health – you can see it. (INT)

Reference was also made to a spiralling decline in the woman's capacity to have any hope in her situation, with frequent occurrence of self-harm and suicidal ideation. On this point a number of Housing Advisors noted that they were aware of females in temporary accommodation who had committed suicide.

Their mental and physical health degenerates; worst case scenario, it leads them to losing their lives unfortunately. There are a few on the books – some I'm surprised they are still alive and some – it's only a matter of time… (INT)

It impacts them in their feelings about themselves. There's absolute hatred of themselves. That's very prevalent in women – because of society's views that as nurturers they have failed. That's much more than any man – how dare she leave her children; would she not think better of her children to get into this type of state? Mentally and emotionally they batter themselves every day. (EXT)

Respondents reiterated that many of the women have few expectations or aspirations.
I think that the impact on the women is a lot of them feel defeated. Most of them feel there's no point in pushing forward because they're pushing against so many barriers that are immoveable. (EXT)

I think sometimes they just don't expect anything different – that's the way it is. They have no aspiration – or even awareness of what aspiration is. There's no expectation – I think some of our women believe that it won't ever get better for them…I think a worthlessness sets in – and then for a woman who has suffered domestic abuse or who has addictions – if they feel worthless then they are easy pickings. (EXT)

An overall sense of despair and a downward cycle in terms of helplessness and disillusionment were noted by all respondents. There was concern that the impact is in itself cyclical and self-fulfilling, as noted by one Housing Advisor:

Any longer-term impact is a reinforcement of what was always the case, the things that led them into homelessness. Homelessness was just a symptom of the other things and then these just get reinforced and reinforced, so that eventually that person feels that this will just be their life, that there won't be anything any better, so they don't try for anything better. In fact, they don't believe that there's anything better out there, and they become more and more disillusioned and their mental health gets worse. And the worse it gets the less chance there is of bringing it back again and improving it. (INT)

External stakeholders in particular who were repeatedly working with the same women coming back through the system also expressed their own sense of futility.

You see when you look at some of the women and you see the amount of services that they are passing through and how ineffective that all is for them and how that is affecting them as people. It's really heart-breaking. They are slipping through the net and are not being included. They are so extremely vulnerable and there is nothing appropriate there. We're really failing them as a society. It's not always up to them – it's about sticking with these women and going above and beyond for them. We're seeing them at the start of this – but I've seen the other end when these women are older. It has a huge impact – and it's difficult for them to get out of the cycle. (EXT)

Counting chronic homelessness

5.14 This discussion on the need for and possible methods of counting chronic homelessness has been included as stakeholders referenced this in their responses. It interlinks directly with consideration of the extent of chronic homelessness explored earlier in this section, together with consideration of the definition of chronic homelessness, and whether its current and agreed configuration is best placed to enable the Housing Executive to count the level and nature of chronic homelessness.

Counting the level and nature of chronic homelessness was confirmed as the right thing to do by internal and external stakeholders alike, albeit there were differences of opinion on what should be counted and how this should be done. In particular, Housing Advisors noted some concern about the multiplicity of systems and recording they had to undertake at present, and the need to think about how additional counting could be stream-lined with current processes. A number of Housing Advisors also noted concern about the consistency of recording information and how in-depth information required to make a judgement against a list of criteria for chronic homelessness may not be forthcoming in a housing application or homelessness assessment.

I'll just do whatever I'm told to do – but I don't think anybody above us truly has an understanding of how much work we're being expected to do. And it does feel – a perception at my level amongst my colleagues – that there's a lot of counting going on – and that everything is counted. And it's then used as a stick to beat us with – with statistics and percentages. We're the people actually dealing with the presenters…. we care about figures – there seems to be a lot of analysis of it but nothing ever changes. It's always just something extra for us to do – which probably sounds very cynical but that's the truth. (INT)

I think the problem is there's too many systems and we're repeating the same information so many times – it would be better if we had one system that could manage everything – the reporting and all of that. HMS[147] to open the application and put all the notes on, if a homeless case – then open a homeless one. Then CMS [148] – more of a management and reporting system – which again you have to put notes in and record it. You really need one system that does it all. To me, a lot of time is spent by yourself recording stuff – which could be better used supporting someone rather than sitting typing. (INT)

Other Housing Advisors felt that they were already collecting and recording most of what would need to be counted as chronic homeless, and that adding this into the system would be relatively straightforward. Some internal respondents felt that the current systems should already be able to produce data and reports on this topic. *A lot of that should just be lifted automatically off the database we're using. We should be able to generate that information.* (INT)

There was also evidence that some Housing Advisors were already keeping information informally. For example, one Housing Advisor noted that they kept some manual records of incidents in temporary accommodation, because they knew people would re-present and it was important to keep up-to-date with which provider would take them and which would not. References were made however by both internal and external stakeholders to how the counting would work given the fact that many people are 'hidden' homeless and would not show up in presentations to the Housing Executive. A further query was raised in terms of at what point a person would be counted, and what happens when they are in and out of placements throughout the year (is one person counted or multiple incidences?) or are hidden in some way or unknown to authorities.

It would be good to see the number of people who are bedded down…but in another sense there are individuals that are hidden away – and that want to be hidden away, that don't want people to know they're there. The safety issues of sleeping rough. That only gives you the number of people sleeping rough at that time. There are other people engaging in street activity – or the hidden side of it – people on someone's sofa or someone's floor…it can give you a count of a certain amount of people but it won't give you the true picture. (EXT)

[147] 'HMS' is the name given to the Housing Executive's on-line computer system, which is used by the Participating Landlords to administer the Housing Selection Scheme and the Common Waiting List.

[148] The Customer Management System (CMS) was introduced in 2017, having been developed in-house by the Housing Executive to support three key areas of business: to capture, record and analyse customer contacts with the Housing Executive; to capture key management information that would allow the organisation to better understand and improve the services it delivers; and to support Team Leaders, Housing Advisors and Patch Managers to understand and manage their workloads. CMS sits apart from HMS and draws data from it, but HMS does not draw data from CMS.

It's important to recognise that a lot of female homelessness is hidden – their accommodation is not safe, they are on the streets, they are sofa surfing from family to friends – to make sure they have a roof over their head. (EXT)

For those who aren't engaging with the Housing Executive – I think they would need to look at agencies that support Foreign Nationals or people who do not have recourse to public funds. (EXT)
It doesn't include EA women, women who are here illegally, women who are trafficked. (EXT)

A number of external stakeholders emphasised that women in particular try to conceal themselves during any count exercise; including being hidden in a sleeping bag alongside someone else, concealing their identity or masculinising their identity, staying in places which are not included in the count e.g. derelict buildings and Hospital Emergency Departments.

A number of Housing Advisors also linked the counting of chronic homelessness to overall service delivery and the need for a more strategic response. One noted the following:

*I do think it is necessary. At what stage are these people actually getting interventions? We're not really resolving the problem for them if they're chronic – if they're presenting two or more times in the one year, making new applications, and their temporary accommodation arrangements keep breaking down. We're here to help them and I do think that (*the counting) *should be implemented and recorded.* (INT)

This generic support for counting chronic homelessness stemmed from a desire to be better able to plan service development and delivery; in particular to have the data and evidence to put forward a case for additional or specific types of accommodation and services for chronic homeless women. Whilst already noted that many Housing Advisors had a focus on this strategic need, the external stakeholder respondents were very clear on the need for a joined-up examination of chronic homelessness numbers, and in addition indicated that the nature of chronic homelessness also needs to be better catalogued.

I think if you don't count it you don't have any evidence that it is there. I think that to properly address chronic homelessness, it's not a Housing Executive issue. It is a very broad holistic multi-disciplinary issue – people talk about dual diagnosis and the lack of it. I think as a starting point if you had a body of work that could say – this is the level of chronic homelessness, these are the reasons or possible reasons – if you think about the mechanisms and different funding and different departments – you've health, justice and housing – then you have to identify a starting point, and then start to think in a joined-up way about how you actually address it. (EXT)

External stakeholders also emphasised the need to find a mechanism of counting chronic homelessness across the sector (statutory and voluntary), and to include data from the various providers in the overall assessment of chronic homelessness. There were concerns noted that if 'counting' was only based on those who presented to the Housing Executive, and where needs were visible, assessed and recorded (some external stakeholders noted that the 'chronic' nature of the woman's homelessness is only discovered once they are in their service – this was not recorded on

the referral from the Housing Executive), that this would constitute a shortfall in terms of the true figure of chronic homelessness amongst women.

I think it's useful. I think there's value in it. And certainly, they are best placed to capture the scale of the referrals…but I think we have to recognise that people who present at HE – they [the Housing Executive] might not be clear of all the issues. This is because of how people refer – and things don't emerge to later. (EXT)

We need to count this for a number of reasons – to see the trends and create evidence, to back up the need for dual diagnosis – to create an evidence base. We need to make this visible – so that we can facilitate wraparound support immediately. And so that agencies can work together to create the right environment – so that the person doesn't go back to being homeless again. If you have the right environment, they are more likely to accept harm reduction. (EXT)

Equally there was acknowledgement that piecemeal data collection and analysis by individual accommodation or service providers could include double-counting of chronic homelessness across the sector, as many of these individuals are seeking and receiving services from multiple organisations in the course of one year.

SECTION 6 RESEARCH FINDINGS – FEEDBACK FROM SERVICE USERS

Introduction

6.1 This section provides an analysis of service user feedback on the topic of chronic homelessness as it related to their circumstances and situation. A total of 24 interviews[149] were undertaken and a full list of organisations who provided access and assisted with the set-up of interviews is provided in Appendix 1. As a result of covid-19 restrictions the majority of interviews were conducted by phone and Zoom video-conferencing, with a small number undertaken face-to-face (Belfast Health Inclusion Service). Notes were transcribed for the purpose of analysis.

6.2 This section provides analysis of the service user feedback under the following headings:

- Current living situation and individual and household details
- Homeless history – including reason for homelessness
- Interconnection to definition of chronic homelessness
- Other background factors – including early childhood experiences
- Placement history and services received – including reasons for placement breakdown and feedback on types of temporary accommodation
- Getting out of chronic homelessness – barriers and how to overcome these
- Impact of the homeless journey on the women

Quotes are provided in *italics* and service users are identified as SU1 etc., with a number allocated to each of the 24 respondents. This analysis is qualitative in nature and interlinks to the topics and themes in the research objectives and tasks as follows:

- The extent of chronic homelessness for women – profile, causes and key issues
- The challenges of delivering services to women who are chronically homeless
- The impact of current services on the cycle of chronic homelessness
- Exploration of the numbers of women experiencing chronic homelessness who do not engage with the Housing Executive

The final research objective and task (Suggestions of more effective service delivery to assist and meet the needs of women experiencing chronic homelessness) is touched on in this section in terms of feedback from the female service users, and examined in more detail in Section 7.

