Department for Levelling Up,
Housing & Communities

Evaluation of the Housing First Pilots

Third Process Report

September 2022
Department for Levelling Up, Housing and Communities

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Foreword

This report provides the latest evidence from the evaluation of the Housing First pilots, building on the previously published first and second interim reports. The pilot programme aims to develop the UK evidence base on delivering Housing First at scale by funding, and robustly evaluating, three pilots in the Greater Manchester, Liverpool and West Midlands combined authority regional areas, with a view to informing future investment decisions. The report sets out key learning and recommendations, at both a central and local level. These findings are centred on the ongoing implementation and sustainability of the pilots along with qualitative outcomes and benefits achieved to date.

To inform this report, ICF conducted a further round of fieldwork in the three Pilot areas comprising qualitative interviews and focus groups with Pilot leads and key staff, provider leads and support workers, local partners and strategic stakeholders. They also conducted in-depth interviews with service users, and analysed Pilot monitoring data and data from the initial baseline surveys. In addition, Homeless Link conducted visits to inform a further review of fidelity to the Housing First principles. This is supplemented by a summary of monitoring information from the pilots and a summary of the baseline data collected for the quantitative evaluation of the programme.

Future elements of this evaluation programme will include further qualitative fieldwork and fidelity reviews, a quantitative evaluation of the programme and a cost benefit analysis.
I would like to thank ICF and their partners for their hard work gathering information from the Pilot areas, the Housing First Delivery Team and Advisers, whose support was critical to the research, the Pilot staff and other stakeholders who participated in the research, and the analysts at DLUHC who provided input to the research materials and reviewed the outputs. Most importantly, I am hugely grateful to the service users who participated for giving us their time and sharing their experiences with us.

DLUHC is committed to continuing to develop its evidence base on the causes of and solutions to homelessness and rough sleeping. Along with the previous Housing First reports it has published initial findings from the analysis of the Rough Sleeping Questionnaire, and regular statistics on Statutory Homelessness in England.

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Executive Summary

Introduction

This is the third interim report of the process evaluation of the Housing First Pilots It. builds on the first and second interim reports and should be read in conjunction with them. This report is based on fieldwork which took place between October 2021 and January 2022.

This report is based on a programme of in-depth qualitative interviews and focus groups with Pilot and provider staff (55 individuals), partners and stakeholders (24 individuals) and Housing First clients (44 individuals) from across the three Pilot areas. The report also draws on the monitoring information produced by each Pilot to the end of November 2021, and the analysis of the characteristics of service users completing a baseline questionnaire in the three Pilot areas.

Numbers housed and supported

At the end of November 2021, **a total of 1,286 individuals** had been referred and accepted onto the Housing First Pilot programme - **including those who had since exited**. A total of 288 individuals had left the programme meaning that at the end of November 2021 **a total of 998 were housed and/or being supported** at that time. The most common reason for exit was loss of contact (58 individuals) followed, sadly by dying while on the programme (55 individuals) reflecting the extremely poor health and susceptibility to premature death of the target population. Of the 738 individuals housed the majority, 64% had been housed between 6 months and two years and three quarters (76%) had been housed for between 6 months and three years. The majority (55%) had been housed in registered provider properties 35% in Local Authority properties, and just 10% in the private rented sector.

Client characteristics

The report provides an analysis of the characteristics of clients from across the three Pilots who had completed a baseline questionnaire. Results illustrate the nature and high level of need of those individuals accessing Housing First. Key characteristics are set out below.

- **Homelessness** - one third had been sleeping rough in the month before being accepted onto HF. Ninety-six per cent reported experiencing rough sleeping previously, 54 % of whom had done so before the age of 25. Many had been homeless for a long time.

- **Employment history and education** - one in five (18 %) had never worked and a further seven in ten (72 %) had not worked in the past year. Half left school before the age of 16, with a further 36 % leaving at 16. Only just over half (54 %) reported having any educational qualifications, including vocational qualifications.

- **Health and well-being -** 61 % reported having a longstanding illness or disability, and 21 % reported having a learning disability. The vast majority of clients self-reported having depression (80 %) or anxiety (79 %). The numbers reporting other mental health conditions were substantial – including around four in ten with trauma

(42 %) or PTSD (40 %) and three in ten with a personality disorder (31 %), psychosis or schizophrenia (31 %). Half reported difficulties with their mental health before the age of 16. Four in ten were prescribed medication for their mental health issues prior to entering Housing First. Many clients reported having multiple mental health conditions, and only 57 % were registered with a GP prior to entering Housing First.

- **Drug and alcohol use -** 71% of individuals reported taking drugs in the previous three months, including heroin or opiates (34 %) and crack cocaine (41 %). Some 33 % described being currently dependant on drugs, 76 % of whom reported becoming dependant before the age of 25. Fewer individuals reported issues with alcohol, although half (49 %) were either currently (16 %) or had previously (33 %) been dependent on alcohol. For a third of these, dependency had begun under the age of 16.

- **Involvement with the criminal justice system** – Three-quarters of respondents reported that they had been a victim of crime in the last six months, most commonly having their belongings stolen (35 %), being threatened (31 %), and being verbally abused (29 %). Three quarters had spent time in prison, although only 16 % had done so in the year prior to recruitment. Over four in ten had antisocial behaviour actions taken against them in the last six months.

Implementation

Referral: At the time of fieldwork referrals into all three Pilots had finished in line with their initial expected end-dates. The quality of referrals was reported to have improved over the lifetime of the programme. Key enablers were: the use of **clear referral criteria** that were well understood by partner agencies; **local multi-agency referral panels** with broad representation from partner agencies and providing the forum for discussion of individual cases and joined up support planning; **multiple and honest conversations with individuals being referred** involving clear explanations of what HF can and cannot offer and being realistic about what a tenancy means in practice; **getting the timing of a referral right** and making use of a 'window of opportunity' to engage with individuals when they were ready to make a change.

Securing properties: Accessing affordable and suitable accommodation continues to be a major challenge across the three Pilots. All three have maintained a focus on building relationships with housing providers and in particular in those areas where there is no access to council owned stock. The willingness of providers to offer tenancies is in part contingent upon their perception of the support to tenants delivered by HF but there is a high degree of variation between providers in terms of their engagement with the programme. Waiting times are also highly variable with some clients housed quickly on referral while others, including those in need of adapted accommodation or wanting to live in specific locations, have had to wait for much longer periods. A key learning point is the need to engage early with housing providers and support the development of housing pathways through establishing service level agreements that set out the level of support available and the steps taken should problems arise.

Maintaining tenancies: The majority of HF clients housed have successfully maintained their tenancies. However, problems do arise that can threaten the stability of a tenancy including HF tenants being either a victim or perpetrator of anti-social behaviour (ASB),

experiencing domestic or financial abuse, having their home ‘cuckooed’, properties being damaged, neighbour disputes, or rent arrears. Solutions can often be found if there is a prompt multi-agency response facilitated by existing good relationships between HF teams and housing providers. Housing provider responses to specific problems were reported to be widely variable with some more amenable to delaying enforcement action than others. The ease with which a client could be transferred to a new property also varied and was in part contingent upon the reason for the move. Hence moves were more likely to be achieved where an individual had been cuckooed than where the tenant had been involved in anti-social behaviour.

Delivering support. Following an intense period of support on moving in to a new tenancy the nature and intensity of on- going support provided is contingent upon the needs of individual clients. Many continue to require intensive support with access to healthcare over a prolonged time period. Helping clients establish new social networks, rebuild relationships with families, re-engage with pre-existing or develop new hobbies and interests, and establish community links are key to fostering stability and promoting independence. There was a strong consensus amongst interviewees at all levels that the majority of clients would need support for prolonged periods of time given the complexity of their needs and fact that recovery and behaviour change for the target population is typically slow and non-linear.

Working with other agencies: As in previous fieldwork there was a strong consensus that effective communication and joint working are key to finding solutions to problems and in ensuring that responsibility for care is ‘owned’ and where appropriate shared. Multi-disciplinary team (MDT) meetings where individual cases are reviewed, and support plans agreed are a feature of all three Pilots. However, degrees of engagement continue to differ between agencies with particular difficulties experienced in negotiating access to mental health services. Across all three Pilots the need for system change to overcome access barriers was discussed both with respect to mental health services and access to appropriate community-based drug and alcohol services.

Recruiting, supporting, and retaining staff: Staff recruitment has been ongoing in the Pilots to build capacity as service user numbers have increased and to replace support workers lost to attrition. Values as well as skills and experience are important considerations in recruiting front-line staff. The demands placed on support workers underline the critical importance of supporting staff both professionally and emotionally. Support workers described the role as rewarding but described challenges and impacts on their own well-being of working with people with experience of trauma and complex needs. These challenges have been compounded by the restrictions resulting from the pandemic that have left some staff feeling isolated and missing the contact with peers that they had valued. The uncertainty over funding had also had a negative impact on staff well-being in some areas. The intensity and type of support available to staff differed across providers although reflective practice sessions were offered to staff in all three Pilots and where taken up this was greatly appreciated.

Working to the HF principles: A number of key challenges to delivering on fidelity were highlighted, including most notably the limited availability of appropriate housing stock, staff shortages, and uncertainties over longer-term funding. These rendered some principles more challenging to operationalise than others. The commitment to *long-term flexible support* was described as particularly difficult to implement given the prevailing uncertainty around funding. The issue of caseload size was central to discussions of

fidelity. In areas where caseloads had been exceeded, support workers reported being unable to deliver the intensity and flexibility of support previously offered. Two of the three Pilots undertake fidelity self-assessments. These score highly on separation *of housing and support* and the *use of an active engagement approach.* A *strengths-based orientation* was also commonly identified as strongly shaping the Pilots' day-to-day delivery. Delivering on *a right to a home* and *choice and control* was described as challenging in the context of a shortage of suitable housing meaning that there was a balance to be struck between on the issue of choice and control, wherein frontline workers needed to have 'realistic conversations' with clients regarding the availability of properties and any potential risks associated with different options. The ability of staff to promote a *harm reduction approach* is compromised by barriers in access to mental health services and to a lesser extent drug/alcohol provision, especially where service users were dually diagnosed.

Client experiences

In this round of fieldwork, a total of 44 participant interviews were carried out across the three Pilots with individuals who had received support from between four months to over three years. Most had been homeless at the point of acceptance onto HF. A minority had had no experience of rough sleeping. Almost all participants disclosed multiple areas where they required support. Including:

- Diagnosed or suspected/undiagnosed mental health conditions.
- Substance misuse: alcohol, crack and heroin being the most common.
- Offending.
- Chronic physical health issues.
- Family and relationship breakdown.
- Adverse childhood experiences, time spent in the care system, and trauma.

Initial engagement and perceptions of Housing First: Experiences of initial engagement differed among interviewees often due to the degree to which they were using drugs and/or alcohol at the time. Relationships between support staff and service users were described as mostly positive and trust was built using various methods in a service user-focused way. Across the three Pilots, participants observed that the commitment and effectiveness of their workers' actions brought results from the outset, and this had supported their continued engagement.

Finding a property and moving in: The process from initial engagement to moving into a tenancy varied considerably for individuals in all three Pilots. Some participants reported being able to move in within 8 weeks while others were not matched with a property for 12 months. Interviewees all felt they were given a degree of choice when finding a property and were able to refuse unsuitable properties. Interim accommodation was provided to most of the interviewees. A minority of those interviewed had elected to sleep rough rather than accept an offer of temporary accommodation, due to traumatic experiences in hostels/supported accommodation. A key theme across all three Pilots was the intensity of assistance provided by HF when the participants first moved in, including:

- Practical support, such as acquiring white goods and furniture.
- Benefits applications.
- Emotional support.
- Support accessing other services/activities.

Sustaining the tenancy Support to sustain the tenancy across the three regions was holistic and service-user lead. Many interviewees receive support by phone, alongside face-to-face visits. Broadly, participants felt supported to access help, but not pressured into it. Many of the interviewees had taken up the offer of substance misuse support, frequently with methadone/Subutex, and maintaining sobriety in their new home. The value of the therapeutic aspect of the relationship between service user and support worker was emphasised as well as the practical support interviewees had received.

Experiences of support Service users witnessed promises being fulfilled and support being delivered in a way, and pace, that worked for them. Accounts of being able to open up for the first time, were common and the positive impact on well-being described. Openness, honesty, and transparency, as well as rapport building were all key to participants' positive experiences with HF support staff. Non-conditionality and 'stickability' of the support offer appeared to be crucial. Knowing that someone was there for them no matter what the situation was a significant factor contributing to the quality of relationship between individuals and HF. Interviewees reported that their support workers made an effort to listen to and understand them, while also helping participants to tackle things which they found challenging.

Consistency of support worker Not all interviewees had the same support worker from the start, with two having had five different support workers within 2.5 - 3 years. In situations when service users requested a change of a support worker, this was felt to have been handled quickly and respectfully by HF. Having a 'second' main worker was valuable and reassuring to some of the service users during times when they needed extra support, or their 'main' worker was on leave. Shared life experience was something which service users valued about their support workers.

Frequency of contact Participants felt that the frequency and type of contact with support workers was on the right level, and that they were able to decide the type and frequency. Increased support and contact usually took place during times of crisis or difficult periods, but also when interviewees request extra assistance with things like appointments.

Ongoing support Satisfaction with ongoing support was almost uniformly expressed by interviewees who reflected on the 'distance travelled' and the changes in their lives. Some reflected that they did not feel the need to work with other services to progress on their path of recovery, because of HF intervention. None reported feeling pressured to seek other services if it was something they did not want or feel ready for. Participants described receiving support with different aspects of managing a tenancy. Areas commonly identified as problematic included making and keeping appointments, paying bills, managing phone calls and finances, safety issues due to antisocial activity in the area, property damage or cuckooing. Settled participants gave accounts of greater focus on areas such as social integration, ability to work towards their aspirations and future plans, as well as engaging in former interests. Reconnecting with family members,

especially children, scored high on the list of achievements for interviewees who considered HF support as a catalyst.