[149] Against a target of 25 interviews.

Current living situation and individual and household details of chronic homeless women

Current living situation

6.3 The research was set up in order to target female homeless service users who were in a range of living situations: emergency/temporary accommodation hostels, move-on accommodation and non-standard accommodation including single lets and B&B/hotel accommodation. Participants also included women who were resettled in the community in their own tenancy, as well as women who had left HMP Hydebank Training College within the last month.

Table 27 outlines the living situation noted by respondents when the research was undertaken. Around half (13 individuals) were in emergency/temporary hostel accommodation or in move-on or longer-term hostel type accommodation. Seven respondents were settled in a social housing tenancy, but their homeless history indicated significant movement and placements due to chronic homeless factors. Three respondents were in non-standard accommodation and one individual was moving and sofa surfing between family and friends. Whilst this study did not include any females currently living on the streets, 18 of the respondents had engaged in some level of street activity, as noted later in this section. In addition, none of the women had moved into a private rented tenancy or owner occupation.

Table 27: Respondents by type of accommodation/living situation

Type of accommodation/living situation	Number of respondents
Emergency/temporary accommodation hostel	7
Hostel/move-on accommodation	6
B&B or other non-standard accommodation	2
Single let	1
Own tenancy – social housing tenancy	7
Owner occupied home	-
Streets	-
Family/friends/sofa surfing	1
Total	**24**

Table 28 indicates the frequency and range of different length of time of respondent's current placement. This indicates that the majority of respondents (16 out of 24) had been in their current placement or living situation for 12 months or less. The remainder had been settled in placements for a longer period of time, albeit that in some cases there had been periods when this had broken down, and in the case of Foyle Valley House, where females with chronic alcohol problems were settled for much longer periods of time.

Table 28: Respondents by length of current placement

Length of current placement	Number of respondents
Less than one month	5
1 – 3 months	2
4 – 6 months	4
6 – 12 months	5
1 – 2 years	5
2 – 3 years	-
3 plus years	3
Total	**24**

Individual details

6.4 The majority of respondents said they were single (21). In eight of these cases the respondent noted that their previous family composition was single, although in two of these cases the individual had some level of contact with an adult child. For the remaining 14 respondents who were now single, their previous household composition was part of a couple (3) and part of a family (11). In three of the latter cases the service user mentioned children who were in care and/or in a kinship care setting. Three respondents said they were now either part of a couple or initially said they were single but then said they had a new partner. In two of these cases the female had children who were currently living within kinship care arrangements.

Household composition of this group of chronic homeless females indicates a number of important factors – firstly the move from being part of a couple/family to being a single person and secondly, the association in this change of household composition with their children no longer being in their care. Finally, there was an indication of the formation of new partnerships for some of the women, and evidence later in the interviews suggested that this was a cycle for some of them.

6.5 The respondents covered a wide age range of 21 to 61 as outlined in categories in table 29. Based on these 24 interviews the average age of respondents was 40. It should be noted that this was not a representatively drawn sample, and so this age range and average age does not necessarily fully reflect the age distribution within the female chronic homeless population.

Table 29: Respondents by Age

Age	Number of respondents
17 - 19	-
20 – 29	4
30 – 39	10
40 – 49	3
50 – 59	6
60 - 69	1
Total	**24**

Chronic homeless women – homeless history including initial reason for homelessness

6.5 The female respondents were asked to outline when and why they had become homeless in the first instance, and then to provide details of their homeless history including whether they had been homeless as a child, the number of periods of settled living situations and the number of periods of placements in a variety of settings. The next sub-section looks at their periods of homelessness and placements against the definition of chronic homelessness.

Age of becoming homeless

Around half of respondents (14) noted that they had first become homeless in their late teens (between ages 15 and 19 – nine service users) and in their twenties (5 service users), mainly during a period of disruption in their lives and linked to leaving their parental home or an early relationship breakdown. For the other respondents (10) homelessness had happened further into their life story (five in their 30s, three in their 40s and two in their 50s) and was frequently linked to the breakdown of a marriage/relationship, something traumatic happening or the loss of a child/children.

Family history of homelessness

Only three of the women said they had been homeless as children, with references to stays in hostels including Women's Aid. Ten respondents were very clear that they had not been homeless during their childhood either as a young teenager on their own or within their family composition. The remaining eleven respondents said that they had not experienced family homelessness but that they had experienced difficult and significant family problems in their childhood and in some cases, this resulted in them living with a different family member or leaving the family home at an early age (before the age of 18).

Reasons for homelessness

Analysis of the initial reason for homelessness noted by the respondents are outlined in table 30. This indicates the main reason given by the 24 respondents; it should be noted that there were often multiple and other additional contributory reasons for their homelessness and these are illustrated in the quotes provided. It is also important to highlight that this analysis relates to how the respondent told their story, rather than being specifically linked to the 'reasons for homelessness' recorded by the NI Housing Executive under the legislation and policy.

Table 30: Respondents by reason for homelessness

Reason for homelessness	Number of respondents
Alcohol and drug addiction	8
Impact of traumatic circumstances/childhood trauma	7
Relationship/family breakdown	5
Mental health problems	2
Vulnerability/unable to live independently	2
Total	**24**

SU 2 gave alcohol addiction as her main reason for homelessness. She said – *I was married. I had three children; the first child I had when I was 18 – they were taken away at birth and I've never seen him, ever. Then I went on to have another son and a daughter who I reared. Whenever they were about 16 or 17 – me and the husband were not getting on at all – I just got up and left. I'm ashamed*

to say that – but that's what I did. The SU attributed these scenarios to her addiction but also traced it back further to her mental health. *I have mental health issues. It actually started around the time the son was taken to be adopted. Then I turned to alcohol as a crutch – I still drink to this day. And I've had quite a few attempts at suicide.*

SU 3 referenced circumstances in her late teens as the reason for her homelessness at the outset. She talked about an unstable move from the care sector into her own tenancy and then having two children in quick succession in her late teens. She then noted – *there was a family breakdown and when they were very young the two kids were took off me. Then I had to go to Simon Community – I've been there quite a few times – I'm well known to them.*

SU 4 talked about a traumatic event in her teenage years when her father died in traumatic circumstances. She said *when he died, I went on drugs two days later. And once he died no support was given.* This SU linked the impact and aftermath of this situation to her cycle of homelessness and other difficulties. *I became homeless at 15 because of the drug use – I left home and slept on the streets.*

SU 8 referenced the death of two of her sisters, one to drugs and one to suicide, as the main contributors to the breakdown in her own move into chronic homelessness. She also mentioned other losses including that of her mother and a young baby, and a lack of support or counselling. She said – *everything changed then and it became very difficult.*

For SU 9 the main reason for homelessness at the initial stage was a breakdown of relationship with her Mum. She talked about arguments and fighting with her Mum, police involvement when her ex-partner got stabbed and a child being removed from her care. After this she said – *I started taking drugs really bad – it f**ked with my mental health. I was on curfews at the hostel and not allowed near different people – it put my head away when I did no wrong. I had no support. It was like I was trapped watching me. I got involved in the wrong crowd – and we were partying at different houses. And I slept at (*name of shop) – *I always slept in that doorway for 2 ½ years on and off. Also at* (name of another shop)*. They threw out big boxes and I would have frozen without those – it was really hard in winter time; it was so cold. I used to wake up co cold every morning – so stiff, I couldn't even move.*

Loss of family and associated loss of accommodation was the biggest contributory factor for SU12. She explained that she had lived with her Granny since her Mum passed away. *She raised me all my life – then my Granny died 2 ½ years ago – I was living with her at the time. But because it was my Aunt and Uncle's house, I had to leave. So the main reason I became homeless – my grandmother died, and I obviously had to move out – I legally couldn't stay. It was the loss of my accommodation – my whole life changed.* This SU also did reflect on how her alcohol addiction contributed to and has kept her in the homeless cycle.

SU 13 outlined a very complex history leading to her homelessness. She said - *all this stuff has led to this situation.* Her partner had committed suicide a number of years ago; she continued at home with the three children but found it very difficult to cope. The SU said – *he hung himself– it's been a very hard six years – I have 2 kids to him and then one other child. I'm addicted to drugs.* The SU

said about this period – *I was trying to kill myself. I was lonely and I was on the drink and drugs. But I lost everything – and I lost the kids.* This SU also linked her addiction and mental health to abuse in her early childhood. She said – *if I had talked – if I'd not been scared of Daddy – we would have been removed from that home. When I was younger, I was very anxious – and I had a difficulty being on my own. If all this hadn't happened, I would still have my children.*

SU 18 said her repeated homelessness was the result of continuous relationship breakdown. She said - *I wasn't able to cope. Now looking back I wasn't well; I couldn't make rational decisions but it was the mental health that triggered it off.* This SU also linked her addiction issues to her wider family breakdown. She said the main reason for taking drugs was to mask her severe mental health problems. *When I was 15 or 16, I realised I had been abused, but I only told Mum and Dad when I was 18.*

SU 19 talked about her journey into chronic homelessness over the previous 2 – 3 years, initially when she was released from prison. She said – *I got into a relationship with a guy who was already an IV drug user. We got a place in the private rented sector but then there was a placement breakdown and we were put out of the community.* The SU said that her children were then removed from her care. The Key Worker noted that the SU is aware that she has not been fit to parent because of her *chaotic lifestyle, homelessness and drug use.*

SU 20 linked her homelessness directly to her alcohol addiction, and this in turn to the loss of her children. She said – *losing the kids started it off. There's no other reason. It started off wee bits here and there. But there were problems getting to see the kids and I started to drink more and more. I depended on it every day.*

SU 21 had moved into chronic homelessness at a much later stage in life, in her early 40s. She had been working in different locations around the world but had returned to Northern Ireland because of physical health problems and had been living at home. She said – *It was a relationship breakdown with my parents. I feel they were bullied by my elder brother who interfered. Mum didn't want me there. She told me, you're not the daughter I loved. And then my parents changed the locks on the door. I had no money for a private rent, so first of all I went and stayed in a hostel and then for a while I stayed with friends.*

SU 24 pointed to her alcohol addiction as the key reason for her homelessness. This was interconnected to Social Services involvement with her children and family. She said – *I have been made homeless. Social Services put me out of my family home.* She explained that she developed a drink problem over the last five years – *it wasn't a problem beforehand.* She said she had not been happy for a number of reasons - *it hasn't been easy in my family – I have three sons all with additional needs and learning difficulties. Alcohol became my crutch – it has taken a toll on me. I just broke.* This situation led to the SU having to leave the family home. She said - *you don't think you need help – you think you can deal with it yourself – manage it yourself. But then I was drinking every day – and drinking during the day as well – I didn't see the demise.*

Homeless history and placements

The female respondents outlined their recall of the different tenancies, places they had lived including hostels and other non-standard accommodation, and the reasons for movement between living situations. It was difficult to place exact quantifiable measurement on this element of the study as some women found it hard to recall each location and setting where they had lived. However, the general feedback indicated the following themes:

- The women demonstrated repeat patterns of high numbers of moves between and within different tenures and accommodation settings including social rented tenancies, hostels, non-standard accommodation and prison;
- Length of time in different settings was often relatively short;
- Movement between and within settings was often chaotic and as the result of the behaviour and/or the actions of the women.