Reflections on Housing First and reported benefits All participants across the three Pilots shared positive reflections of HF. Some participants reported they were referred to HF through services they received at the time and had trust in their support worker at said service/s, leading them to approach HF with an open mind. However, many participants reported that their experience HF was qualitatively different to other homelessness services they had accessed throughout their time in "the system". This often hinged on the intensity and nature of support received, and the genuine effort HF put into acquiring a property for participants. Participants gave a multitude of examples, general and personal, when asked about the benefits of being on HF. The most highly reported benefits were being offered the opportunity to accept a tenancy in an area chosen by the participant, and the level of flexible, ongoing support received.

Other benefits commonly included:

- Getting assessments, support, and treatment for mental/physical health conditions.
- Substance misuse support.
- Benefits applications/support.
- Moral and emotional support.
- Help with budgeting, accessing funds and grants/food banks.
- Help in finding meaningful activities.

Next steps Some participants were anxious about the possibility that HF support would end in the near future. Participants who rely heavily on HF for help with engagement with statutory services were particularly worried. In these cases, service users were very worried that without a HF worker advocating for them, other services would no longer provide the support that they needed and that this would jeopardise their tenancy. No participants expressed any desire to return to rough sleeping, and several were enthusiastic about their plans for the future, including employment, education, and volunteering.

Outcomes and benefits

Interviewees provided evidence of clients experiencing positive impacts across the full range of outcomes typically measured for HF programmes (e.g., housing retention, substance misuse, health, criminal activity, social support etc.). What was notable in these accounts was the 'distance of travel' experienced by these clients many of whom had been homeless for long periods of time due to a combination of childhood trauma and other adverse life events. For some these outcomes were experienced as life changing. Significant benefits that could not be captured by traditional outcomes measures were also reported including for example celebrating a birthday with a cake for the first time ever and learning to ride a bike. There were also outcomes for the homelessness sector overall. First and foremost, HF was recognised as providing a solution for individuals with multiple and complex needs who had been known to services for long periods of time and for

whom solutions had been wanting. Furthermore, there was evidence that HF had improved awareness amongst service providers of the needs of the experiences and needs of homeless people and contributing to heightened understandings of the value of working in more person-centred, flexible and trauma informed ways.

Looking ahead and sustainability

At the time of writing this report stakeholders' primary concern was the uncertainty of funding to support existing clients and, by extension, implications for the long-term sustainability of (these and other) HF programmes in England. This was anxiety-provoking for both service users and staff at the point of fieldwork in areas where the Pilot end-date was imminent. Uncertainty had impacted on staff retention and the willingness of housing providers to offer properties to HF clients with knock on effects on the ability of providers to adhere to some of the HF principles. Frontline staff expressed considerable anxiety about the possibility of 'abandoning' and potentially (re-)traumatising clients should HF support end. This highlights a critical imperative for stakeholders within the homelessness sector, including central and regional governments, to consider what open-ended support 'looks like' practically in terms of procurement as HF programmes are scaled up.

Conclusions

By the end of November 2021, the HF Pilots were supporting 998 individuals - 78% of whom were housed. The majority had sustained their tenancies with nearly half (48%) having done so for between one and three years. The vast majority continued to require support with only a very small number (32 individuals) 'graduating' from the service. Besides housing outcomes stakeholder accounts provide evidence of a range of other outcomes including reduced substance use, better health and increased social integration as well as outcomes that are difficult to quantify but nonetheless very important.

Key learning points from the process evaluation fieldwork include the following:

- *Commissioning and monitoring:* variability in the scale, characteristics and needs of the target group and nature of the local housing portfolio should be borne in mind when planning and commissioning local HF service. Commissioning HF from an external provider facilitates integration into the local mosaic of homelessness and other services locally which supports local ownership and buy-in. Including healthcare specialists within HF partnerships helps overcome some of the barriers to access to healthcare experienced by HF clients.

- *Fidelity to principles:* Key challenges to adhering to the key principles of HF have included the limited availability of appropriate housing stock, staff shortages, and uncertainties over longer-term funding. The commitment to long-term flexible support is challenging given the current short-term contract culture. Small caseloads need to be protected to avoid support delivery becoming reactive and 'crisis-focussed'.

- *Recruiting and supporting staff:* Consideration of both values and professional experience are important when recruiting HF staff. Adequate and appropriate support for front-line staff is critical and reflective practice invaluable. High

caseloads can have a detrimental effect on staff members' health and wellbeing, leading to a high level of stress-related absence and limiting the capacity of staff to engage in activities aimed at promoting their wellbeing.

- *Supporting service users:* Honesty with clients over the potential time taken to secure a property is important to maintain trust and engagement. Support workers need to capitalise on 'windows of opportunity' to engage clients. The time immediately following a move into a new tenancy represents a key opportunity to discuss goals and interests and support community integration and avoid social isolation.

- *Working with other agencies:* It is important to establish robust service level agreements with housing providers from the beginning that set out clearly the type and level of support provided by HF staff and the steps that would be taken should problems with a tenancy arise. These should ideally include an agreed pathway for rehousing tenants when a move is necessary.

- *Sustainability:* There is a need for a longer-term commitment to funding for HF. There is an appetite for the monitoring of fidelity to HF principles as the approach is scaled up nationally to avoid programme dilution. The preservation of low caseloads will be essential. Broad systems change is needed if the barriers to healthcare affecting HF's clientele are to be addressed sustainably going forward.

1. Introduction

This report is the third interim report of the process evaluation of the Housing First Pilots, with the process evaluation being one of the three main 'strands' of the evaluation alongside an impact evaluation and cost benefit analysis.

It is based on a programme of in-depth qualitative interviews with Pilot staff, partners, strategic stakeholders, and clients; the review of Pilot monitoring information to the end of November 2021; and an analysis of service user characteristics for those individuals who have completed a baseline questionnaire across the three Pilot areas. It documents developments, achievements, and key learning since the previous round of fieldwork which was conducted approximately one year earlier. It builds upon the content of previous interim evaluation outputs and should be read in conjunction with these.

Overview and update of the three Housing First Pilots

Greater Manchester Combined Authority Housing First (GMHF)

The GMHF Pilot covers the ten local authorities of Manchester, Bolton, Bury, Rochdale, Stockport, Oldham, Tameside, Salford, Trafford, and Wigan, and is delivered by a consortium of seven partners led by Great Places Housing Group and endorsed by the Greater Manchester Housing Partnership (GMHP). A central Combined Authority contract management team and a lead provider were jointly responsible for subcontracting arrangements with other 'end-to-end' and specialist service providers. The region was divided into four zones, and the first service users were recruited and housed in March 2019. The Pilot has a co-production group of people with lived experience of homelessness and had benefited from previous experience of delivering Housing First in the region. Key features of the GMHF Pilot include efforts to ensure consistency across the local authorities through the development of the GMHF brand, a central team, common job specifications and pay rates, shared training, a Quality Assurance framework, and standardised referral criteria. The Pilot also benefits from the inclusion of specialist mental health input which has recently been enhanced to include four Dual Diagnosis Practitioners (DDP) and a 0.2 FTE consultant clinical psychiatrist.

Liverpool City Region Combined Authority (LCRCA)

The LCRCA covers the six local authorities of Liverpool, Sefton, St Helens, Wirral, Halton, and Knowsley. The Pilot followed a 'test and learn' approach to early delivery, recruiting a team of support workers and team leaders in Spring/Summer 2019 and the first cohort of service users by the end October 2019. LCRCA operated on an 'all region' basis during the test and learn stage, which was found to cause logistical and efficiency challenges. In 2020 the decision was made to adopt a locality model delivered internally rather than commissioned out as originally intended. There are now six teams (two covering Liverpool, and a shared team for Knowsley and Halton) comprising support workers and a team leader, working as a single unit with their own caseloads, and with a shift system to enable out of hours coverage. A central team that includes a Lived Experience Lead, two Operations and Lettings leads (one strategic and one operational), a Commissioning lead, and Best Practice and Partnership lead work to ensure consistency and fidelity of

approach through a Quality Assurance framework and common recruitment, induction, and training processes. LCRCA also have a lived experience group who have played an active role in staff recruitment and developing and reviewing policies and procedures.

West Midlands Combined Authority (WMCA)

The WMCA covers the seven local authorities of Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, and Wolverhampton, with Birmingham City Council acting as the accountable body. Each local authority commissioned their Housing First services separately, with Birmingham Voluntary Service Council (BVSC) contracted to support the process through the development of a common service specification and job descriptions for support workers. The Pilot followed a strengths-based approach, underpinned by psychologically informed environments (PIE). Since the launch of the Pilot there has been some recommissioning of services in Birmingham and at the time of fieldwork for this report two local authorities (Dudley and Sandwell) were delivering in-house and four through externally commissioned providers and one through a combination of the local ALMO[1] and an externally commissioned support provider. The first service users were recruited and housed in January 2019 through an early adopter pilot, with three local authorities benefiting from early experiences of Housing First delivery as early adopters or as a self-funded service. The local commissioning model and the subsequent range of delivery approaches is unique among the three Pilots.

Context for the process evaluation

The evaluation fieldwork on which this report is based was undertaken between October and December 2021. At this time there was considerable uncertainty over the potential for future funding for the Pilots with funding formally scheduled to end in March 2022 in Greater Manchester, August 2022 in LCRCA, and March 2023 in the West Midlands, in line with their three plus two years funding model. Given the funding position at the time of fieldwork, stakeholders in all Pilots were concerned about the future sustainably of their programmes and extensive effort had been made by all three in planning for different future scenarios. Concerns over sustainability and the impact of funding uncertainty at this timepoint are therefore reflected in this report.

Following the completion of fieldwork, the combined authorities were informed of the opportunity to bid for two years additional funding via the Rough Sleeping Initiative (RSI) programme and at the time of writing bids were being moderated with allocations to be announced in the near future. This will have ameliorated, to some extent, worries about the ability of the Pilots to continue to support service users in the medium-term, albeit that uncertainty in the intervening period has been highly disruptive to service planning and delivery. The impact of any additional funding and revised plans for sustainability will be explored in the fourth and final round of fieldwork now scheduled for October 2022.

Methodology

This report is based on a programme of in-depth qualitative interviews and focus groups with Pilot staff, partners, strategic stakeholders, and a sample of HF clients in each Pilot

[1] Arms-length management organisation responsible for the management of council owned housing stock.

area. In addition, the report draws on the monthly monitoring information (MI) produced by each Pilot to the end of November 2021. The report also includes a profile of the total number of service users who have been baselined across the three Pilot areas.

Qualitative interviews and focus groups took place with the following stakeholders:

Pilot and provider staff – reflecting local management and service delivery arrangements. Interviews took place with Pilot and provider leads; staff with key responsibilities for operations, securing properties etc; support workers/navigators and team leaders. The interviews were undertaken online due to ongoing face-to-face contact restrictions, and took place either individually or, in the case of the support workers, as online focus groups. **Total across the three Pilots = 55**

Partners and stakeholders – in each area a sample of Pilot partners and wider stakeholders were interviewed to reflect local partnership arrangements, and included consultations with representatives of local authorities, housing providers, and external statutory and third sector providers. **Total across the three Pilots = 24**

Pilot participants/clients – qualitative interviews with a sample of HF clients in each Pilot area including follow up interviews with a small number who had been interviewed for the last round of fieldwork. The majority of interviews were undertaken by telephone/online with a minority done face-to-face in line with the preferences of participating individuals. **Total across the three Pilots = 44**

Draft fieldwork tools were developed for each interview group and signed off by DLUHC in advance. For the participant interviews, individuals with lived experience were involved in co-designing the topic guide. Finally, given the nature of the contractual and delivery model followed in the West Midlands, each round of process fieldwork focuses on different local authority areas although Birmingham is included in each round given its size and the number of service users supported there. In addition to Birmingham, fieldwork for this report was focused on the Dudley, Solihull, and Walsall WMCA local authority areas.

Structure of the report

The remainder of this report is structured as follows:

- **Section 2** presents an analysis of Pilot MI until the end November 2021to show progress in terms of numbers of clients recruited and housed and the duration of tenancies.

- **Section 3** provides an analysis of client characteristics based on data collected in baseline interviews.

- **Section 4** examines the day-to-day implementation of Housing First drawing on qualitative data collected through interviews with pilot and provider staff, partners, and strategic stakeholders.

- **Section 5** draws on the series of qualitative interviews with clients to present their experiences and perspectives of engaging with Housing First.

- **Section 6** examines the evidence for outcomes and benefits for clients and organisations.
- **Section 7** explores questions of sustainability; and
- **Section 8** presents a series of conclusions and key learning points.

The report is supported by an appendix that contains a summary report of the fourth fidelity assessment undertaken by Homeless Link between September 2021 and December 2021.

2. Numbers housed and supported

This section draws on the monthly monitoring information (MI) submitted by the Pilots to review their achievements to the end of November 2021, in terms of:

- The number of service users recruited and the numbers exiting.
- The number of service users housed, leaving their accommodation and the duration of their tenancies and;
- Properties accessed by housing type.

Individuals recruited and exiting the programme

Pilots are required to submit monthly monitoring data to DLUHC. This data includes individuals currently housed, accepted onto the programme but not yet housed and total numbers recruited and housed both formally and currently. Data also specifies the reasons for programme exit.