These themes are illustrated through the following cases.

SU 1 said – *I've had about 10 houses but I haven't been in a hostel. When I lose a tenancy I move in with friends and family.* The service user indicated different reasons for losing tenancies including where a private landlord had decided to sell the property through to where she has been asked to leave social housing tenancies. *I lost the plot a bit.* The service user linked her addictions to a breakdown in previous tenancies and that this usually happened around the 12-month mark. She talked about going from place to place and sofa surfing with friends and family in between tenancies. SU 1 had been in a social housing tenancy for around 12 months at the point of this interview, but this time she was in receipt of Floating Support. She said that she felt better able to help herself but still appreciated the daily phone-call, together with a hot meal delivered each day during lockdown because of Covid-19.

SU 3 noted numerous tenancies all of which had broken down and numerous placements in between. She said – *I've had numerous tenancies through different people but I never lasted in them. There was never enough support.* Later in the interview she said – *they are looking into supported living for me. I think it would be good as there would be someone to turn to.*

In the case of SU 4, whilst she had been homeless on and off for around 20 years, she had very limited hostel experience and limited rough sleeping. Her default position had been to stay with family and friends and keep moving around. This cycle was punctuated by periods in prison. The SU said she had been in prison 22 times, mainly for shoplifting and petty theft, and part of this was linked to her drug habit and also a gambling addiction. SU 4 talked about the difficulty of getting stable accommodation on release from prison and mentioned *I was sleeping on my Mum's floor on a mattress* and *each time I'm released I stay on sofas of family and friends.*

Whilst SU 6 was still in her late 20s she catalogued stays in a number of hostels. Her Key Worker suggested that the cycle perpetuated because the service user has no or limited support. She said – *the service user becomes chaotic and then moves from hostel to hostel when things happen.*

SU 8 outlined a pattern of movement and sofa surfing. She said – *I was in and out. I was sofa surfing, staying here and everywhere – my head was in the wrong place. Then there was a period I had my own house and then I used to stay on a Travellers site as well – I moved about a lot.*

For some service users, repeat placements in particular types of hostel or service were linked to their addictions. SU 11 noted at the time of the interview that this was her third time at Stella Maris hostel. This service user talked about stays in a range of hostels and settings throughout Northern Ireland including standard and non-standard accommodation. SU 12 had a similar story with placement in multiple single lets for short periods of time, and constantly having to move on.

SU 18 outlined a very detailed homeless and placement history. She suggested that she has had around 50 tenancies mostly in the private rented sector, all of which have broken down because of her addictions and mental health, and connected to various relationship breakdowns. This service user also indicated a long list of hostels in Belfast. SU 21 provided a similar list of placements in hostels in the North West, plus a period of 4 – 5 months in a B&B in Ballymena.

SU 22 (aged 21 years old) catalogued her homeless journey and different placements; this illustrates the number and frequency of placements for some of these women. She said – *After the situation with my parents I went to the Welcome Centre and from there to the Annsgate shelter just for one night. I've been from hostel to hostel – I was in one hostel for a week and then another for 7 months – I was kicked out due to violence. Then I was back to Annsgate hostel for three months. I was sleeping out rough with a boyfriend – this was for about six months. It was very cold and I was constantly in hospital – in A&E with urine infections. From Annsgate I then went to a hostel for a few weeks and then to another hostel. After this point I was again sleeping on the streets.* At the time of the research the service user noted that she was speaking with her Housing Advisor to try and get a place at Flax Foyer.

Chronic homeless women – interconnection to definition of chronic homelessness

6.6 This sub-section analyses the feedback from respondents against the definition of chronic homelessness. This definition, taken from the CHAP report, is outlined in full on page 10 of this report (also see Appendix 3).

Fourteen respondents indicated that they had had more than one episode of homelessness in the last 12 months. Whilst the primary target group for the research was chronic homeless women under this definition, a significant number of participants had been within this element of the definition (more than one episode of homelessness in the last 12 months) at a prior point; in other words they were now more settled in a tenancy or other accommodation and as a result able to participate in the research study. This accounts for three of the respondents. A further group of women (7), who again would have met this part of the definition at some point in their chronic homelessness, were now settled in more long-term hostel and supported accommodation e.g. Foyle Valley house or had been in another setting e.g. prison; so at the point of interview they did not meet this element.

Similar to the criteria above, eleven respondents met the next criteria in the definition of chronic homelessness – multiple (three or more) placements or exclusions from temporary accommodation in the last 12 months. Again, this number seems low for a study targeted at chronic homelessness,

but more in-depth probing demonstrated that the majority of the women interviewed had met this criteria within the last couple of years, but were now in a more settled position or indeed had only 1 – 2 placements during the last 12 months. Undoubtedly the impact of Covid-19 played some part in this, as the women were less able to move from placement to placement, and temporary accommodation providers were working to ensure stability and longevity of placement.

Table 31 provides an analysis of the number of respondents who met the six additional indicators in the definition of chronic homelessness. This indicates that almost all of these women had a history of mental health problems and addictions (both 23), together with experience of violence and abuse (22), and with high levels (18) who had engaged in some type of street activity. Around half of respondents (13) had been in prison, although given the nature of responses it was not always possible to determine that this had been within the last period of 12 months. A lower number (5) indicated that they had been a 'looked after child' although, as noted later, a higher number of women said there had been some Social Services involvement in their early childhood and family life. The following discussion provides further insight into the level and nature of these factors amongst respondents.

Table 31: Respondents background/needs linked to chronic homeless indicators

Chronic homelessness - Indicator	Number of respondents
An individual with mental health problems	23
An individual with addictions e.g. drug or alcohol addictions	23
An individual that has engaged in street activity, including rough sleeping, street drinking, begging within the last 3 months	18
An individual who has experienced or is at risk of violence/abuse (including domestic abuse) - risk to self, to others or from others	22
An individual who has left prison or youth custody within the last 12 months	13
An individual who was defined as a 'looked after' child	5

Mental health problems

As indicated by the nearly universal inclusion of this criteria in service users' lives, mental health problems were a recurring and significant factor in their chronic homelessness. In many cases diagnosis had been at an early age; SU 3 referenced – *I was diagnosed at a young age with depression. It was quite early when I was 13 – there was a lot going on in the family home.* This service user highlighted that she was on medication, did not receive any mental health support and had since been diagnosed with manic depression and post-traumatic stress disorder.

SU 6 said that her mental health had been very poor because of past trauma, addictions and being on the streets. She said – *numerous times I was trying to commit suicide, I was slicing my wrists. I woke*

up in ICU in the Mater hospital. Also I had ODs on the heroin. These were unintentional but I was taking a cocktail of drugs – Lyrica[150], diazepam and crack[151].

Mental health problems were verbalised in different ways by different service users and it was clear that these ranged from relatively small-scale through to much more significant diagnosis. SU 11 noted: [a number of years ago] *I had a psychotic fit and it was very serious. I'm on lots of medication.* SU 13 referenced 29 suicide attempts, noting that these were just the ones on her records. She said – *my mental health has been poor since I was 15 and I can't handle pressure or cope with things.* She said that the GP had diagnosed an emotional personality disorder and would like to prescribe a mood stabiliser, but the service user said – *but can't until I'm off pregabalin.*

Addictions

Similar to mental health, all but one of the respondents cited a current or past addiction. SU 4 said – *I've had drug use nearly all my life. I was on heroin from the ages of 14 to 18 – and then I didn't touch it since. Then I became addicted to prescribed medication and I was buying it on the streets. And then I got a gambling addiction.*

SU 7 noted – *I was binge drinking and it was out of control. From my early 20s anything I could have got. I started drinking every day – it was fitting in with your friends. Then I met a fella and he introduced me to smoking cannabis. I wanted to fit in and not be the odd one out. Then it was tablets and then heroin. The first time I took it was to do myself in – but then someone had naloxone – only for that or I would be dead.*

SU8 described how she had become involved in drugs following the death of her son and her Mum, and how she had used it to mask her trauma and feelings of grief. She said – *After that there I bought diazepam off the streets. It helped me to deal with their deaths. Once I got a taste of it – say I was on five a day and then the next month I was on ten a day – but it wasn't doing enough for me. So then I was on Lyrica and buds – and then blues[152] and zanex*. [After further family bereavements]…*then I hit the drink. I can't go for a week without taking something – I need it to help me through, especially when I'm on the streets. If I'm just sitting then I'm overthinking everything.*

In a number of cases respondents referred to recent hospitalisation because of their addiction. The Key Worker for SU16 noted – *whilst her drinking has minimised it is still every day and she is in and out of hospital. Her body can't cope with it. She has ongoing health problems – lesions to the liver and cirrhosis of the liver and she's on a heart monitor. She has been very ill.*

The importance of dual diagnosis of mental health and addictions and associated need for services had also been highlighted in Section 5 by stakeholders.

[150] Pregabalin.
[151] Crack cocaine.
[152] Tranquiliser.

Engagement in street activity

18 of the respondents noted street activity. In most cases this was infrequent occasional sleeping out. SU 3 noted – *I slept in the streets a few times.* A small number of respondents had slept rough for much longer periods of time, as already cited for SU 22. Street drinking was also noted by five respondents. SU 10 said in relation to street drinking – *I do it every day.*

Experience of or at risk of violence/abuse

Nearly all of the respondents said they had either experienced violence or abuse or felt vulnerable or at risk of this at some point. Responses ranged widely from abuse in early childhood; SU 14 said – *I was sexually abused by my own father* through to service users noting abusive relationships with partners.

Leaving prison or youth custody

Thirteen of the women had been in prison, although as already noted it was difficult to be precise about the timing of this in all cases. Three interviews were set up via HMP Hydebank and this was with females who have been in prison on multiple previous occasions and had only recently been released. Around half the women had only been in prison once or twice and for quite short periods of time.

In contrast, half of the respondents had multiple prison sentences. When asked about the number of times she had been in prison SU 3 said – *loads of times, I actually don't know to be fair. I don't remember.* And as previously cited SU 4 mentioned 22 periods of time in prison.

Defined as a 'looked after child'

This factor was recorded against five of the respondents.

Chronic homeless women - other background factors – including early childhood experiences

6.6 As noted earlier, many of the women pointed to difficult situations and experiences in their early childhood life. In some cases the women suggested that this had led to elements of their homeless journey or story, including mental health problems, the start of addictive behaviour and dependencies and a spiral into abusive relationships and ultimately homelessness. Service users made various comments about their childhood. One service user said - *I grew up in a bad family home. There was a lot of pressure from my mother – physical and emotional pressure.* In a number of cases respondents said that as a result of poor relationships at home, and in some cases abusive relationships, they had left home at an early age, from age 16 onwards.

Reference was made to a range of factors in childhood including early trauma, loss of a parent or family member, a parent with an addiction, leaving home at an early age, pregnancy at an early age and sexual abuse. More in-depth analysis of these background and contributory factors in early childhood is provided in the following cases.

SU1 noted that her Mum and Dad *had a lot of problems* and that she had been in foster care as a child because of her Mum's alcohol addictions. Her Mother had died when the SU was in her teens; she stated *this was because of drink.* The SU also noted that by her mid-teens she was living with her Dad

and *fell pregnant*. Her daughter was effectively brought up by her paternal grandmother, with whom she currently lives.

SU6 outlined trauma in her childhood. She said – *when I was younger, I lost family members to a house fire.* The SU talked about the lack of counselling and support, and that as a result she developed behavioural problems. *As a result the school put me out and I went to Pathways* (Alternative education provider) *but I ended up messing about even more.* She said that she started drinking and got involved in drugs in her early teens. *It spiralled out of control. I needed the right type of help. I was running about like other teenagers, having boyfriends, binge drinking and I fell pregnant. After the fire I was drinking more – binge drinking. And I was taking legal highs and ecstasy and cannabis and other tablets.*

SU 7 said that she experienced early trauma when her father passed away when she was a teenager. She noted that the circumstances of this were traumatic for her; he had been an alcoholic and a street drinker and had died as a result of a head injury. The SU said she saw all of this as the main reason she became an alcoholic and also why she gravitated towards street drinkers in the city centre.

SU 9 outlined a very unsettled and difficult childhood. She said – *Mum and Dad were both alcoholics. Dad was just drink but Mum was drink and drugs. There was always violence and arguments, and I had to look after my brother and sister. Even when I was in my early teens my Mum kept me off school to look after my sister – I got them to bed and made sure they were fed.* The SU noted Social Services involvement from an early age, and she had lived at her Granny's for a period of time as well. She had run away at one point for six months when she was under a Care Order and placed in an Assessment centre; she said – *everyone was looking for me.* At this stage she became pregnant.

SU 18 talked about a number of factors in her early childhood. She said - *From a young child I was abused – emotionally, sexually and physically – it was within the family. It started at a very young age. Because of this I was flying off the handle – and there was no input to help me with this or to understand it. So I was abusing cannabis and drink from a young age. I left the family home as a teenager and stayed at someone's house – really, I was squatting.* The SU reflected that these childhood and teenage experiences then lead her into a life of addiction, mental health problems and moving around, mainly as a result of relationship breakdown.

SU 21 said that whilst there was no background of family homelessness or Social Services involvement there had been difficulties in her childhood. She said *Mum and Dad separated and that had a big impact. Then I started to drink alcohol and smoke cannabis.* The Key Worker also noted that the SU and her Mum left Scotland and moved back to Ireland and the SU was placed in an Irish only speaking school at a relatively young age (with no Irish language herself) which she had found very difficult.

Chronic homeless women – placement history and services received

6.7 The number and range of types of placement was examined in sub-section 6.5. This looked at the number of moves, the movement between different tenures and types of accommodation and placement, the frequency of moves and length of placement and the impact moves had on the women's behaviour and well-being. The female respondents were also asked for their thoughts on

why some placements broke down and why they moved in this way; and where relevant if this was linked to either the type of temporary accommodation and/or their behaviour. Table 32 outlines the broad themes that emerged from this discussion.

Table 32: Key themes – Placement and accommodation breakdown

Placement and accommodation breakdown	Responses and quotes from respondents
Asked to leave by the accommodation provider	This was the most frequently cited reason for placement breakdown. The main reasons for this related to inappropriate and challenging behaviour on the part of the respondent, getting into fights with other residents, non-payment of service or additional charges etc. In the majority of cases the women noted that they had found various rules and regulations difficult to abide by e.g. curfews, no alcohol rules etc. SU 2 noted – *Rules and regulations. There are quite a few, you had to be in by 12 midnight or else you were locked out. I remember there were times I ended up sleeping behind the train station. They phoned the police on me.* In other cases the women noted that their other types of behaviour resulted in them losing their temporary accommodation (in some cases more permanent accommodation). SU3 said – *because of my addiction and offending, that's why I am homeless. A lot of it has been petty theft and shop lifting – and some more serious incidents.*
Asked to leave by landlord (HE and private rented sector)	For those women who had their own tenancy (multiple tenancies), there was evidence of them being issued with a notice to quit. Again this was frequently linked to their behaviour in the tenancy including poor upkeep and cleanliness, late and non-payment, inappropriate behaviour including noise, drinking and parties.
Asked to leave by their family or by the community	This was noted by a couple of women who said they were threatened to leave an area by community groups and in some cases by their family, who could no longer cope with their behaviours.
Multiple moves	A number of the women noted that they had moved around a lot, and were not settled for long periods of time, as they had moved between different partners
Leaving accommodation because they felt unsafe or insecure	SU 2 noted – *we (women) are vulnerable – men can just batter on. There's more hostels for men – we need something just for women.*

Impact of chronic homelessness and the homeless journey on women

6.8 This sub-section examines respondents' feedback on the impact chronic homelessness has had on their lives and them as individuals. Table 33 provides a summary of the key responses and themes emerging from this topic, alongside some quotes which evidence how the women verbalised the impact on them and their lives. The number of respondents impacted has been calculated based on what the women said explicitly; however, this is likely to be an underestimation against each of these impacts.

Table 33: Key themes – the impact of chronic homelessness

Impact of chronic homelessness	Number of respondents	Quotes from respondents
Impact on physical and mental health	15	*It's put my head away – I felt suicidal, running around pregnant. I didn't know where to go – heavily pregnant and carrying my bags.* (SU19)
Impact in terms of addictions, risk taking behaviour etc.	7	The SU said – *I felt down, like my stomach was a washing machine feeling – it's never been easy.* The Key worker said *– she sedated herself, so not to feel her feelings. It's not using drugs for recreational purposes or to enjoy herself. It's using them to numb and sedate her feelings, to not have to think about it. To sleep during the day so as not to think about her kids.* (SU 21)
Impact on emotions and frame of mind – feelings of helplessness, hopelessness	8	The SU said she feels very alone and that no-one really cares for her. *Missing or dead – no-one gives a crap about you.* (SU 25)
Impact on contact with children and family relationships with adult children and wider family.	10	*The situation was that they (Social Services) were cutting contact less and less. And when I did see the child they were crying leaving me. And even when I was at the Child Contact Centre, the minute contact was finished I was into the toilets. I had the gear with me, and I took heroin straight away afterwards. It was the only way I could cope with the state I was in. It was the pain of not having the child – it was to get that numbness.* (SU6) *The love for him, this sent me over the edge. I felt he was taken off me – and I wanted to have my child. And then, when he was gone, I wasn't told, I wasn't informed, no-one phoned me. I contacted them umpteen times but I was never given that chance. I just feel it was all against me – and now I don't get to go to the school plays or to see his school reports. And it just makes me really angry but also so sad.* (SU7)

Impact of chronic homelessness	Number of respondents	Quotes from respondents
		Service users talked not only about children under the age of 18, but also their adult children and grandchildren. SU5 said *I have grandchildren and I don't see any of them.*
Impact on overall life – instability and lack of connection/ community	14	*I didn't like getting moved about so much – I knew it was always temporary.* (SU12) *Sometimes there was a wee bit of hope and a bit of trust – but then when that went – it was back on the scrap heap.* (SU18)

Some of the service users talked in more positive terms about how they were trying to bring their life back together again. SU 6 noted – [For a number of years] *my life was just going down in a spiral – I've lost out on so much. But now I've turned a big corner – my life is going up. When I was on the streets and homeless, to me my only way out was death. But now I want to try and make something of my life.*

SECTION 7 CHRONIC HOMELESSNESS AMONGST WOMEN: SERVICE RESPONSES ELSEWHERE

7.1 This section provides a brief literature review of responses to chronic homelessness amongst women, in particular models of practice elsewhere in the United Kingdom and Republic of Ireland.

Effective services for chronically homeless women – review of literature

7.2 The text in this sub-section (paragraphs 7.2 – 7.4) was provided by Professor Nicholas Pleace and Dr. Joanne Bretherton, Centre for Housing Policy, The University of York. The evidence base here is relatively thin, compared to a much more detailed evidence base on homelessness among men, particularly lone men with high and complex support needs. The key debates over the last decade have centred on whether housing-led and Housing First services are more effective than is the case for other forms of congregate and communal supported accommodation and existing models of floating support service.

7.3 According to available evidence, services that focus on co-production, i.e. working with and drawing on the experiences and strengths of homeless people with high and complex needs, respecting their opinions and developing support that closely reflects what they say they need, tend to be more effective than models that are less flexible. Housing First can outperform some older models of homelessness service in these respects and deliver superior results in ending homelessness for a sustained period among people with high and complex needs, including those who have experienced long-term and recurrent homelessness[153].