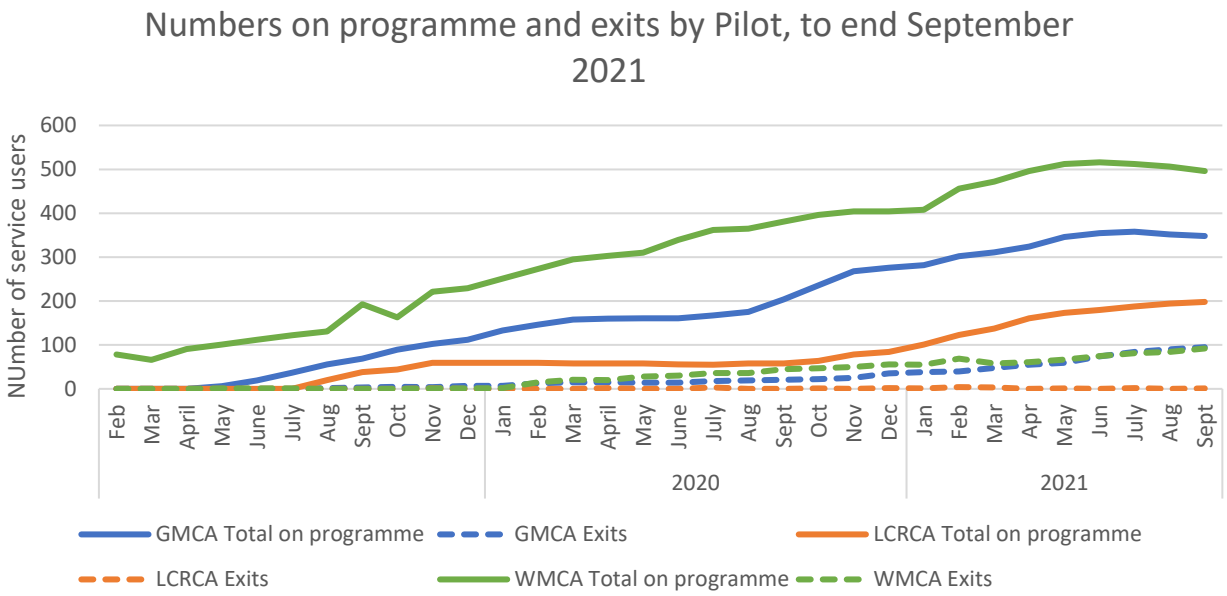
At the end of November 2021, **a total of 1,286 individuals** had been referred and accepted onto the Housing First Pilot programme **- including those who had exited**. This was distributed by Pilot as follows:

- GMHF – 443 individuals against a target of 373.
- LCRCA – 237 against a target of 216; and
- West Midlands – 606 against a target of 500.

Over the same period a total of 288 individuals left the three Pilots, which represented 22% of all those recruited over the same period. At the individual Pilot level, 96 had exited the GM Pilot (22% of all those recruited over the same period), 28 exited the LCRCA Pilot (12% of all recruits), and 155 exited the West Midlands Pilot (25% of all recruits). This means that at the end of November 2021 **a total of 998 were housed and/or being supported** at that time.

Figure 2.1 shows recruitment to the programme and the numbers exiting per month by each of the three Pilots.

Figure 2.1: Numbers on programme and exits by Pilot, to end November 2021



Data submitted by the Pilots includes the main reasons why service users had left their HF programmes, summarised in Table 2.1 for the programme overall and by Pilot (see below). Sadly, service users dying whilst on the programme is the second most frequently reported reason for exit after loss of contact, underlining the fact that the target population's often extremely poor health and susceptibility to premature death[2] does not cease upon receipt of Housing First. It is notable that the number of graduations from the programme is very small – less than 3% of the total number of people accepted onto the HF programme across the three Pilots. This underscores the fact that the majority of HF service users will need support for longer than the three years that the Pilots were originally funded for.

[2] Aldridge, R. et al. (2018) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis, *Lancet*, 391: 241-250.

Table 2.1. Reasons for exiting the programme by Pilot

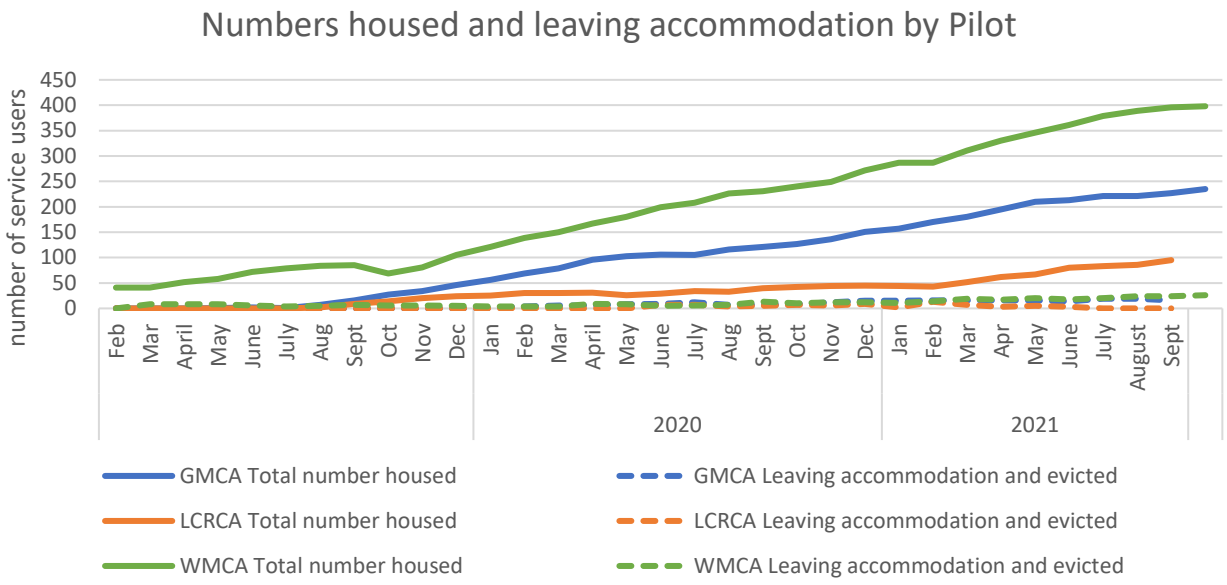
Reason for Exiting	GMHF	LCRCA	WMCA	Total
Lost contact	22	1	35	**58 (4.5%)[3]**
Dying whilst on the programme	21	10	24	**55 (4%)**
Entering alternative accommodation	11	2	22	**35 (3%)**
Moving away from the area	10	3	22	**35 (3%)**
Withdrawing consent	20	2	12	**34 (3%)**
Graduations	3	3	26	**32 (2.5%)**
Imprisoned[4]	9	6	7	**22 (2%)**
In hospital/detox[5]	9	1	7	**17 (1%)**
Total number exiting the programme	**96**	**28**	**155**	**279 (22%)**

Numbers housed and exiting tenancies

Across the three Pilots, a total of 738 individuals were housed in independent tenancies at the end of November 2021, representing 57% of all those recruited by the Pilots and 74% of those remaining on the programme at that time. Figure 2.2 charts the numbers housed and leaving their accommodation or being evicted per month by Pilot.

[3] Percentages are of the total number of HF clients recruited to the programme
[4] N.b, There will also be number of service users in prison at any timepoint who will not have left the programme
[5] N.b As above there will also be a number of service users in hospital/detox who will not have left the programme

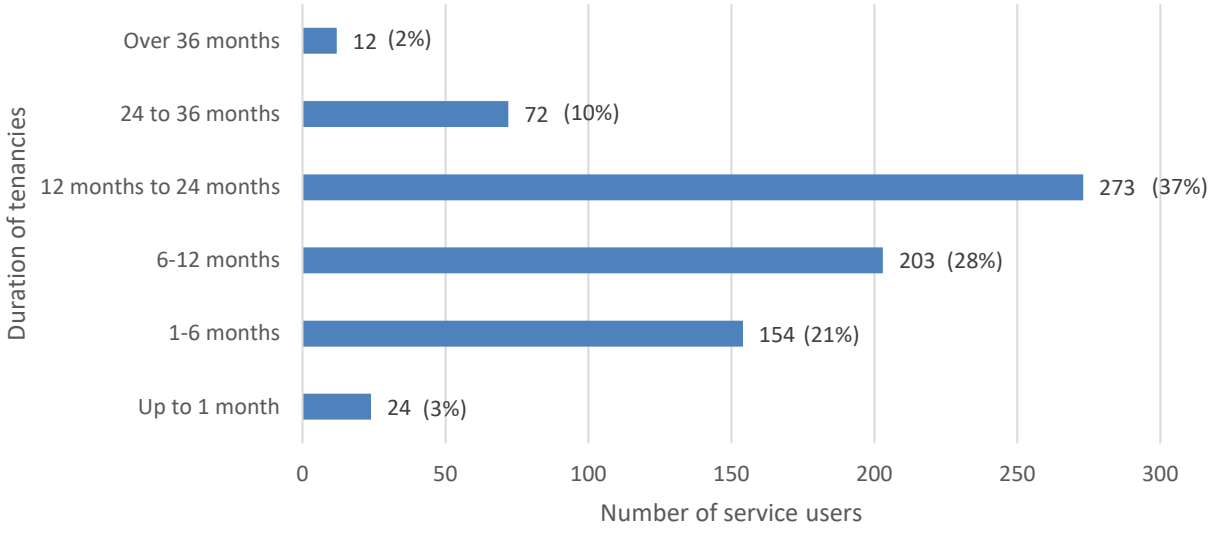
Figure 2.2. Numbers housed and leaving accommodation by Pilot



Tenancy sustainment

Figure 2.3 shows the length of time that current tenants had been accommodated across the three Pilots at the end of November 2021. Care should be taken in interpreting both the share of service users housed and the duration of their accommodation, as they represent flow measures which can be expected to change once remaining service users are housed and others sustain their tenancies for longer going forward.

Figure 2.3: Duration of tenancies - all Pilots, at end November 2021



Of the 738 people housed at the end of November the majority, 64% had been housed between 6 months and two years and three quarters (76%) had been housed for between 6 months and three years. The duration of tenancies amongst service users in each Pilot area is shown in Table 2.2 below.

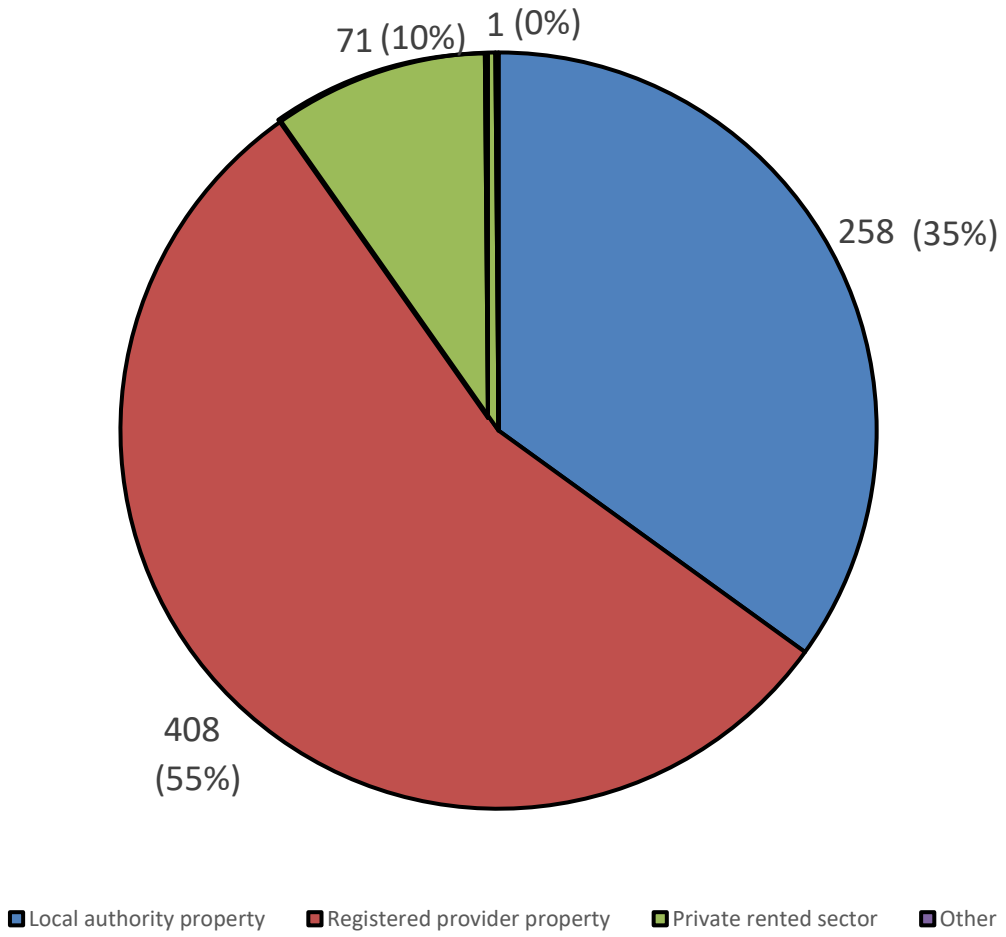
Table 2.2: Duration of tenancy at end November 2021 by Pilot area

Duration	GMHF	LCRCA	WMCA	Total
Up to 1 month	8	10	6	**24 (3%)**
1-6 months	48	24	82	**154 (21%)**
6-12 months	68	37	98	**203 (27.5%)**
1-2 years	94	27	152	**273 (37%)**
2-3 years	28	7	37	**72 (10%)**
Over 3 years	0	0	12	**12 (1.5%)**
Total number housed	246	105	387	**738**

Accommodation by property type

The different types of property sourced to accommodate service users varies between the Pilots, reflecting the nature of the housing stock available in their areas. Figure 2.4 shows the distribution of properties by type for individuals housed at the end of November 2021. The chart highlights the dominance of registered provider properties (which account for 408 or 55% of all properties secured to date) followed by local authority properties (258 or 35%). Only a small number of properties had been secured in the private rented sector (just 71 or 10% of all properties secured).

Figure 2.4: Accommodation by property type, to end November 2021



There are variations however between Pilot areas in the type of property secured. The most marked amongst these is in the difference between the numbers housed in local authority properties within WMCA compared to the other two Pilots. This reflects the access that some providers have to council-owned stock – including in Birmingham which is the largest local authority within the combined authority area. In summary:

Property type	GMHF	LCRCA	WMCA
Registered Provider	197 (80%)	100 (95%)	111 (29%)
Local Authority	30 (12%)	0	228 (59%)
Private Rented Sector	19 (8%)	5 (5%)	47 (12%)
Total number housed	246	105	387

3. Profile of the Housing First clients

This section provides a profile of 312 clients accepted onto Housing First across the three Pilots by November 2021 and completed a baseline questionnaire. The baseline questionnaire recorded their characteristics and circumstances at the point at which they began to receive support from Housing First. Their circumstances and life experiences highlight the high level of complex needs of those coming into Housing First.

After providing a few demographic statistics, this section provides a picture of Housing First clients prior to entering Housing First in terms of:

- Their experiences of homelessness, both more recently and during their lives.
- The extent to which they had a social support network on which to rely.
- Their employment history and educational qualifications.
- Their health, including their mental health and learning disabilities.
- Their use of drugs and alcohol, both more recently and during their lives.
- Their recent experiences as victims of crime.
- Their contact with the criminal justice system, both recently and during their lives.

The 312 clients included 157 from the GMHF, 89 from the WMCA and 66 from Liverpool. In the tables below, they have been weighted to reflect the proportion of clients supported by each of the three Pilots.[6]

Throughout this section, where there are fewer than three clients in any particular subgroup (e.g., an ethnic group category; clients taking a particular substance), subgroups have been omitted from the figures or combined to minimise any risk to the identity of the client.

Demographics

Although respondents covered a wide age range, most were between 30 and 39 (36 %) or 40 to 49 (35 %). Three in ten (29 % of) clients were women and nine in ten (88 %) identified as heterosexual or straight.

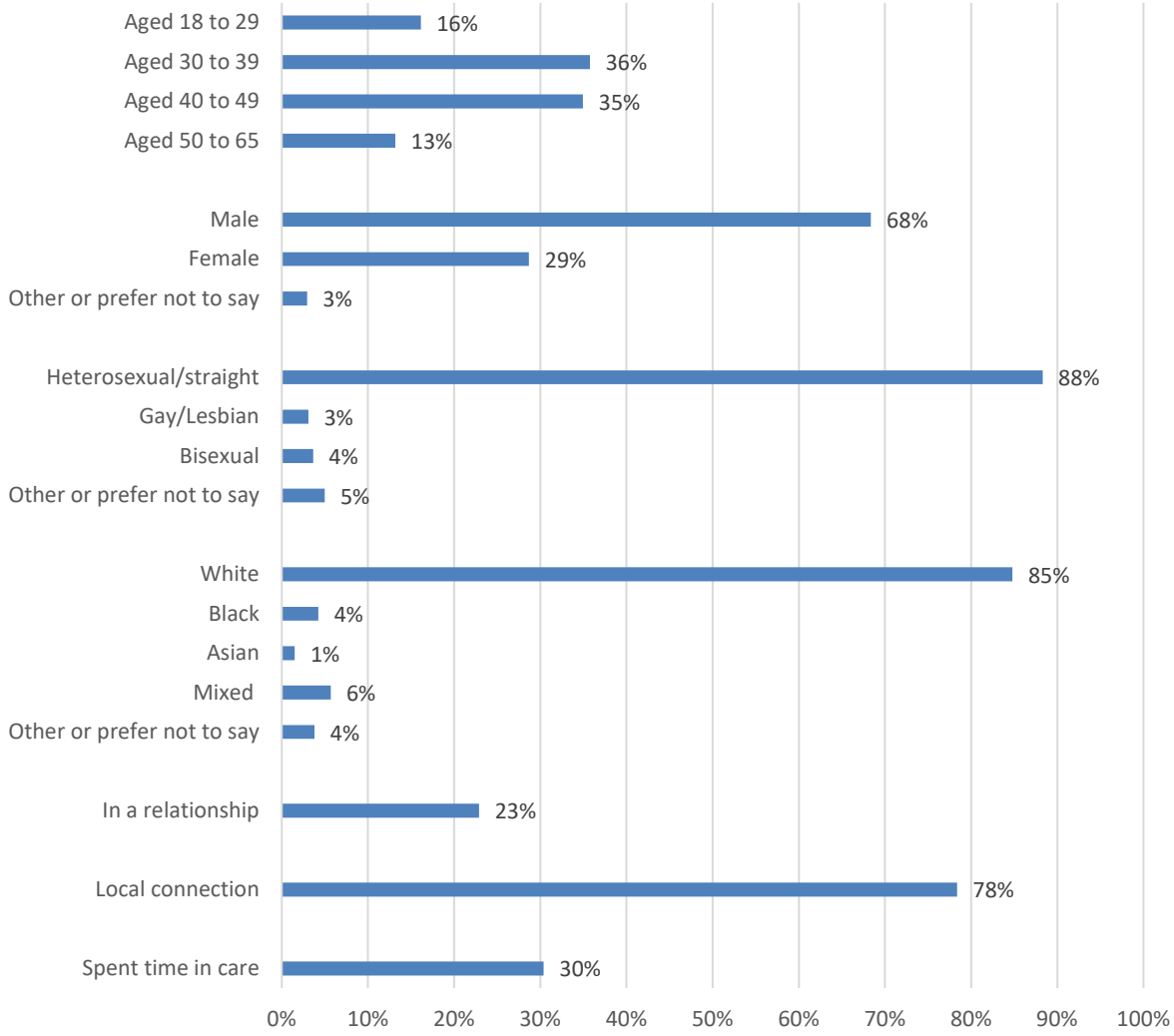
The substantial majority of clients (85 %) were White. Four per cent were Black, one per cent were Asian, and six per cent were from mixed backgrounds.

A quarter (23 %) of clients were currently in a relationship and eight in ten (78 %) said that they had a local connection to the area.

[6] The WMCA accounted for 47 % of the clients coming into Housing First; the GMHF accounted for 34 %; with remaining 18 % in Liverpool.

Previous experience of care was common: three in ten (30 %) of those entering Housing First had been in care during their childhood or early adulthood (Figure 3.1).

Figure 3.1: Demographics of respondents



Base: Housing First client respondents (312)

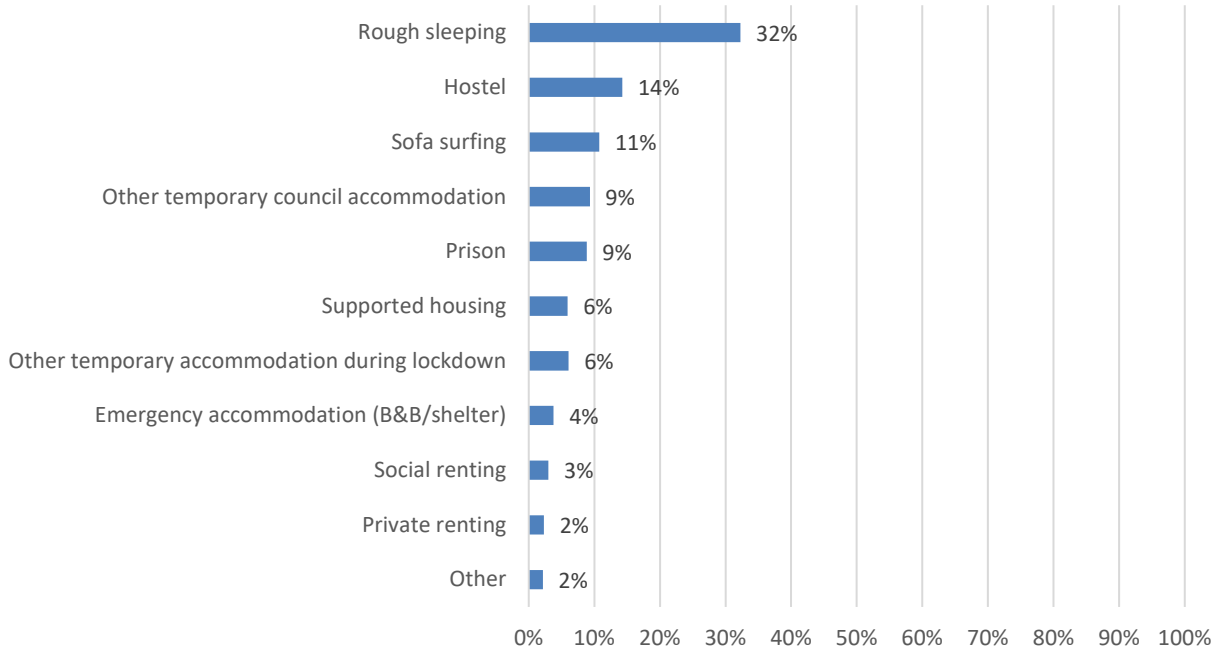
Experience of homelessness

A third (32 %) of respondents had been sleeping rough for most of the month prior to entering Housing First, and a further 11 % had been sofa surfing with family or friends.

Fourteen % had been in a hostel, four % had been in emergency accommodation, and 15 % had been in temporary accommodation arranged by the council (nine %) or arranged during lockdown (six %) in the month before entering Housing First.

Six % had been in supported housing, three % had been in social housing and two % had private rented accommodation for most of the previous month (Figure 3.2).

Figure 3.2: Main accommodation in previous month

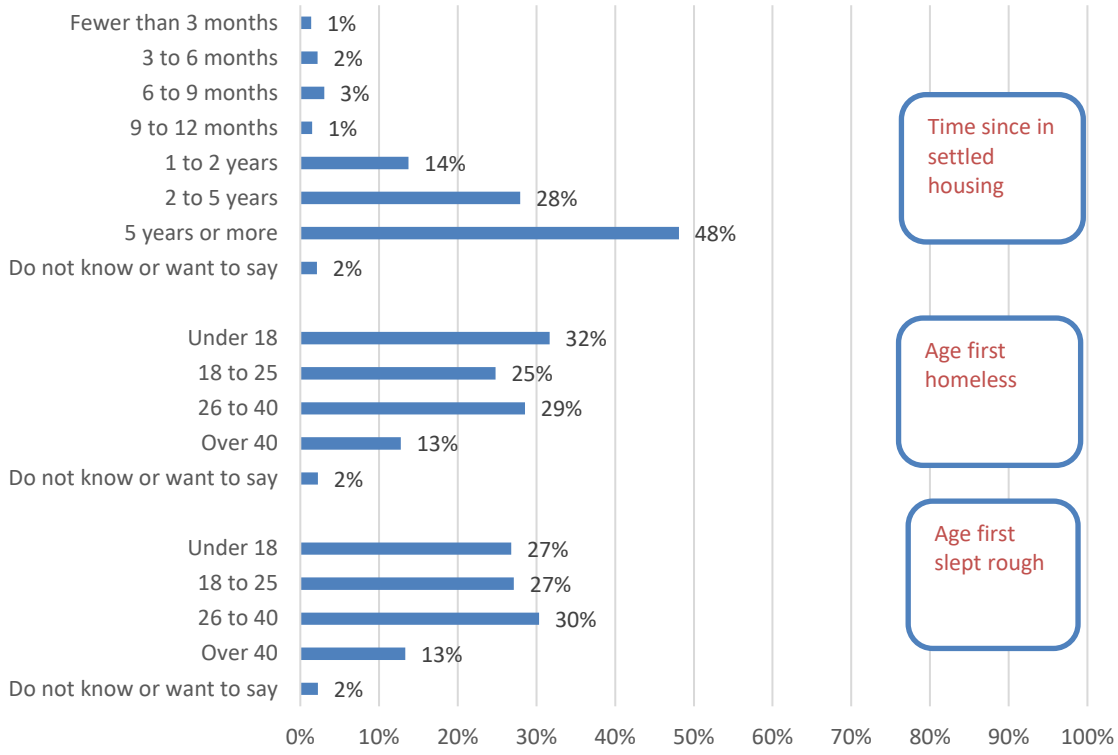


Base: Housing First client respondents (312)

The vast majority (91 %) of respondents had experience of rough sleeping: a quarter (27 %) of these clients had been rough sleeping before the age of 18, with a further quarter (27 %) first experiencing it as a young adult (between 18 and 25).

Many of the respondents had been homeless for a large number of years. Among those not in settled housing in the month before they came into Housing First, three in ten (28 %) had not been in settled housing for between two and five years and half (48 %) had not been for five years or more (Figure 3.3).

Figure 3.3: Experience of homelessness and rough sleeping



Bases:

Time since secure housing: all those not in settled accommodation in month before offered Housing First (257)

Age first homeless: all those spent time without settled accommodation (302)

Age slept rough: all who ever slept rough (285)

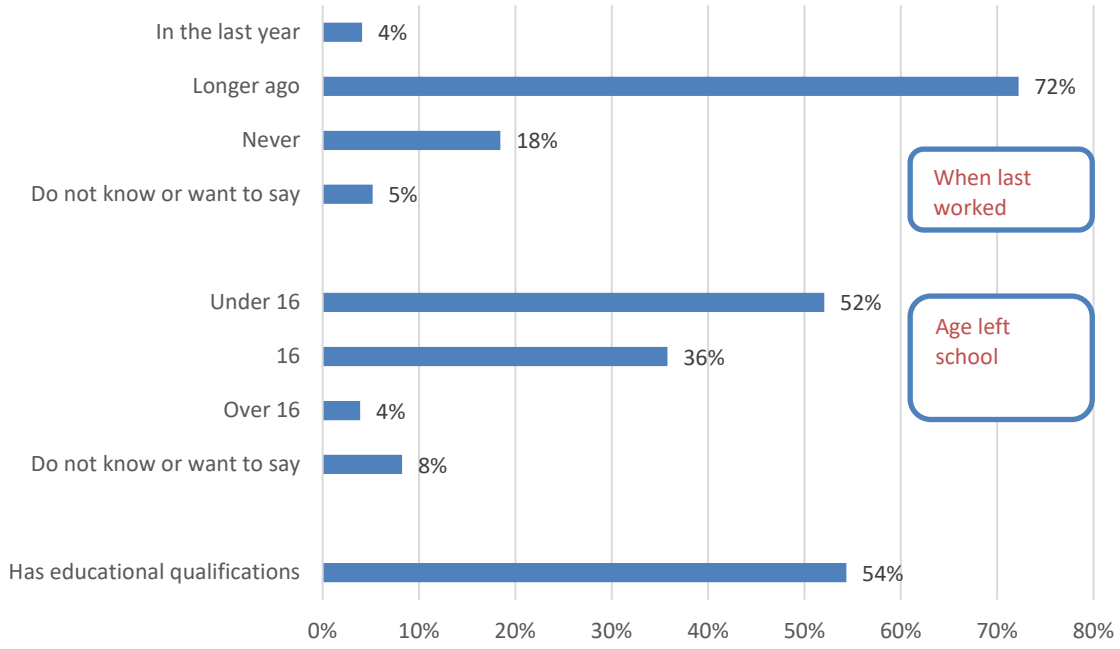
Employment history and education levels

Most respondents were a long way from the job market at the point of recruitment to Housing First, with one in five (18 %) never having worked and a further seven in ten (72 %) not having worked in the past year.