7.4 Breaking this down by gender is problematic, in the sense that there is (still) a broad tendency for service and programme evaluations to note that a given percentage of the homeless people using a given service or programme are female, but then to perform little or no analysis that contrasts male and female experience, quite often because the subset of service users who are women tends to be small. Dedicated research on Housing First services for women is still quite unusual, but an early study in Greater Manchester reported that[154]:

- Using a Housing First service model that was designed by and run by women, using a co-productive model, delivered very high rates of success in rehousing women whose experience of homelessness could be long-term or recurrent and whose needs were high and complex.
- There was evidence of improvements in health and wellbeing: women using the Housing First service had been broadly characterised by low-level 'survival' and addiction-related crime before they received support, and when using Housing First, offending rates dropped off to nothing.
- Women using Housing First designed for their needs reported it offered a much better, more understanding and more effective form of support than was available from other services.
- Success was in part linked to the service provider being a social landlord with access to housing offered by other social landlords, meaning it was able to offer adequate, affordable housing with security of tenure relatively quickly.

[153] Pleace, N. (2018) *Using Housing First in Integrated Homelessness Strategies* London: St Mungo's. www.mungos.org/publication/using-housing-first-integrated-homelessness-strategies/

[154] Quilgars, D. and Pleace, N. (2017*)* op. cit.

Review of other services and responses to chronic homelessness amongst women

7.5 Whilst there is a very limited seam of evidence in relation to services and responses to chronic homelessness amongst women, table 34 identifies a few additional services which interconnect fully with this client group or one aspect of their needs.

Table 34: Other services and responses to chronic homelessness amongst women

Service/Response	Details
Westminster VAWG[155] Housing First project	This is a partnership project between Westminster City Council, Solace Women's Aid and housing associations including Women's Pioneer Housing, L&Q, Peabody and Southern Housing. The Westminster VAWG Housing First project, started taking referrals in spring 2019 and was one of the first Housing First services in England to be delivered by a specialist domestic abuse support provider in the women's sector (Solace Women's Aid).
Whole Housing Approach toolkit[156]	This toolkit covers a range of topics/issues relevant to women experiencing chronic homelessness. The toolkit is a reference guide for local authorities, housing providers and specialist domestic abuse services interested in setting up Housing First for women. In particular the toolkit highlights the following: *Countless studies have argued the importance of trauma informed support when working with women affected by multiple disadvantage.[157] It is widely acknowledged that trauma informed, and strengths-based approaches work best for this group of women.*
Pilot project between Shelter and Styal prison, Manchester[158]	This pilot project with women leaving Styal prison, was supported by the prison, the Cheshire & Greater Manchester Community Rehabilitation Company and the CRC's resettlement service delivered by Shelter. The pilot supported 20 women with complex needs, who were deemed to be most likely to reoffend. The pilot created a wrap-around service for the individual both in prison and in the community. Evidence from the pilot suggests it had a positive impact on many of the participants. This project operated alongside Shelter's Through the Gate service in the prison; the resettlement workers met with women 12 weeks before release in order to assess their housing need and look at other issues such as employment, training and education.

[155] VAWG – Violence Against women and girls.

[156] Toolkit on Women experiencing VAWG_DAHA.pdf (homeless.org.uk)

[157] AVA & Agenda (2017) The core components of a gender sensitive service for women experiencing multiple disadvantage: A review of the literature. Retrieved from https://www.barrowcadbury.org.uk/wp-content/uploads/2017/02/Mapping-the-Maze-The-corecomponents-of-a-gender-sensitive-service-for-women-experiencin-multiple-disadvantage-January-2017.pdf

[158] Event at Styal aims to help women prisoners – Merseyside (merseysidecrc.co.uk)

Service/Response	Details
Brighter Futures, Stoke[159]	This Housing First service incorporated a women-specific post, targeted at working directly with homeless females with chronic needs. In addition, women's programmes provide support to females who are on community orders and post custody licence/supervision.
Tus Nua, Depaul Dublin[160]	Depaul note that this is the first service of its kind in Ireland supporting women leaving prison. It was established in response to research and evidence of the acute need for programmes to assist women released from prison, in their transition to independent living in the community. The Tus Nua apartments accommodate 15 women for a period of up to six months, with a key worker and support plan covering life skills, budgeting, alcohol harm reduction, detox access, and physical and mental health support. The overall aim of the service is to prevent the risk of reoffending by supporting women in the short and longer term after leaving prison, and recognising the risks of homelessness.

[159] Housing First - Brighter Futures (brighter-futures.org.uk)
[160] Tus Nua - Depaul Ireland (depaulcharity.org)

SECTION 8 CONCLUSIONS AND RECOMMENDATIONS

8.1 This section pulls together a number of overarching themes in this research – firstly in terms of the analysis of data relating to chronic homelessness amongst women, secondly looking at the key themes highlighted by stakeholders and thirdly, reviewing the feedback from service users themselves. Conclusions and recommendations are provided under each of these headings.

Conclusions from data collection

8.2 This study noted that counting chronic homeless women is challenging on a number of levels; not least that many are hidden to services and are not recorded by service providers or in street counts. Furthermore, counts can be limited by the mechanisms and definitions used, missing vital elements of the typology of chronic homelessness e.g. length or repeated nature of homelessness.

This research provided some indication or estimation of the total number of chronic homeless women in Northern Ireland. Feedback from stakeholders (Section 5) suggested that numbers ranged between 50 and 100 cases in Belfast, around 30 cases in Derry/Londonderry and fewer numbers elsewhere in Northern Ireland.

The data collection exercise (Section 4) used available NIHE data and secondary data provided by a wide range of other providers in the fields of health and homelessness. The study examined the number of female presenters to the NIHE, and looked at various factors such as repeat presentation and specific reasons for homelessness e.g. domestic violence, to build some picture of what numbers presenting to the Housing Executive could be deemed to fall into the chronic homeless category.

The data available indicated the following:

- The NIHE data suggests around 250 female repeat presenters per year (this figure equates to around 5 or 6% of presenters, a similar figure to that suggested in earlier research[161] which concluded that between 5 and 10% of any homeless population could be identified as experiencing chronic homelessness;
- Depaul noted a total of 146 females over a 5-year period who could be defined as chronic homeless, indicating an average of 29 chronic homeless women per year in or using their services;
- Over a 2-year period Belfast Inclusion Health service noted around 55 females in the chronic homeless category; suggesting an average of 27 – 28 per year;
- Simon Community NI noted 36 cases of chronic homeless women over a 2-year period; averaging 18 per year;
- Extern identified 82 chronic homeless women over a 5-year period; an average of 16 per year;
- The Welcome organisation identified an average of 57 chronic homeless women per year over a 3-year period.

This exercise confirms that in any one year, upwards of 50 chronic homeless women are using a variety of temporary accommodation and other services.

[161] *Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization Results from the Analysis of Administrative Data,* Kuhn and Culhane, 1998.

Whilst all these individual counts and recording mechanisms cannot be totalled, and equally it is impossible to know the level of presentation of any one service user across two or more services, there is some correlation in the type of numbers being recorded by organisations, and the estimates made by stakeholders in the interview process, notwithstanding the limitations highlighted earlier in this report about the use of secondary data, and in particular in Section 4. In addition, analysis of the data sets shows linkages to wider research on chronic homelessness in terms of a high interconnection with domestic violence/abuse, a connection to care background, and reference to mental health issues, addictions, interconnections to separation from children or involvement of Social Services with children and physical health problems. The data sets also pointed to a higher incidence of chronic homelessness amongst women aged 20 – 39, with not insignificant numbers in the 40 – 59 age brackets.

Recommendations about data collection

The exercise of trying to estimate the level of chronic homelessness amongst women, and the findings from this exercise, suggest a number of recommendations for future data collection and measurement in this area. These can be summarised as follows:

- **The need to look at counting chronic homelessness amongst women across both the statutory and the voluntary sector.** Counting chronic homelessness by only one organisation or sector e.g. NIHE will lead to an incomplete picture due to the hidden nature of some woman. In addition, the number and frequency of moves between accommodation and in and out of services, means that counting can lead to over-counts and undercounts. This can be overcome through data sharing or linkages across organisations and sectors. Whilst this would need careful consideration against a background of GDPR, as well as resource implications, this would enable actual counting in terms of records; but would have the added benefit of enabling tracking of an individual's journey and working collectively to provide joined-up solutions of accommodation, health and other services.

- **The need to review the agreed definition of chronic homelessness** in advance of any roll-out of measurement across the Housing Executive offices. As presently defined, some chronic homeless women will not fall into the time period of 12 months for repeat homelessness and/or being excluded from three or more placements, and as such will not be counted as chronic homeless. The definition as currently framed in the CHAP report potentially misses this important element – of females presenting in different services (statutory and voluntary) over a longer period of time, and not within the exact timescales and criteria covered in the definition. Given the gap in implementing measurement as a result of the impact of covid-19, it is perhaps timely to take the opportunity to amend the definition in the light of these findings, notwithstanding that the definition will be reviewed at the one-year point, post implementation, and to enable further examination of how this is counted in practice, through the provision of guidance and training at District office level.

Conclusions from stakeholder feedback

8.3 A number of key challenges, questions and conclusions emerged from the analysis of internal and external stakeholder feedback:

- In cases where hostels won't take someone because of their mental health problems, they may end up being placed in a B&B or single let without any support, which can be to the further detriment of their mental health.
- On the one hand, chronic homeless women tend to have high needs including mental health problems and addictions, whilst on the other hand many hostels operate low thresholds and are unable to accommodate those with high needs. Rules, curfews and expectation levels within the hostel setting are difficult for those with chronic needs to adhere to. There appears to be a mismatch between the needs of chronic homeless women and what accommodation is available.
- The Housing Executive has a duty to secure accommodation for those who are eligible but, in doing so, Housing Advisors are dealing with a wide range of non-housing related factors, all of which impinge on a person's ability to sustain a tenancy. Are placements in single lets and B&Bs the most suitable option for chronic homeless women? In addition, it can be difficult for Housing Advisors to obtain the full history in the homelessness assessment/Housing Solutions process with this particular client group because of the complexity and range of their needs.
- In the context of trying to deal with repeat homelessness and placement breakdown, some of the placement options are in themselves viewed as contributing to repeat homelessness.
- The women do not have an address, and in many cases have no phone or their phone goes missing (or is 'sold'). It is difficult for the Housing Executive to keep in touch with them this becomes detrimental if they are trying to place the service user, etc. This barrier cuts across all the service providers, making ongoing contact and communication difficult.
- Whilst statutory services may be in place (mental health services, for example), the nature of the women defined as chronic homeless and what else is going on in their lives, means it is difficult for them to keep regular appointments. The women then lose these services, which are the very services that would have enabled them to maintain some level of stability.
- Statutory services for mental health and addictions require the individual to be sober/drug free in order for a mental health assessment to take place; this is unachievable for the vast majority of the chronic homeless population. Dual diagnosis is still limited in its availability Northern Ireland wide.
- Women return to situations – going back to an ex-partner or abuser – because of a combination of attachment and normalisation, but also because of a lack of adequate interventions.

Recommendations from stakeholder feedback

8.4 During the course of the interview process, and based on the type of questions and discussions outlined above, Internal and external stakeholders made a number of suggestions about how practice could and should be developed in response to the overall identified need of chronic homelessness amongst women, and in relation to the multiple criteria contained within the definition of chronic homelessness. These can be summarised as follows:

- **The need to quantify the extent and understand the nature of chronic homelessness amongst women.** Counting chronic homelessness through the statutory homeless assessment was viewed as being a positive step forward. Housing Executive personnel highlighted the need for flexibility in how they will do this, noting the need for guidance which will assist this part of the count. External stakeholders also emphasised the need to find a mechanism of counting chronic homelessness across the sector (statutory and voluntary), and to include data from the various providers in the overall assessment of chronic homelessness. This theme was noted earlier in paragraph 8.3.

- **The need for further training and resources** to be put into the interview process via Housing Solutions; so that the extent and nature of the situation for each individual is fully probed. This linked to comments around the complexity of interviews with chronic homeless women, and the need to fully identify their complex needs at an early stage in the process.

- **Age and needs specific responses** – that accommodation, services or other interventions need to take into account the two age groups identified – under 35s and over 35s; together with the specific needs relating to each of these age groupings (further expanded below).

- **The need to respond to and deal with key factors** - which have contributed to the woman's entry to and retention in chronic homelessness. In particular, stakeholders suggested that this cohort of women require a trauma or counselling based therapeutic approach, which will first and foremost deal with their underlying issues. In many cases this related to adverse childhood trauma, violence or abuse in early life or throughout their lives and the loss of children from their parental care. The absence of this therapeutic approach, provided in a timely and ongoing way for these women, has meant that they are unable to move out of their chaotic and homeless state. In addition, there is a need to develop mechanisms across all relevant agencies for early identification of women who may move into chronic homelessness (through pathways of leaving care, homelessness, release from prison etc.), with the provision of relevant preventative measures at that point.

- **The need for targeted addiction and mental health services** for this grouping, acknowledging the need for services for women, and services for those that are embedded in chronic homelessness. In particular, having access to mental health services which are not time-limited and do not operate policies where the person is placed at the bottom of the list if they do not show at an appointment. The model of the Belfast Inclusion Health service was viewed as very appropriate for this grouping, and there was support for developing this model, albeit on a smaller scale, in other areas with significant levels of chronic homeless women.

- These two areas – **adequately dealing with past trauma and dealing with addictions/mental health** – were viewed as being fundamental to any successful pathway or transition out of chronic homelessness. Without this, stakeholders suggested that the woman would remain 'trapped' in this chronic status.

- **The need to develop specific temporary accommodation** suitable for this grouping (including standard or non-standard). Under this theme stakeholders made suggestions about the need for female-only hostels, including provision for in-house therapeutic services, with planned move-on options including stand-alone accommodation connected to a hostel site and units in the community with associated Floating support. In addition, there was recognition of the need for this approach across Northern Ireland; and that such provision would need to be resourced in order to facilitate a high threshold level, minimising the rules/regulations/restrictions that the behaviour of this group of women cannot uphold/abide with. These suggestions went alongside a universal commitment to avoid placing chronic homeless women in short-term and often one-night accommodation with no support and with no plan in place to move out of this type of accommodation.

- **Specific approaches for some groups.** Specific references were made to how things could be further improved for chronic homeless women being **released from prison**, with calls for more to be done in terms of the timing of release dates, the level and type of advance release planning, as well as structural factors in relation to the retention of tenancies for those on short-term sentences. There was also consideration that more focus should be placed on young women **coming out of the care system** with a view to preventing chronic homelessness in this grouping in the first instance.

- **Further development of models already operational in Northern Ireland.** Housing First was viewed as being successful for women as a model of providing intensive support alongside the rehousing element.

Conclusions from service user feedback - chronic homeless women

8.5 Feedback from the female respondents indicated a number of factors or barriers which they felt prevented them from getting out of chronic homelessness. Some of the service users had overcome these barriers and were now in their own social tenancy. These factors are categorised in table 35 together with quotes to support these findings.

Table 35: Key themes – Getting out of chronic homelessness - barriers

Barriers to getting out of chronic homelessness	Responses and quotes from respondents
Ongoing addiction or mental health difficulties – linked to inability to sustain or retain a tenancy	Respondents noted that their addiction and/or mental health played a part in preventing them from moving out of homelessness. In part, this was due to needing support and the appropriate type of services. SU3 noted – *I'm still fighting that on a daily basis. I attend an addictions unit which helps and I'm on a substitute.* In other cases service users felt hostels were unsuitable because alcohol and drugs were available in these settings. SU6 noted: *The fella in the room on one side of me sold heroin and the one on the other side sold crack. I couldn't stay there so I left there.* This service user went on to say: *When I went into hostels you would meet people and start a relationship. I'm not saying it was their fault but within three weeks of being there I ended up on heroin. It was the people I fell in with.* SU10 said: *A barrier to moving to my own tenancy would probably be my drinking. I have tried to reduce the amount I'm drinking and the times, but I just can't.*
Lack of accommodation options/ Wrong type of accommodation – question of mixed gender hostels	This was mentioned by a number of service users. They were not saying that the temporary accommodation was in itself wrong; but just not a good fit for them and their needs. SU3 said: *A hostel coming out of prison is a slow set-up to failure. You are meeting the same people with the same issues – alcohol dependency and drug addiction. It has happened to me a few times – you get released into a hostel and it's made. It's better this time because I'm on licence and I've been released into a B&B and not a hostel.* There were a number of comments about the 'other people' in hostels. A number of the women suggested that it was both unfair and unsuitable for them to be in mixed hostels or sharing communal facilities with men. SU5 talked about one hostel saying: *The problem is they accept sex offenders. They say they don't but I know they did. And they were grooming me – I named and shamed them and asked – what's he doing in a hostel with vulnerable people?* This service user also talked about being in a mixed hostel where *I was asked to do a sexual act. Hostels can be a very harsh place to be.* Other respondents had a broader viewpoint, noting that they had felt outnumbered in terms of gender in various hostels. SU6 noted: *I was the only*

Barriers to getting out of chronic homelessness	Responses and quotes from respondents
	girl amongst 14 fellas. She went on to say that she had felt uncomfortable and had then moved on to another mixed gender hostel. However here she also said she was sexually assaulted. One respondent (SU7) noted that past negative experiences had resulted in her moving onto the streets. She said: *I was raped at the hostel so I then left hostels. For the simple reason that I felt safer on the streets – I was with a guy then.* When asked about mixed hostels she said: *I feel very vulnerable. It's not secure or safe – you shouldn't have to feel this way.* This service user talked more widely about male violence in mixed hostels. She said: *I found there were quite violent men there and it was frightening. I got involved with one man and of course I thought I can change him. But that wasn't the case.* Whilst some service users were negative about the rules in female only hostels and services, overall they were positive about what they perceived to be safe and secure environments.
Cycle of relationships	Many of the women talked about continual movement in and out of and through the chronic homeless cycle. In many cases this was due to a combination of the other factors discussed here. One underlying and repeated theme was the impact of starting new relationships and what then happened when these were short-lived and ended. SU7 said: *I've just really gone from hostel to hostel and then to the night shelter. Each time I was getting involved with the wrong type of man – and then I had to get out of the relationship and move on again.*
Other factors	Lack of support, particularly on an ongoing basis, was noted as a key factor in placement breakdown and a barrier to getting out of homelessness. SU3 noted: *Women need more support and more counselling.* There were some interesting points in this discussion with the women; those who had experience of rough sleeping talked about their *street family* and how they missed that close bond and feeling of safety, when they were on their own in a hostel or tenancy. Others talked about the support they felt when living in a hostel in comparison to being alone in a tenancy or single let. SU13 noted: *I could get a flat if I want but I don't want to be on my own – I feel secure here. I wouldn't have that on the outside – I have no family and very few friends.*

Those females who had experience of being in prison made some specific references to how they felt the system had failed them in the past, and how they would like to see services delivered to them prior to leaving prison. They acknowledged that this was starting to happen. SU5 said: *A lot of women come out (of prison) with just a bag of clothes and a bus pass. Well, they're going to have a long walk.*

They are told, you've nowhere to go, so just present to the Housing Executive. For a lot of them, they don't know where they're going when they leave – maybe staying with friends and back into the cycle. Coming out and not knowing where you are going – how does that help? Even if you could source a private rent, there is no way of getting there or seeing it in advance, plus you have no money.

This theme was continued by SU6 who felt the system of getting a release date with no notice once time was served for remand prisoners, did not help produce a smooth transition. She said: *You could be on remand for 14 months and during that time you can't get any help. You don't get mental health or psychology support and you don't get any housing advice. Then they come along and say "that's it, time served", and you are released.* SU12 made a similar point: *Accommodation was never discussed* (pre-release from prison). *I was given my release date and there was nothing.*

Recommendations from service user feedback - chronic homeless women

8.6 Table 36 categorises the range of suggestions made by the female service users in terms of what would help them (or what had helped them) get out of chronic homelessness. Again quotes are provided to support the findings. These are provided here as direct **recommendations** from the client group.