Half (52 %) left school before the age of 16, with a further 36 % leaving at 16. Only just over half (54 %) of Housing First clients reported having any educational qualifications, including vocational qualifications Figure 3.4)[7].

[7] Respondents were asked if they had any qualification with a free text response if responding 'yes'.

Figure 3.4: Employment history and education



Base: Housing First client respondents (312)

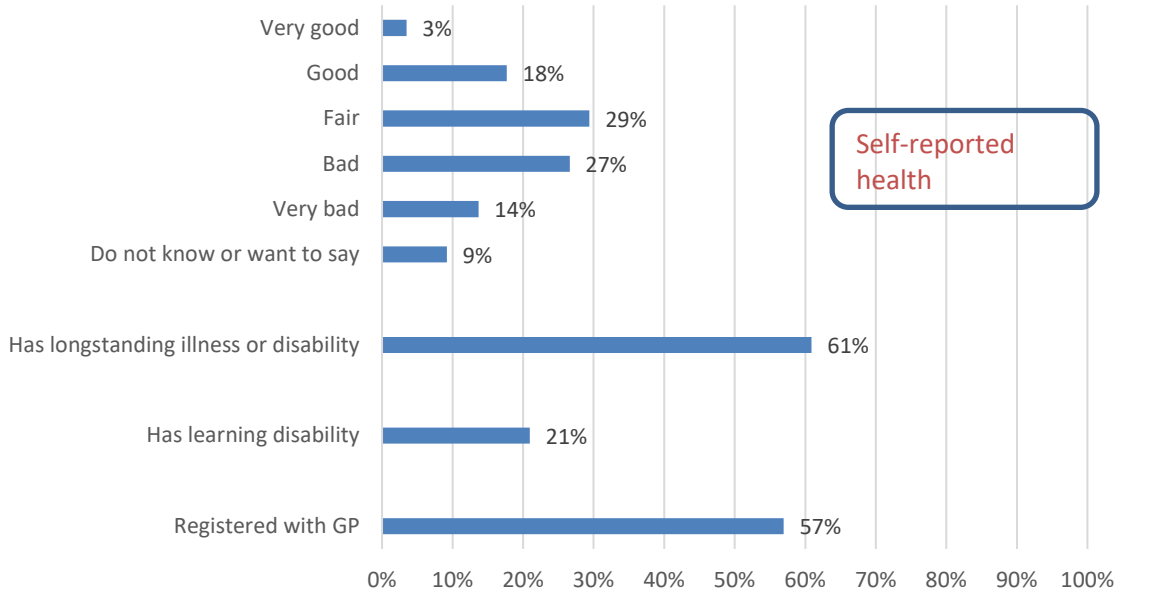
Health and wellbeing

Respondents reported experiencing a range of health issues, with high levels of need in relation to both physical and mental health at the point of recruitment.

Using a five-point scale from ‘very good’ to ‘very bad’, only one in five (21 %) rated their health as very good or good. Six in ten (61 %) reported having a longstanding illness or disability, and one in five (21 %) reported having a learning disability (Figure 3.5).

Only just over half (57 %) of respondents were registered with a GP prior to entering Housing First. This highlights the numbers of clients who did not have GP access to support in relation to their mental or physical health.

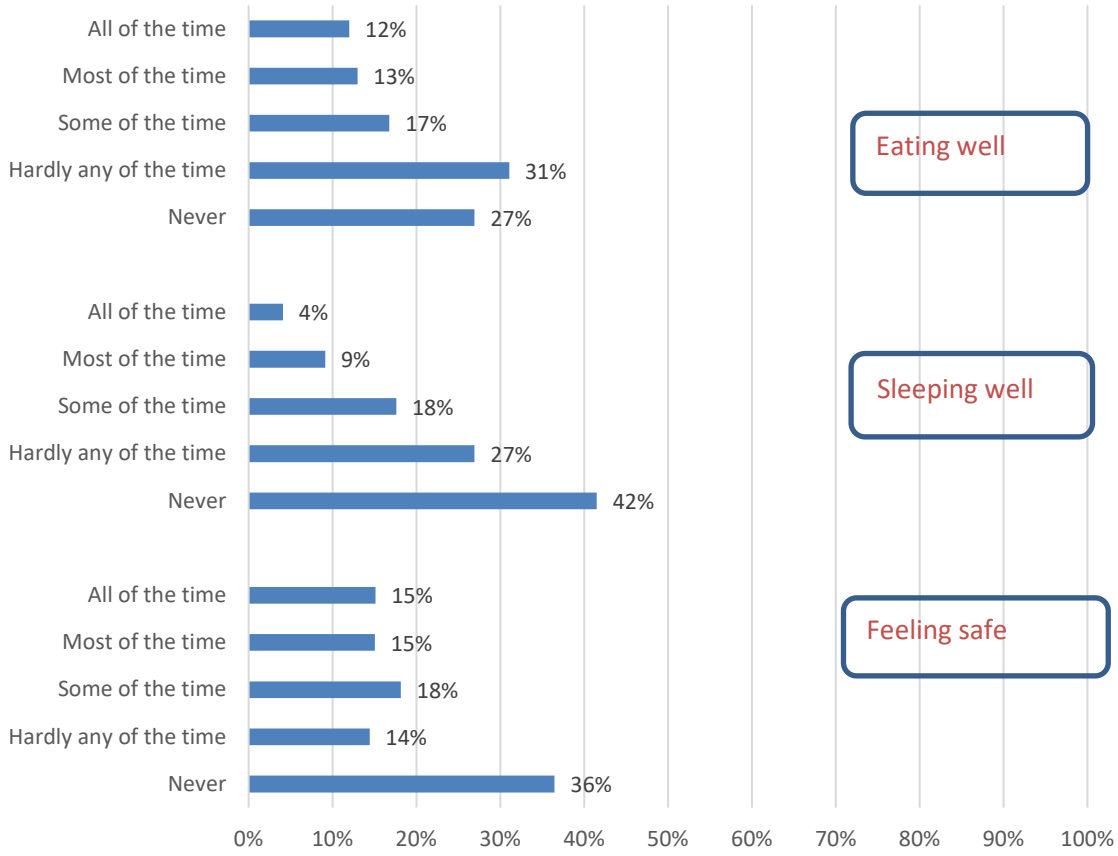
Figure 3.5: Health and GP registration



Base: Housing First client respondents (312)

Respondents were asked how well they were eating and sleeping in the period prior to entering Housing First, as well as how safe they felt, using a five-point scale from 'all of the time' to 'never'. Figure 7 highlights the very poor living conditions for many clients. Only minorities of clients were eating or sleeping well or feeling safe all or most of the time. Three in ten (31 %) clients said they hardly ever ate well, with a further 27 % saying that they never did. Four in ten (42 %) clients said that they never slept well and a third (36 %) never felt safe.

Figure 3.6: Wellbeing

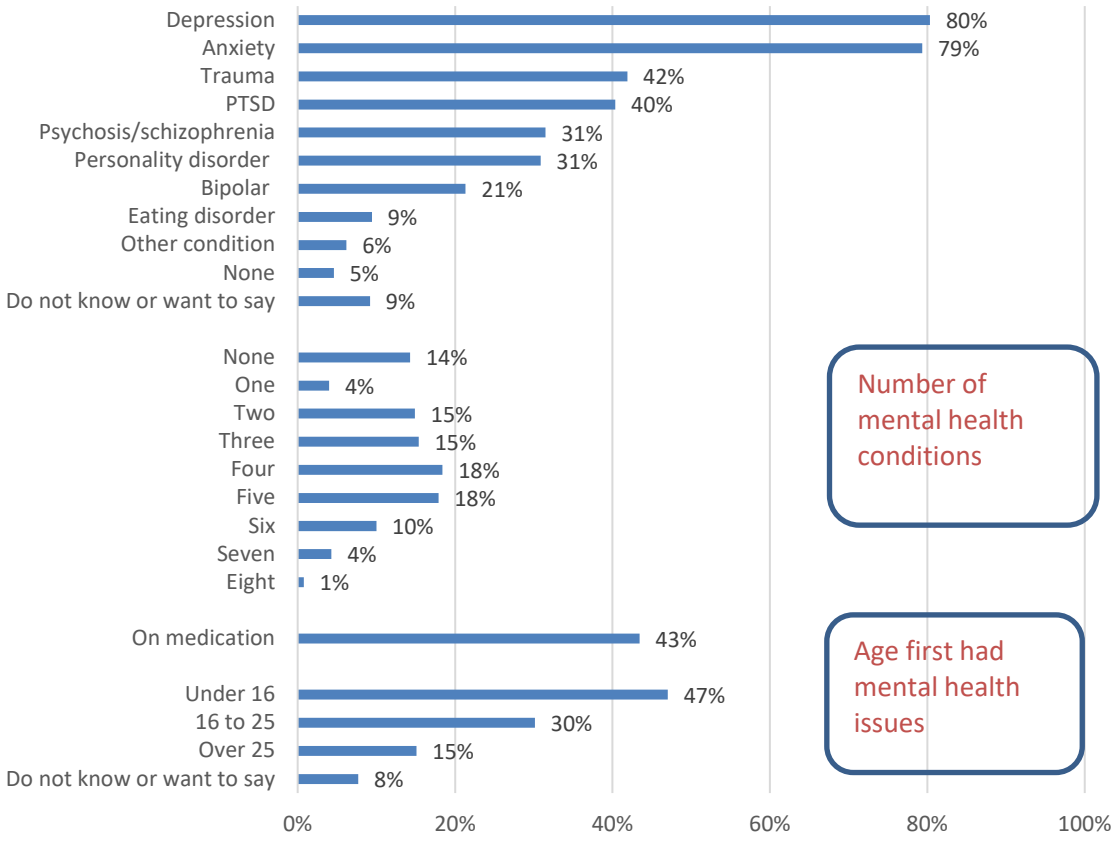


Base: Housing First client respondents (312)

The Housing First baseline questionnaire asked clients to self-report whether they had a range of mental health conditions at the point their entered Housing First (Figure 3.7). Only five % of respondents reported having no mental health conditions, with a further nine % saying that they did not know or want to say. The vast majority of self-reported having depression (80 %) or anxiety (79 %). The numbers reporting other mental health conditions were substantial – including around four in ten with trauma (42 %) or PTSD (40 %) and three in ten with a personality disorder (31 %), psychosis or schizophrenia (31 %). Many clients reported having multiple mental health conditions.

Among those with mental health issues, four in ten (43 %) were prescribed medication for their mental health issues prior to entering Housing First. Their mental health issues had usually started when they were young. Half (47 %) reported having difficulties with their mental health before the age of 16, with a three in ten (30 %) between the ages of 16 and 25.

Figure 3.7: Self-reported mental health conditions and age of first issues

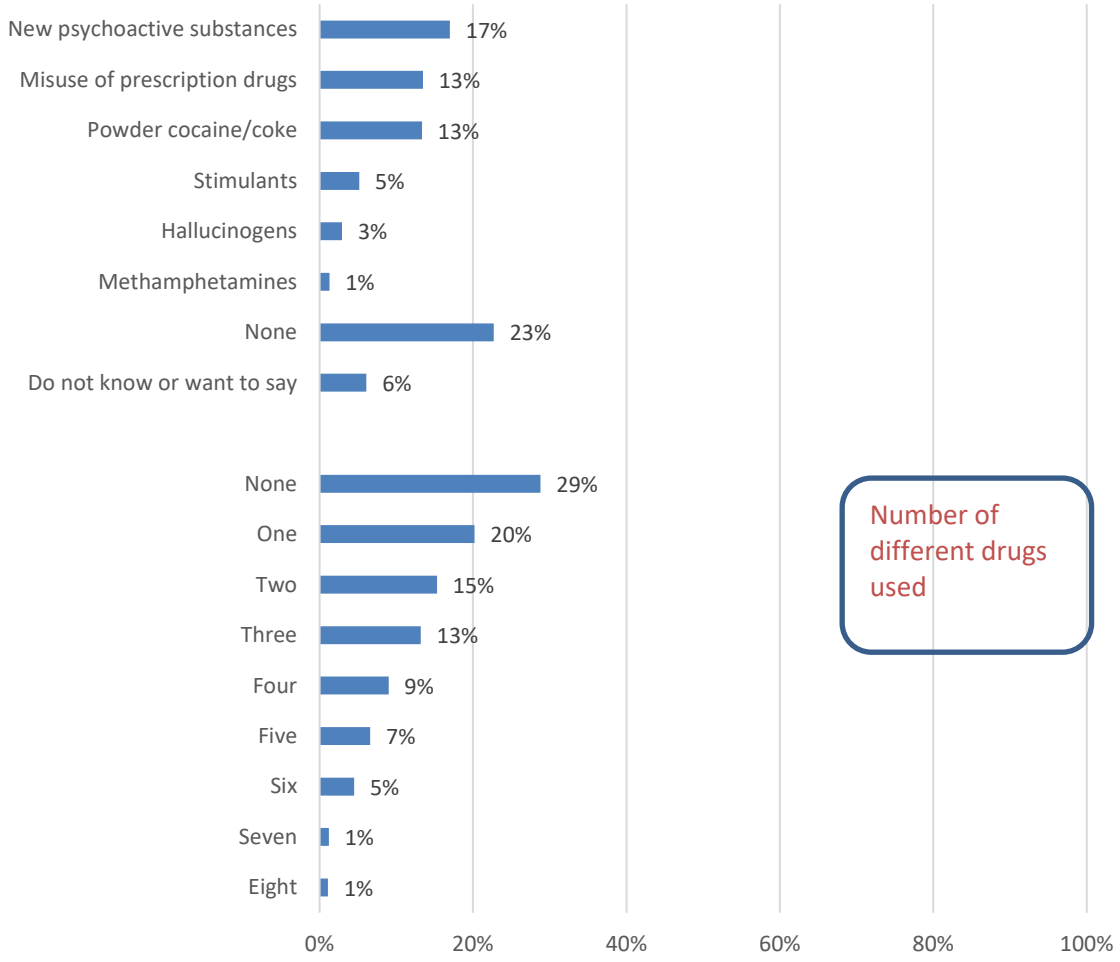


Base: mental health conditions: all respondents (312); whether on medication for mental health issues and age first had mental health issues: all with current mental health issues (275)

Drug and alcohol use and dependency

Drug-taking and drug dependency was common among respondents prior to recruitment to Housing First (Figure 3.9). Seven in ten (71 %) reported taking drugs in the last three months, often taking several different types of drugs. Four in ten had used crack cocaine (41 %) and cannabis (40 %), and a third had used heroin/opiates (34 %) and methadone/Subutex (34 %).