Table 36: Key themes – Overcoming barriers to get out of chronic homelessness

Overcoming barriers to getting out of chronic homelessness	Responses and quotes from respondents
Receiving support for ongoing mental health problems	Respondents talked about having better and more accessible mental health support; and that this would enable them to organise their lives better and go about finding and keeping accommodation. SU6 who had considerable prison experience said that she had only recently got the necessary support in her late 30s, although she had been in and out of prison since her early 20s. The women who had lost formal contact with their children linked this to their mental health; in many cases they suggested the need for some sort of in-depth and focussed counselling and trauma support. SU20 said: *Looking back at the start, if there had been an offer of help before they were taking the kids off me. There was no support from any professionals.*
Receiving appropriate support for addictions	SU3 noted: *I'm still fighting that on a daily basis. I attend an addictions unit which helps and I'm on a substitute.* Service users particularly emphasised the need to have support in this area that was not timebound and/or did not cease due to their behaviours.
The 'right type' of temporary accommodation	More than half of the respondents suggested that females should have women-only hostels and services. SU5 talked about one scheme of single lets that she had been in. She said: *It was all female. I felt safer and more secure – and there was great camaraderie between the girls.*

Overcoming barriers to getting out of chronic homelessness	Responses and quotes from respondents
	SU6 talked about her stay in a female only crash facility. She said: *I loved it because it's just girls – they are more private and clean. The staff are there all night and I felt safe – and they are always there if you need to talk. Girls have different problems, there could be different things like sexual abuse and domestic abuse – you need to have services for them.* SU8 was also very positive about this facility. SU12 talked about a female only facility and said: *We're together, women helping each other. And there's the support of staff – I never had this type of support before.* A number of service users also mentioned supported living; they felt this would benefit them. SU25 said: *I think it would be a good thing for me because there would be help making food, someone to support me if I'm having a bad day. I can't cope on my own.*
Life-skills and tenancy ready	Whilst service users indicated that their goal was to have their own tenancy and be able to maintain it, they also recognised that previous attempts had ended in failure, in part because they did not have the knowledge or skills to maintain the house or the tenancy. One service user who had just come out of prison referenced the fact that for many of them – those leaving care or prison – they had not learnt the necessary budgeting, cooking and other skills necessary to look after themselves. She said: *When you're in prison you lose all your independence and you lose yourself. There needs to be half-way houses, so that when you come out you've somewhere to get used to things again.* (SU5) The option of a half-way house was noted by a number of respondents; SU20 talked about being in a move-on flat associated with a hostel, where she had her own space including her own kitchen, living room and bedroom, and that this had helped her towards maintaining her own tenancy. Other service users and their Key Workers recognised the importance of ensuring that someone was ready to have their own tenancy. The Key Worker for SU 19 said: *She has become a lot more independent; she is now more equipped to move on. We'll help her with support to get a starter pack and a discretionary grant.*
Access to affordable and accessible accommodation	Another underlying theme in the women's responses was the unavailability and cost of getting their own tenancy. They highlighted the length of social housing waiting lists and the financial barriers for them getting into and remaining in the private rented sector. SU7 summed this up by saying: *They should have been offered housing long before now – and there are void properties that could be brought back into use.* SU8 said: *I don't know how*

Overcoming barriers to getting out of chronic homelessness	Responses and quotes from respondents
	long it will be until I get a place – the waiting list is terrible. I have 130 – 140 points. The female respondents made various suggestions around the need to have available long-term and permanent accommodation, otherwise their cycle within the homeless sector was more difficult to break. Immediate access to and knowledge of how to get accommodation was also a barrier; the respondents suggested that more information should be provided at critical points in their homeless journey e.g. when leaving care, through other wider support services, when leaving prison. Some of the younger females talked very positively about their interaction with the young people's Housing Advisors in Belfast Region of the Housing Executive. The Key Worker for SU9 noted – *I think it's imperative to have a young person's adviser making referrals and signposting. They can speak direct to them and they can depend on them.*
Floating support	Two of the respondents were in receipt of the Housing First service and received ongoing Floating Support. They credited this approach with enabling them to sustain their tenancy. SU 1 said about the Floating Support service: *I'd be lost without it. I wouldn't be living if I didn't have it. They have helped me with going to appointments to do with housing, helping me with my benefits.* One respondent who had been in prison multiple times said that past difficulties had been due to a lack of support, but that she was coping better this time round because of support. SU3 said: *In the past there was failure because of the lack of support when you are coming out (of prison). I had Beyond the Gate a couple of times and now more recently support from the prison – they have all been brilliant – a good support network and it means you are not on your own.* Another respondent with prison history felt that having support enabled her to maintain her tenancy, which in turn lead to *no chance of me re-offending.* SU5 noted that her Key Worker had helped her with benefits, a grant for furniture, opening a bank account and being in contact on a weekly basis. Floating support was viewed as important by many of the women and by their Key Workers. The Key worker for SU17 noted that: *she is very vulnerable – and has been open to financial, sexual and physical abuse*, recognising that this female would need ongoing support in the community if she was to retain an independent tenancy. Service users also emphasised

Overcoming barriers to getting out of chronic homelessness	Responses and quotes from respondents
	the importance of continuity of support. SU18 commented on what had helped her get out of chronic homelessness: *Just having someone to talk to – the same person along the way. Having the same Key worker so I don't have to explain my story and go back over it again.*

Appendix 1: Stakeholder interviews – Housing Executive respondents, temporary accommodation and service provider respondents and access to service users for interviews

NI Housing Executive personnel - Name	Region/Area
Paige Lewis	Belfast
Kelly McAleese	Mid & East Antrim
Julie Savage	Ards & North Down
Ciarrai Reilly	Mid Ulster
Michael Walsh	South West - Omagh
Maura Donaghy	South West
Kiera McMullan	Mid Ulster
Aileen McGuiness	South Down
Theresa Ferguson	West (Waterloo Place)
Anna McCormack	West (Waterloo Place)
Kerrie McCormack	South Antrim
Heather McElnea	South
Ashleigh Russell	Belfast
Liam O'Hanlon	SP Manager, Homelessness Services

Type of organisation	Name	Organisation
Key Stakeholder organisation	Danielle Finlay	MDHST, Extern
	Nichola McFall	Housing Rights
	Ciara Scollay	MACs – Floating Support
Temporary accommodation and service providers	Maureen Slater	Foyle Valley House
	Kate Harrison	Women's Aid
	Karen McAlister & Keelan McClelland	Simon Community NI
	Catherine McGarrell	Depaul
	Jamie Wallace	Depaul
	Colleen Hamilton	The Welcome Organisation – Annsgate and other services

Organisation	Number of interviews achieved
Depaul – North West[162]	2
NI Prison Service – Hydebank	3
The Welcome Organisation, Belfast	4
Depaul - Stella Maris, Belfast	3
Foyle Valley House, Derry	5
Belfast Inclusion Health Service	3
Extern	2
Simon Community NI – Belfast and Derry	2
Total	**24**

[162] This covers Foyle Haven Day Centre, Housing First and also Floating Support services – SU 1 and 2 use a combination of these services.

Appendix 2: Chronic Homelessness Action Plan (CHAP), 2020 – List of Objectives

The objectives set out in the 2020 Chronic Homelessness Action Plan[163] were as follows:

1. To design specific criteria for measuring chronic homelessness to identify existing and emerging needs to inform the development of appropriate responses to address and prevent chronic homelessness.

2. To develop mechanisms across agencies for early identification of those who are at risk of homelessness or chronic homelessness and implement preventative measures as appropriate.

3. To implement a range of support services to help people sustain their accommodation.

4. To implement arrangements to ensure services engage with people who are experiencing, or at risk of experiencing chronic homelessness, as quickly as possible subject to the needs of the client.

5. To make the stay in temporary accommodation as short as possible, subject to the needs of the client.

6. To consider a range of housing options for clients experiencing chronic homelessness including Housing First model and ensure they are supported into permanent accommodation as soon as possible, subject to the needs of the client.

7. To promote interagency cooperation to address chronic homelessness and ensure mechanisms are in place to implement and oversee the Chronic Homelessness Action Plan.

[163] CHAP, 2020, page 7.

Appendix 3: Definition of Chronic Homelessness

The Homelessness strategy 2017-22[164] sets out a definition for chronic homelessness based on a Crisis report (2010)[165], which defined those chronically homeless as "a group of individuals with very pronounced and complex support needs who found it difficult to exit from homelessness."

To enable data on chronic homelessness to be counted a criteria has been developed which notes that an individual can be said to be experiencing chronic homelessness if they meet **one** of the indicators listed:

1. An individual with more than one episode of homelessness in the last 12 months (This includes those individuals who would met the second test of the statutory homelessness assessment)
   OR
2. An individual with multiple (3 or more) placements/exclusions from temporary accommodation during the last 12 months.

AND two or more of the following indicators apply:

- An individual with mental health problems (This refers to anyone who has met the vulnerability test as a result of their mental health within Homelessness Policy Guidance - 'Consider whether, when homeless the applicant would be less able to fend for himself or herself than an ordinary homeless person, and so would suffer injury or detriment in circumstances where the ordinary homeless person would not')
- An individual with addictions e.g. drug or alcohol addictions. (Vulnerability may be indicated by a history of drug addiction or alcoholism and/or the risk of relapsing if that relevant individual is already vulnerable as a result of it.)
- An individual that has engaged in street activity, including rough sleeping, street drinking, begging within the last 3 months
- An individual who has experienced or is at risk of violence/abuse (including domestic abuse) - risk to self, to others or from others
- An individual who has left prison or youth custody within the last 12 months
- An individual who was defined as a 'looked after' child (residential and non -residential care)

These indicators were issued for use by Housing Advisors and Patch Managers with further explanatory guidance notes.