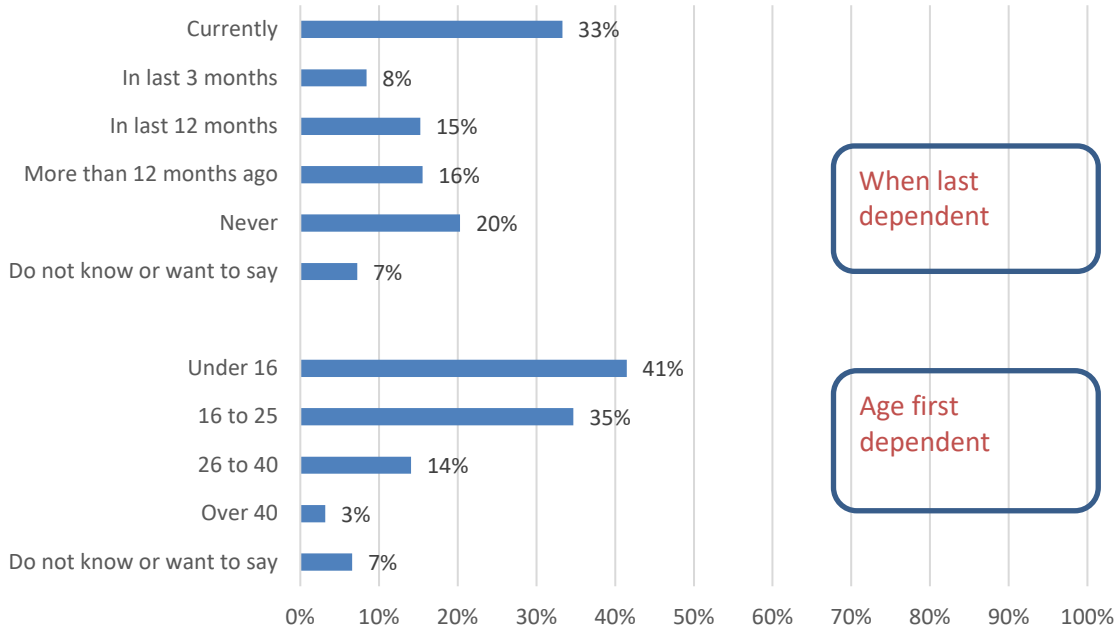
Figure 3.8: Use of drugs in previous three months



Base: Housing First client respondents (312)

Only one in five (20 %) respondents reported never having been dependent on drugs, with a third (33 %) currently dependent. Dependency usually started at a young age, with four in ten (41 %) of those ever dependent on drugs having been so under the age of 16, and a further third (35 %) coming dependent between the ages of 16 and 25 (Figure 3.9).

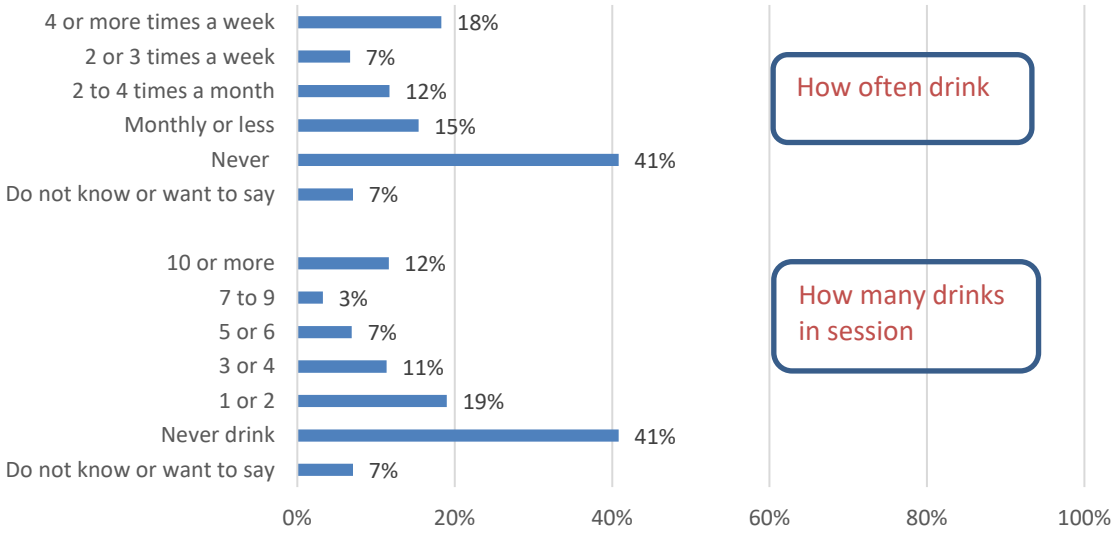
Figure 3.9: Whether dependent on drugs and age first dependent



Bases: whether dependent: all Housing First client respondents (312); age at first dependent: all those ever dependent (233)

Fewer respondents reported had issues with alcohol than with drugs. Four in ten (41 %) of clients reported never drinking alcohol and only 12 % reported drinking ten or more drinks in a typical session at the time of completing a questionnaire (Figure 3.10).

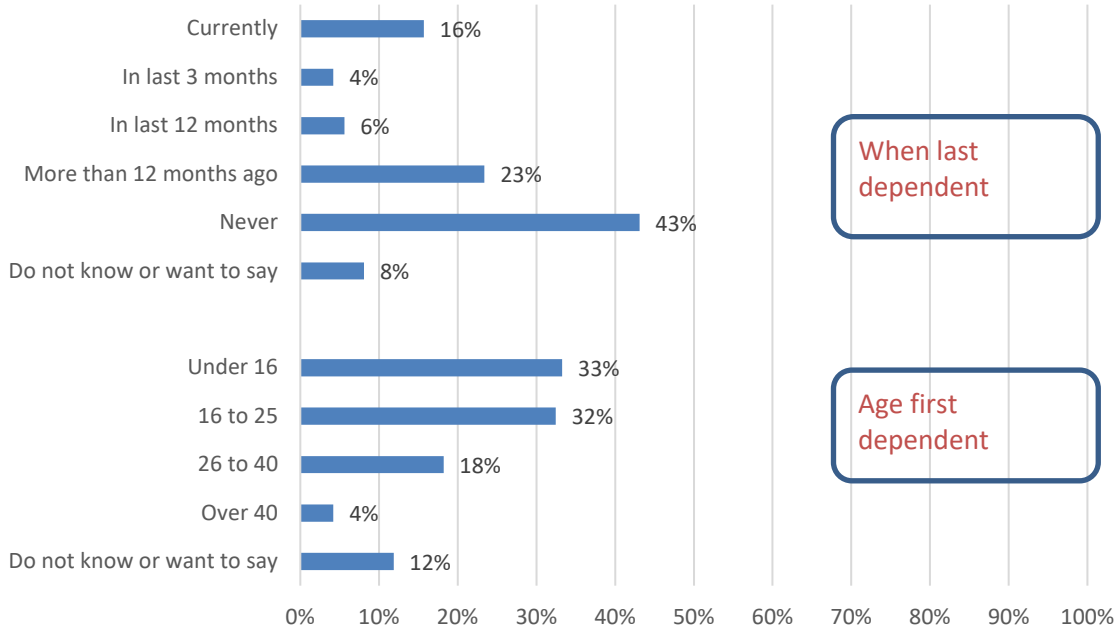
Figure 3.10: Frequency and amount of alcohol drunk



Base: Housing First client respondents (312)

However, half (49 %) of respondents were either currently (16 %) or had previously (33 %) been dependent on alcohol. For a third (33 %) of these, dependency had begun under the age of 16 (Figure 3.11).

Figure 3.11: Alcohol dependency and age first dependent

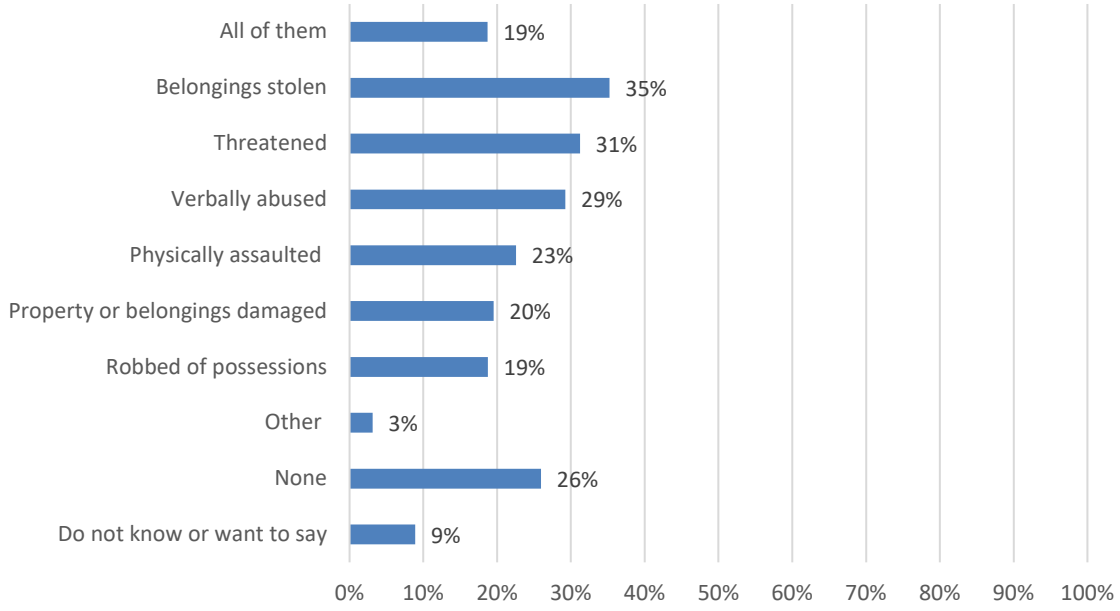


Bases: whether dependent: all Housing First client respondents (312); age at first dependent: all those ever dependent (159)

Victim of crime

Respondents were very likely to have been victims of crime prior to recruitment to Housing First, with only a quarter (26 %) saying that they had not been a victim in the previous six months. Given a list of potential crimes, one in five (19 %) said they had been a victim of each crime on the list. Among others, the most common forms of crime that they experienced were their belongings being stolen (35 %), being threatened (31 %), and being verbally abused (29 %) (Figure 3.12).

Figure 3.12: Victim of crime in previous six months



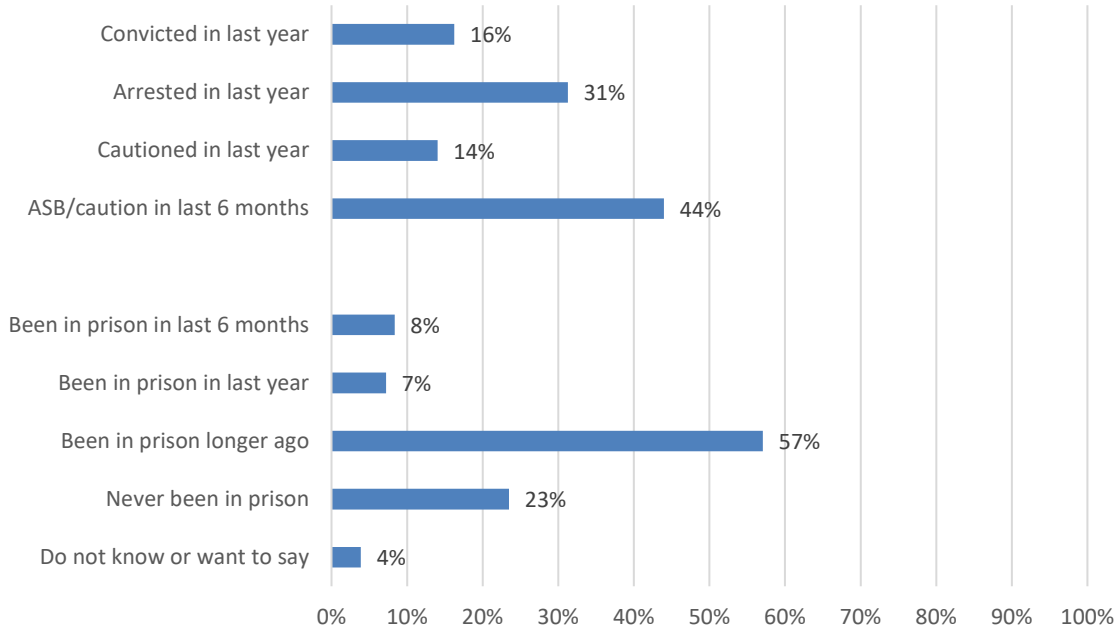
Base: Housing First client respondents (312)

Contact with the criminal justice system

Substantial proportions of respondents had had contact with the criminal justice system within the past year prior to receiving Housing First support. Over four in ten (44 %) had antisocial behaviour actions taken against them in the last six months. Within the past 12 months, 14 % had received cautions, three in ten (31 %) had been arrested and 16 % had been convicted of a crime.

Three quarters (73 %) of respondents had spent time in prison, although only 16 % had done so in the past year prior to recruitment (Figure 3.13).

Figure 3.13: Contact with criminal justice system



Base: Housing First client respondents (312)

4. Implementation

This section draws upon a series of qualitative interviews and focus groups with Pilot staff, partners, and strategic stakeholders to provide an update on progress with implementation across the three Pilot areas since the last round of fieldwork. It reviews the evidence of what is working well, emerging benefits, and outcomes and documents the new and ongoing challenges faced by the Pilots.

Referral

Referrals into all three Pilots have now finished in line with their initial expected end-dates. This means that for GMHF referrals were accepted up until April/May 2021, for LCRCA up to the end of November 2021 and for the WMCA until the end of June 2021.

There was broad agreement across the three Pilots that the quality and appropriateness of referrals had improved over the lifetime of the HF pilot programme with the number of inappropriate referrals declining. Key facilitators included:

- The use of **clear referral criteria** that were well understood by partner agencies. All three Pilots used a form of the NDT/CHAOS Index to assess eligibility with both GMHF and WMCA implementing this approach from the beginning. In LCRCA the Index was introduced in 2020, just over a year since Pilot inception. Interviewees reported that it represented a huge improvement on the previous 'test and learn' phase during which there was an absence of clear and commonly understood referral criteria.

- **Local multi-agency referral panels** with broad representation from partner agencies and providing the forum for discussion of individual cases and joined up support planning. In all three areas where a referral was deemed unsuitable for Housing First, panels also facilitated referrals into more appropriate services thereby minimising the risk of an individual being left without support. In WMCA stakeholders felt that their devolved model had supported the efficacy of local panels as member agencies have a good knowledge of their rough sleeping population and the support that is on offer locally. In LCRCA the locality delivery model and development of the panel approach since 2020 has hugely supported multi-agency working and buy-in to the principles and practice of HF.

- **Multiple and honest conversations with individuals being referred** involving the clear explanations of what HF can and cannot offer and being realistic about what a tenancy means in practice. Consultation with relevant partner agencies and the use of existing databases to access key information (for example the use of Mainstay in LCRCA) was also described as key.

- **Getting the timing of a referral right**. Making use of what support workers described as a 'window of opportunity' to engage with individuals when they were ready to make a change. For example, some individuals are reported to be particularly receptive to an offer of HF when undergoing a transition, such as when leaving an institutional care setting or prison.

> *There's lots of people who would be eligible or need Housing First in terms of what their support needs are. But you've got to get them at the right time … The probation worker said, you know, 'I've got someone who's … just been released from prison and he wants to make a go of it and … maybe a month later it will be too late, he'll be more chaotic.* (Stakeholder, Local Authority)

> *The trick is to capture the window of opportunity…. the point when they are psychologically ready to make a change… where addiction is the issue, they are a moving target.* (HF Team Leader)

Despite the reported decline in inappropriate referrals, stakeholders in all three Pilots described on-going challenges. As in previous rounds of fieldwork there were continued reports of some agencies apparently using Housing First as a 'dumping ground' with the suggestion that HF is sometimes seen as a last resort for people that have been 'in the system' for a long time and for whom other options have not been successful. In addition, interviewees reported that there were some individuals referred for whom HF was inappropriate due to a lack of capacity or because their healthcare needs were too specialist and could not be met by HF. There was agreement that individuals fitting this profile would be better supported by some form of alternative provision or sheltered housing where these needs could be more appropriately catered for. One stakeholder interviewee noted that the issue of capacity was a subject of debate within the multiple and complex needs sector, especially as regards HF clients whose capacity fluctuates as a result of drug and/or alcohol use leading to (episodic) self-neglect. This means that there can be a lack of clarity regarding whether they fall within or out of statutory safeguarding and social care responsibilities.

Other interviewees commented that these challenges were reflective of the absence of alternative options for people with multiple and complex needs across the homelessness sector:

> *We're now squeezing everyone…who's at risk of rough sleeping or in the complex needs [group] - pushing towards Housing First and we still need more choices, really'.* (Stakeholder, Local Authority)

In some areas frontline staff reported that they had worked with a number of individuals who they felt were not fully aware of what Housing First was or understood what a tenancy would mean in practice. One team manager noted that:

> *Nearly half of our service users didn't really know what they were being referred to… they didn't have the lived experience of managing a tenancy or know what it entailed*. (HF Team manager)

Others noted that some clients had said they wanted to receive Housing First but struggled to maintain engagement with HF workers once referred. For these clients the speed at which they could be offered a tenancy could be unsettling leading to disengagement and a return to the streets. Conversely, it was reported that some clients came to the programme with unrealistic expectations, believing that they would be able to move into a fully furnished property immediately and that when this did not happen felt let down and confused. This could also lead to client disengagement with subsequent challenges for support workers in re-establishing trust.

Securing accommodation

The primary challenge faced by all three Pilots continues to be access to affordable and suitable accommodation, although the degree of challenge varies between and within Pilots. Areas that lack access to council owned properties especially in city centre locations or more affluent suburbs face particularly acute problems. In addition, supply has been adversely affected by the pandemic which has led to a significant slowdown in tenancy turnover. Housing providers also noted that competition for properties amongst a number of other (short-term government) funded initiatives targeting a similar cohort had further restricted the number of properties available for HF.

Waiting times for properties vary hugely within Pilots primarily due to the paucity of, and competition for, affordable accommodation within particular local authority areas. These can be compounded when individual service users are very specific about the location or type of property they want. In some areas waits of up to 47 weeks were reported representing a source of frustration for HF staff given the negative effect on some service users' motivation and morale.

> *[Housing First service users initially] have some enthusiasm and some motivation to change. Sometimes them being in there [supported temporary accommodation] can keep that at bay for a while, but if they're in there a long time and then lonely or isolated, they'll start … falling into negative cycles again, and sometimes people will worsen…* (Stakeholder, Local Authority)

Frontline staff reported that delays in securing property offers can place immense strain on their relationship with service users. They and interviewees in management positions emphasised the need to be 'honest' with users about the time it could potentially take to access a property so as to minimise the negative effects on their relationships.

> *It's just been such a massive struggle to maintain a good relationship with a couple of my service users because of that issue [delay in accessing housing] …We need to be extremely honest about, you know this is what we want to do. This is how we would like it to be, but this is also the reality of, you know, the availability of affordable housing in this area.* (HF Support Worker).

While efforts have been made to reduce waiting times between offer and move in additional challenges were noted under lockdown restrictions in terms of securing repairs and white goods delivery that further contributed to delays.

Challenges with securing appropriate properties have been offset over the past year by a growing willingness amongst some registered providers to commit to supplying properties as their familiarity with Housing First grows and they become more confident with the level of support on offer. That said, at the time of fieldwork interviewees across all three Pilots reported that the contemporaneous insecurity over HF future funding was beginning to impact on providers' readiness to commit properties due to the perceived risk that the level of support could decline or disappear in the near future. Furthermore, all three Pilots reported that there remain some providers who have failed to deliver on pledges to supply properties made through SLAs largely because they continue to view HF tenants as too 'high risk'.

Central teams in both GMHF and LCRCA have maintained a key focus on fostering buy-in from housing providers and generating a pipeline of accommodation. In both these Pilots access to council owned stock is extremely limited or non-existent rendering close partnership working with housing providers doubly important. Furthermore, dedicated housing leads noted a number of challenges faced by combined authorities to securing tenancies for HF clients centred on the fact that they lack statutory powers over housing allocations or existing housing pathways, as well as barriers to entry into direct leasing arrangements.

In both GM and LCRCA the vast majority of properties have been supplied by registered providers. This is also true in those local authorities within WMCA that lack access to council owned stock. Relationships with housing providers differed within Pilots, with some demonstrating a willingness to engage while others continue to be reluctant. Interviewees explained that providers *"approach homelessness differently… some are forward thinking but others are 10 years behind…".* This has meant that the response from housing providers has varied enormously particularly as working with HF service users requires flexibility and willingness to do things in new ways:

> *Some housing associations will bend over backwards…it's their culture – that's who they are, it's not just because they want to help HF. With others however, you are opening a can of worms sometimes that they don't want to be opened.'* (HF Senior Lead)

For example, in one local authority area within WMCA support workers spoke in very positive terms about their relationship with one registered provider – "they are] *absolutely amazing…I couldn't praise them enough" e*xamples given of close collaborative working when sourcing properties, providing on-going support, and preventing potential evictions. These experiences were contrasted with a second key provider, who were described as unwilling to establish relationships with HF tenants and quick to escalate problems to threat of eviction.

In GMHF some housing providers reported being proactive in attempting to identify and put forward suitable properties for the Pilot. Some interviewees reported taking care to avoid offering flats in large housing schemes and/or areas known to have significant issues with drugs or anti-social behaviour:

> *I've tasked all of my colleagues that are involved with taking notice … when a customer leaves a property … one-bedroom properties in particular … that they need to flag them all up with me so I look at the suitability for those properties for the Housing First project.* (Stakeholder, Housing)

In LCRCA the lettings team produce a detailed lettings report each month which is circulated to Housing First partners. The data provided includes figures on tenancy requests, tenancy sustainment, and tenancy waits by local authority and housing provider. Reports also include a performance summary for each local authority enabling a form of benchmarking. These are reported to have helped focus attention and subsequent action in areas where there are sticking points and, in some areas, have resulted in further tenancies being secured. Where housing providers are represented on local referral panels, this has enabled housing officers to understand the level of support on offer through HF which in turn has made them more confident in coming forward with property pledges:

> *At [name of LA] we have the housing associations on the panel, similarly with [name of second LA], and they do very well around the engagement and the buy in of the housing association partners because it's all transparent. It's all visible and they know what they're getting and they're part of that risk management and risk awareness setting. So, I think that it is to [name of third LA] detriment [that they are not represented], but we're working on that. We kind of chip away at that.* (Senior Team Leader)

Across all three Pilots the need to engage early with housing providers was stressed, ideally at the planning and commissioning stage of programme development. Stakeholders highlighted the need to support the development of RP housing pathways through establishing SLAs that make clear the level of support provided to tenants by HF and set out in detail the steps taken should problems with a tenancy arise. Further to this, and as previously reported, buy-in from frontline RP staff is essential, given that support at senior management levels does not necessarily translate into housing offers.

In all three Pilots the numbers of service users housed in PRS properties remained low. The combination of prohibitive rent levels (exacerbated by a high level of demand for properties amongst the general public) and ability of PRS landlords to 'cherry-pick' tenants meant that PRS utilisation was widely (but not uniformly) deemed unfeasible.

> *I just feel there is a lack of properties. So, there is a problem with move on in general, and you know private landlords can cherry pick who they want nowadays because private rent is at a premium at the minute and social tenancies [are also] at a premium as well.* (Stakeholder, Local Authority)

In GMHF a few interviewees suggested that investment in initiatives external to HF programmes, such as a review of Local Housing Allowance (LHA) rates and/or greater investment in PRS incentive schemes, might potentially improve the feasibility of the PRS as a source of housing for HF tenants going forward.

The ability to house service users is clearly greatly facilitated by access to council owned stock. In Birmingham, the largest local authority within the WMCA, the council has provided over 85% of HF accommodation. Here relationships between the Birmingham lettings team and HF providers were described as 'excellent' with fortnightly meetings taking place between both parties to discuss live cases and prioritise individuals for accommodation offers. The allocation process does not put a formal limit on the number of offers made and there was agreement among interviewees that the council had been good in terms of matching clients to properties and offering choice if clients were not happy with the first property they were shown. Interviewees felt that most housing officers had gone 'above and beyond' demonstrating flexibility around viewings and a good understanding of the client group:

> *Some of the housing officers are absolutely great, [the officers] that work within the council, they're more than happy to help… if a client misses a viewing they'll rearrange, they get Housing First.* (Support Worker)

Dudley provides an in-house HF service but also have access to their own housing stock. Here exceptions are made for HF clients who would, under business-as-usual procedures, be excluded from housing allocations. This has enabled people to be housed promptly and to be accommodated in their chosen areas.

Maintaining tenancies, dealing with ASB and tenancy transfers

While the vast majority of Pilot clients have successfully maintained their tenancies, a number of problems have arisen which have threatened the viability of some. These have typically included HF tenants being either a victim or perpetrator of anti-social behaviour (ASB), experiencing domestic or financial abuse, having their home 'cuckooed', properties being damaged, neighbour disputes, or rent arrears. The following case studies are illustrative of a few of the kinds of issues encountered and means with which they have been addressed.

Case Study 1 - Frank

Frank was very happily settled into his home when his next-door neighbours started making complaints. The complaints centred around the level of noise coming from his flat which included the TV being turned up and loud banging and clapping sounds. His support worker investigated the situation and discovered that Frank was struggling with deafness and having epileptic fits. He was supported to access the right healthcare and subsequently put on the correct medication and had a hearing aid fitted. Mediation between Frank and his neighbours has led to them understanding the situation and their complaints have ceased.

Case Study 2 - Mandy

Mandy had been settled in her new home for a few months before a distressing incident triggered a decline in her mental health. She began throwing things at passers-by and verbally abusing people. She was on the point of being sectioned and her landlord issued her with enforcement action. An MDT meeting was held including HF support workers and psychologists and a set of support measures put in place. As a result of these interventions Mandy '*has completely transformed…she's given up alcohol and is now running'.* Consequently, the housing provider instructed their legal team to retract their enforcement action.

"I think that approach of the housing association…I mean this was serious antisocial behaviour and actually really quite dangerous. But they haven't [evicted her] they've taken onboard everything that's been said about her, they've supported all those interventions…" (Support worker)

Interviewees widely agreed that a solution can usually be found if 'everyone gets around the table', that is, that joint working had been key to the mitigation of issues where they had arisen. This was said to be most effective when housing officers and HF support workers already had a positive working relationship. Similarly, regular contact between housing officers and HF support workers was deemed to be very helpful in identifying and remedying problems at an early stage before they escalated into a crisis.

Housing provider responses to specific cases wherein problems had arisen were reported to be widely variable. At one end of the spectrum, representatives of some RSLs in GM described operating outside of their usual organisational policies and procedures with HF tenants to ensure that enforcement action was initiated later than is the case for other

tenants and/or only as a last resort, and then always in close liaison with GMHF staff. At the other end of the spectrum, a housing provider in WMCA was taken to court by a HF provider in order to prevent the eviction of a client who had gone into rent arrears, which the HF provider had offered to pay.

The responses of individual housing officers were also reported to be widely variable, with some being much more supportive and constructive in ameliorating difficult solutions and devising solutions than others. The following comments from support workers in relation to two clients in WMCA are illustrative:

> *She [the officer] offered her [the client] a lot of help … I think they dealt with it really well really because they could have just evicted her for the criminal damage she'd done, but I think they understood the situation. I think she understood and took into consideration that she [the client] has been on the streets for a long time and she has addictions and has been in this violent relationship for years and kind of gave her that chance to turn things around so that she doesn't lose her flat.* (Support Worker)

> *[The housing provider] did not understand our client group at all … They didn't respond to things very well. They were expecting a lot from him that he couldn't do at that moment in time. They were threatening to evict him. For example, they never gave him his fob to get into the building so he had to sleep outside the building in the snow, and they were expecting him to then go to their office which is miles away to pick this fob up when he's got mobility issues and could not go anywhere.* (Support Worker)

Although examples of effective joint working in response to ASB recalled by interviewees were numerous, a few support workers in GM did nevertheless note that some landlords had sometimes put pressure on them to pass on messages regarding the enforcement of tenancy agreements and/or (threats of) action relating to ASB. They reported being very uncomfortable about and having to actively resist this on occasion given the potential conflation of their and housing officers' roles in the eyes of service users. They emphasised the need for the roles to be kept distinct to preserve fidelity (particularly as regards the separation of housing and support) and protect their relationships with service users.