[164] Available on the Housing Executive website

[165] *A Review of Single Homelessness in the UK 2000 – 2010 Anwen Jones and Nicholas Pleace', Crisis (2010)* www.crisis.org.uk/data/files/publications/ReviewOfSingleHomelessness_Final.pdf

Appendix 4: Tables - Temporary Accommodation provision by Council Area

Belfast City Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	Simon Community	242 Antrim Rd	10
	Life Housing Northern Ireland	Life House	6
	Belfast Central Mission	Grampian Avenue	6
	MACS Supporting Young People	Supported Housing (Care Leavers) Service	18
	Barnardo's	Leaving Care Service - Belfast	10
Single Homeless with Support Needs	HarmonI	Utility Street Men's Hostel	59
	North Belfast Housing Association Ltd.	Flax Foyer	37
	Simon Community	414 Falls Road - 1	21
	Simon Community	Cliftonville Avenue	20
	Simon Community	3-5 Malone Road	42
	Simon Community	11 – 13 Saintfield Road	21
	Legion Of Mary Regina Coeli	Regina Coeli House	20
	Extern Northern Ireland	The Ormeau Centre	29
	The Salvation Army	Centenary House Direct Access	68
	The Salvation Army	Calder Fountain Resettlement	12
	Queens's Quarter Housing Ltd	University Area	77
	Legion of Mary Morning Star	Legion of Mary Morning Star Hostel	38
	Mind Wise New Vision	Inverary House	12
	East Belfast Mission	Hosford House 2	26
Homeless Families with Support Needs	Depaul Northern Ireland	Cloverhill (Depaul Ireland)	18
	Depaul Northern Ireland	Mater Dei (Depaul Ireland)	13
	First Housing Aid & Support Services	Ardmoulin (Belfast)	21
	The Salvation Army	Thorndale Family Centre	38
	The Salvation Army	Glen Alva Family Centre	20
	The Salvation Army	Grosvenor House (T.S.A)	18
	Ark Housing Association	Roseville House	24
	Ark Housing Association	Moyard House - Ark HA	17
	Simon Community	Conway Court	24
	NIHE	New Haven	8
	NIHE	Templemore House	8
People with Alcohol Problems	Rosemount House Limited	Rosemount House/ 294	20
	Apex Housing Association	Springwell House	27
	Council for Social Witness	Grays Court	7
	Depaul Northern Ireland	Stella Maris (Depaul Ireland)	23
Offenders or People at risk of Offending	Extern Northern Ireland	Innis Centre	20
	Extern Northern Ireland	Dismas	14
	Council for Social Witness	Thompson House	19
Women at Risk of Domestic Violence	Belfast and Lisburn Women's Aid	46 Ulsterville Ave	20
	Belfast and Lisburn Women's Aid	64-68 Deerpark Road	13
Single Homeless Crisis AccomService	Welcome Organisation	Annsgate Crisis Accommodation Service	10
	The Salvation Army	Centenary House Night Shelter	21

Derry & Strabane Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	First Housing Aid & Support Services	Jefferson Court	20
	First Housing Aid & Support Services	Francis Street Project (Supported Accom)	8
	Praxis Care Group	Foyle Young People Supported Accommodation Service	4
	Praxis Care Group	Foyle Young People Stepdown Service	15
Single Homeless with Support Needs	Simon Community	Simon Community-Waterside	33
	Apex Housing Association	The Foyer	48
	North West Methodist Mission	McCrea Chambers	47
	First Housing Aid & Support Services	Shepherds View	16
	First Housing Aid & Support Services	Dillon Court Homeless, Strabane	38
Homeless Families with Support Needs	NIHE	7 Bradley Park	5
	Clarendon Shelter Ltd	Clarendon Shelter (Service)	18
	First Housing Aid & Support Services	Sath Accommodation Service	7
	NIHE	Clooney Mews	10
	NIHE	Seamus Roddy House	8
	NIHE	Drumard Close	9
People with Alcohol Problems	Apex Housing Association	House In The Wells	24
	Apex Housing Association	Foyle Valley House	14
	First Housing Aid & Support Services	Damian House	12
Women at Risk of Domestic Violence	Foyle Women's Aid	Ashleywood House	15
	Foyle Women's Aid	Rose House	9

Antrim & Newtownabbey District Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	Action for Children	NI Supported Lodgings Service	15
Homeless Families with Support Needs	NIHE	Antrim Hostel	3
	NIHE	Loughview House	5
	NIHE	Hillview House	8

Armagh, Banbridge & Craigavon Council Area

Primary Client Group	Organisation Name	Service Name	Units
Single Homeless with Support Needs	Simon Community	Simon Community Avon House	9
	Simon Community	Simon Community Linen Court	29
Offenders or People at risk of Offending	Simon Community	Simon Community 21 Edward Street	20

Causeway Coast & Glens Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	Simon Community	Mount Street Mews	15
Single Homeless with Support Needs	Simon Community	Lodge Road	15
Homeless Families with Support Needs	NIHE	Glenvara Drive – Coleraine	5
Women at Risk of Domestic Violence	Causeway Women's Aid	Causeway Women's Aid Refuge	10

Fermanagh & Omagh Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	Shelter (NI) Ltd.	SLATE	11
	Action for Children	Rossorry Grove Supported Accommodation	13
People with Alcohol Problems	First Housing Aid & Support Services	Ramona House	8
Women at Risk of Domestic Violence	Omagh Women's Aid	78 Old Mountfield Road	6
	Fermanagh Women's Aid	Fermanagh Refuge	3

Lisburn & Castlereagh Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	MACS Supporting Young People	Lisburn Supported Housing	9
Single Homeless with Support Needs	Simon Community	2 Flush Park - 1	30
Women at Risk of Domestic Violence	Belfast and Lisburn Women's Aid	7 Beechland Way	12

Mid & East Antrim Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	Barnardos	Grove Road	5
Single Homeless with Support Needs	Simon Community	1 Curran Road	18
	Living Rivers Trust	Living Rivers Trust Hostel/8 Linenhall	20
	Simon Community	Millhouse	18
Homeless Families with Support Needs	Larne Community Care Centre	Larne Community Care Centre	4
Women at Risk of Domestic Violence	Women's Aid Antrim B'mena Carrick Larne & N'abbey	Women's Aid Antrim B'mena Carrick Larne & N'abbey - Carniny Court	13
	Cithrah Foundation	Selah	5
	Women's Aid Antrim B'mena Carrick Larne & N'abbey	Ruth House	6

Mid Ulster Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	Belfast Central Mission	Thomas Street, Dungannon	4
	Belfast Central Mission	Tafelta Rise, Magherafelt	13
Single Homeless with Support Needs	Depaul Northern Ireland	Castlehill (Depaul Ireland)	22
	Extern Northern Ireland	MUST Hostel	20
Women at Risk of Domestic Violence	Mid Ulster Women's Aid	Duffy House	9

Newry, Mourne & Down Council Area

Primary Client Group	Organisation Name	Service Name	Units
Young People	MACS Supporting Young People	Newry Supported Housing	7
	MACS Supporting Young People	Downpatrick Supported Housing	8
Single Homeless with Support Needs	Simon Community	63-65 Bridge Street, Newry	17
	Simon Community	14 Saul Street, Downpatrick	8
Homeless Families with Support Needs	NIHE	Glebetown	5
People with Alcohol Problems	Cuan Mhuire (NI) Ltd.	Cuan Mhuire - Supported Living Accommodation (Short Term)	50
Women at Risk of Domestic Violence	Women's Aid Armagh Down Ltd	Lyne Lodge	11

North Down & Ards Council Area

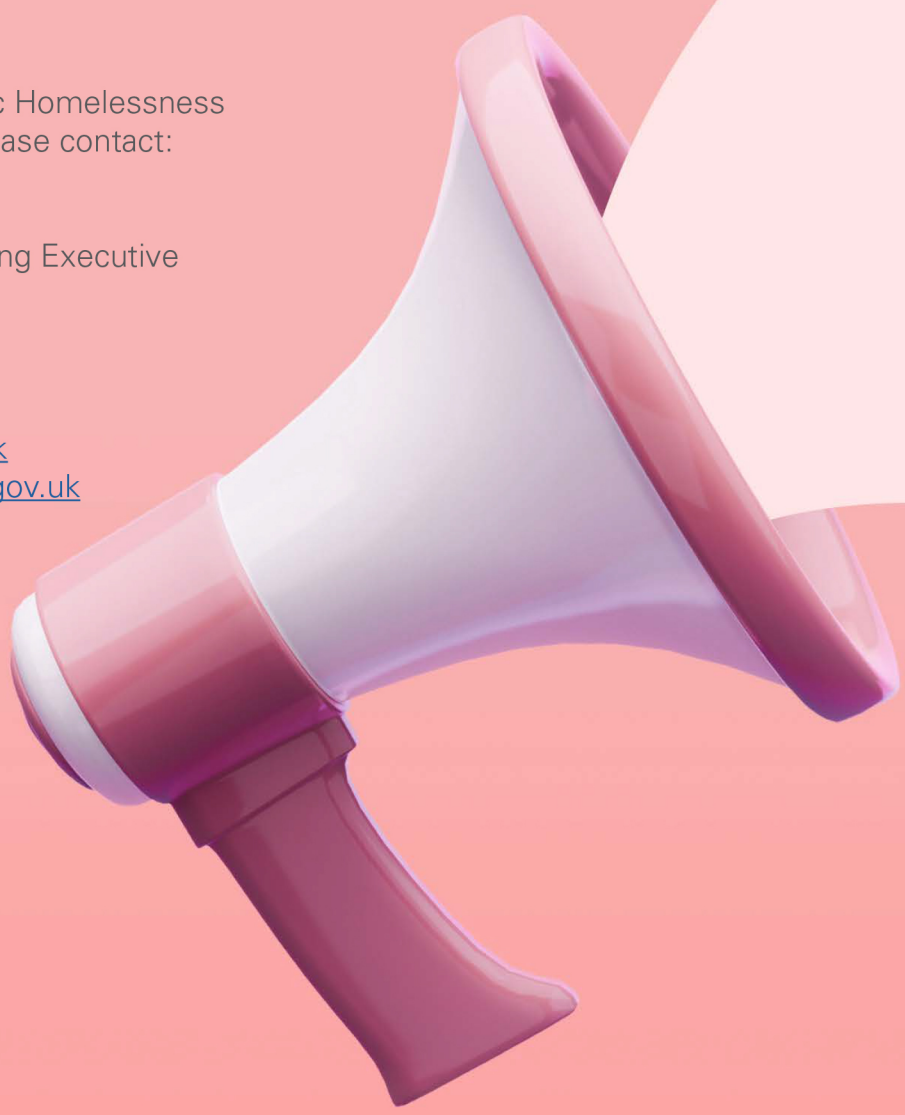
Primary Client Group	Organisation Name	Service Name	Units
Young People	Belfast Central Mission	Riverside Place	12
Single Homeless with Support Needs	Simon Community	41-45 Central Avenue - 1	25
Homeless Families with Support Needs	NIHE	Beaufort West Winds	5
Women at Risk of Domestic Violence	North Down & Ards Women's Aid	7/9 Dufferin Ave	7

This report can be found on the Housing Executive website:
www.nihe.gov.uk

For any information on
The Impacts of Chronic Homelessness
for Women Report, please contact:

Research Unit
Northern Ireland Housing Executive
2 Adelaide Street
Belfast BT2 8PB
Tel: 03448 920 900

Web: www.nihe.gov.uk
Email: research@nihe.gov.uk



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