In cases of cuckooing, it was noted that a rapid response was crucial given the tendency for these situations to escalate very quickly, and interviewees emphasised that the police should be involved from the outset. Sometimes homes can be re-claimed safely, but it was generally accepted that in some cases managed moves are necessary to preserve the safety of the person affected (e.g., if drug gangs are involved). Housing providers and other stakeholder interviewees made a point of noting that cuckooing affects non-HF tenants also, and that HF clients have the added protection of support provided by the programme as compared with other social housing tenants.

The ease with which a client could be transferred to a new property varied – appearing to depend in at least some instances on the reason underpinning their need to move. Some interviewees in LCRCA for example reported that the housing providers they worked with were quick to respond positively in instances where a tenant had been a victim of cuckooing but were 'very apprehensive' about moving someone who had caused neighbourhood disturbance and required intensive support from other agencies. In WM, support worker interviewees reported that it can be very difficult to secure a second

tenancy for clients who have lost their properties due to cuckooing and/or a combination of persistent drug-use, anti-social behaviour and damage done to the property.

> *It's hard to house people after they have lost their tenancy as no-one wants to take them on…Some of these housing providers just won't touch them.* (Support Worker)

For clients who undergo a property transfer it was noted that while a HF provider is able to assist with the move there is usually no further recourse to the personalisation fund to support the furnishing of a second property. Furthermore, the problem of simultaneous payment of rent on two properties was also reported in some cases, underscoring the need for agencies to work closely together to manage tenancy transfers. The need for clear protocols regarding tenancy transfers was noted as a key learning point in this phase of the Pilot, with a call for the development of these being particularly prominent in WM.

> *They can have two tenancies open…they keep piling up the rent arrears, because the rent is being paid to the new tenancy but at the same time to the old property where they haven't given the keys in, or the removals haven't been... They keep on pilling on their rent arrears…it's helpful to have agencies working together to make sure that doesn't happen'.* (Support Worker)

The ability to move people out of area given the regional 'reach' of the Pilots with centralised structures, as is the case in GM for example, was noted by some interviewees as being beneficial in cases where a move would offer protection from ASB and/or give someone a better chance of moving away from a street-based lifestyle. The ability for support to 'follow' service users to other boroughs, including some who reportedly had 'gatekeeping issues', was deemed to have been integral to their subsequent successful tenancy sustainment of some tenants in GM.

Delivering on-going support

This round of fieldwork further confirmed that after what is typically an intense period of activity around the time of and immediately following the move into a HF tenancy, the intensity and nature of support varies significantly depending upon each client's needs. Many continue to require intensive support with access to healthcare in particular over a prolonged time period. Provider interviewees also emphasised that, once clients were settled in their tenancies, helping them to establish new social networks, rebuild relationships with families (where desired), re-engage with pre-existing or develop new hobbies and interests, and establish community links were key to fostering stability and promoting independence.

> *For lots of people they realise actually once they're through that front door, they might be really isolated or really lonely, or as dysfunctional as a previous lifestyle might seem to lots of people it is actually functional and … there there's people around them or it's what they're familiar with or they used to. Lots of behaviours are really habitual, and people will revert back to those … or those groups of people encourage them to get involved in things that they might want to break away from. But it's because they've got nothing else going on. So [it's important to help service users to] embed themselves within the community, forging new relationships.* (HF Team Manager)

On this issue, frontline worker interviewees noted that the period shortly after an individual is accommodated – when the 'excitement' and flurry of activity necessitated by sourcing furnishings and sorting out utilities etcetera had subsided – was often when service users would begin to feel the effects of social isolation. This they suggested presented a critical window within which to (re)initiate conversations about interests and goals, especially as they relate to meaningful activity and community integration. As previously reported, their ability to support service users in these areas had been severely curtailed by the pandemic given that many community activities ceased operation for some time, albeit that some had begun to be reinstated at the point of fieldwork.

That issue aside, frontline staff interviewees reported that service users' receptivity to offers of support to combat social isolation and/or promote meaningful activity were widely variable. In GM for example, a few support worker interviewees reported that they had had substantial success with some individuals, especially those who were described as more 'extroverted' and/or where their employer offered in-house activities (e.g., gardening, art/craft etc.) targeting people with similar life experiences. Others however noted that whilst they had been successful in helping some clients become familiar with their local area on a one-to-one basis (e.g., accompanying them on walks, cafes visits, bingo etc.), it had been difficult to support them to engage with activities that involve interacting with the general public. This reticence was typically attributed to service users' (sometimes quite extreme) levels of anxiety and/or lack of confidence.

More generally, there was a strong consensus amongst interviewees at both strategic and frontline levels that the majority of clients would need support for prolonged periods of time given the complexity of their needs and fact that recovery and behaviour change for the target population is typically slow and non-linear. In this vein, echoing the findings of recent research in England[8], only a very small minority of people housed by the Pilots had 'graduated' because they no longer required HF support at the point of fieldwork.

Interviewees emphasised that even those clients that remain stable for a period can experience a crisis or setback necessitating more intensive support. Frontline staff described numerous examples of clients who had been progressing well until a crisis was triggered by a negative experience or set of circumstances. For example:

> *I had one of mine [service user] come off drugs completely, she even came off her methadone. But just recently she's relapsed, so I've had to put all the support back in place with [name of drug and alcohol service]. She's just had a bit of a blip I think after everything she's been through…she's been through domestic violence and has been quite stressed because her ex-partner's coming out of prison.* (Support Worker)

Support worker interviewees reported that they had initiated conversations with current clients who may no longer require HF support in the not-too-distant future but emphasised that this was only true for a small minority of cases. For the majority the expectation was that they would need on-going support for a number of years to come. A key learning point has therefore been that any attempt to model demand for HF support should work on the

[8] Blood, I. et al. (2021). *Reducing, changing or ending Housing First support*. Available at: https://hfe.homeless.org.uk/sites/default/files/attachments/Reducing%2C%20changing%20or%20ending%20Housing%20First%20support.pdf.

assumption that for the vast majority of clients support will be required long-term, and certainly for longer than the 3 years that the Pilots were originally modelled on.

> *You can't say "oh well, they've been in a property for two years, so they're doing better, or need less support than someone who's been in there two months". It doesn't work like that.* (Support worker)

Working with other agencies

The last process report highlighted the critical importance of good partnership working and the value of agreeing responsibilities, and processes as early as possible to help foster a culture of shared practice. In this latest round of fieldwork interviewees again emphasised that effective communication and joint working are key to finding solutions to 'sticking points' and in ensuing that responsibility for care is 'owned' and where appropriate shared.

> *The most successful is when more agencies have been involved…and then we can …work together to work out the best approach and best support plan for that person* (Support Worker)

> *There's just such a recognition that actually having multiple partners around the table works and not just for Housing First…finding a solution for individuals whom Housing First would not be suitable for. It means that they're able to be signposted toward their appropriate agencies very, very quickly.'* (Stakeholder, Combined Authority)

Multi-disciplinary team (MDT) meetings where individual cases are reviewed, and support plans agreed are a feature of all three Pilots. In some areas these sit in parallel to local panel meetings while in others, meetings are organised in response to a particular crisis that an individual is facing.

In WMCA HF providers feel they benefit from the fact that they are locally commissioned and are in a position to build on existing partnerships and networks. In LCRCA members of the Central Team have a specific focus on developing partnerships and facilitating multi-agency working, described as particularly important given that HF is delivered by the CA who are effectively one-step removed from local authority influence and delivery. Here the development of local panels has clearly supported multi-agency working and helped foster a sense of shared responsibility in meeting the needs of HF service users:

> *It's like a whole team of professionals working on the same page as if you were working for the same organisation… it feels like that. It feels team based.* (Support Worker)

> *We've developed a rapport and relationships between agencies. People have different level of good will when they have rapport. They are more likely to work together to support an individual rather than working against each other*. (Senior team member)

In all three Pilots, examples were given of very positive collaborative relationships, but degrees of engagement continue to differ between agencies. In WMCA it was noted that partnership working with community focused services had been most successful including those funded through the RSI, outreach drug and alcohol services, and third sector

organisations such as those working with victims of domestic violence, food banks and other homelessness providers. Partnership working with DWP has also been positive who were commended by HF providers for having developed flexible processes, for example in regard to alternative payment arrangements for HF clients.

In GM, some interviewees gave examples of statutory services being very responsive to the needs of GMHF clients, whereas others recalled instances where statutory bodies were not necessarily 'stepping up to the plate' even where they had a duty of care.

> *They [probation workers] do respond quickly, they attend MDTs [Multi-Disciplinary Team meetings], they're really on top of things. In my experience…I don't really have issues…chasing them up and getting them to, you know … do their job.* (Support Worker)

> *Because there's pressures in other areas, if we're happy to do it, they'll let us … My sense is that in some respects the Housing First worker needs to step back and let other agencies do what their duties are … There's learning around that.* (HF Team Manager)

In LCRCA interviewees reported a degree of variation between both agencies and local authorities in terms of their willingness to engage as partners with HF. As such some local referral panels have better representation from key agencies than others. One in particular was consistently described as a 'model of good practice' with the Chair praised for her professionalism, wide knowledge of local service provision and facilitative style that delivers integrated working while ensuring '*people are held accountable for their promises'*.

Others however were reported to have struggled with getting representation from Adult Social Care who were described as '*a difficult service to get on board'* and tending to be more reactive and inflexible in their approach than other services:

> *We all work flexibly, or we all work preventatively, but Adult Social Care seem to be more rigid than others, so it's not that they're not present, it's just getting them to flex or think differently or think even upstream is quite difficult.* (HF Senior team member)

It was widely acknowledged across all three Pilots that many of the services that HF teams engage with, most notably mental health, drug/alcohol treatment and Adult Social Care, are stretched beyond capacity and that this has been exacerbated by the pandemic. These pressures have compounded challenges of access, with some tightening eligibility criteria in the past year. As in previous rounds of fieldwork interviewees highlighted gaps in mental health provision with frontline staff expressing considerable frustration at barriers to access for their clients including a lack of flexibility with appointments, and 'did not attends' (DNAs) in particular, with respect to people with a dual diagnosis:

> *It's three strikes and you're out with mental health…. these services don't seem to understand that our clients have highly complex needs – they have undiagnosed mental health conditions, and they are rough sleepers... just because you have a house doesn't mean you stop being a rough sleeper…So expecting them to be on time and off the books with three DNAs just doesn't work* (Support Worker)

> *If the client is using substances, it always comes back to that. So, they will say they [the client] needs to sort their addictions out first but it's not that [the client] hasn't got mental health problems it's that the substances they are using is making it worse but that is their coping strategy for their mental health issues. So, I feel like sometimes you are going round in constant circles trying to get people help.* (Support Worker)

Some interviewees felt that the problem of access begins in primary care and that GPs sometimes lack understanding of service users' mental health needs. They reflected on how high the bar was set for referral and discussed the need for a different pathway into mental health services to overcome existing barriers:

> *It's been an absolute fight to get some of my Housing First clients in touch with mental health services because it's going through the same procedure as what everybody else is going through. First you have to get the client through the GP and getting the GP to agree that they need a mental health referral. The procedure for the mental health referral and the waiting list is absolutely ridiculous. Unless you are on the edge of a bridge about to jump, you are not in a crisis. And if you do feel you have fallen into crisis, then you need to attend A&E and a psychologist will tend to you there and then, and then you go back onto the referral scheme and the waiting list.* (Support Worker)

In GMHF barriers to access to drug and alcohol services were also described:

> *The lack of flexibility around some of the support services, predominantly the drug and alcohol team … they have these set processes, and if you don't do this this and this, they cross you off their list. That really isn't any help to someone who is in crisis and struggling.* (HF Team Manager)

Here the HF Dual Diagnosis Practitioners (DDPs) provide a valuable 'bridge' to relevant provision. However, several interviewees, including a number of frontline workers, reported that the DDPs appeared to be very stretched and that the Pilot would benefit from having more people in the role.

> *The DDPs are gold dust ... [Their support means that] mental health services cannot bat off anyone with substance misuse saying its drug induced.* (Support Worker)

> *It helps massively having the dual diagnosis practitioners to help push that multi agency, wrap around involvement from adult social care…* [they] *really champion the customer's needs.* (Stakeholder, Housing)

Providers in Birmingham noted that while rough sleepers have access to a specialist GP service, pop-up clinics and a drop in, these services are generally no longer formally accessible to HF clients once housed. The same is true for outreach services offered by the drug and alcohol team who transfer HF clients to a community hub once housed. While there is a degree of flexibility afforded to some clients, HF providers felt that there is a gap in community-based provision for service users who although technically housed continue to spend a lot of time rough sleeping. It was noted that these clients find it difficult to attend appointments at given times and in specified locations meaning that they can miss out on

treatment and support. One support worker reported that one of her clients had told them they would prefer to be a rough sleeper '*because everyone comes out to you*.'

Across all three Pilots the need for system change to overcome access barriers was discussed both with respect to mental health services and access to appropriate community-based drug and alcohol services.

> *Housing First can circumvent the system it can't change the system. You need a whole system response to people with complex needs. Housing First can't deliver that alone. A rough sleeper is still a rough sleeper when housed. Going in-doors they still have the same complexity as when on the streets - there is a need for a neighbourhood-based support network – it's unrealistic to expect mainstream local services to respond in the same way with the same level of access… the change needs to come from the top.* (HF Team Manager)

> *I think it's totally reasonable to say it [DDP provision] shouldn't be needed. But it obviously is otherwise there wouldn't be a problem. I don't think what it should do is replace existing services. It shouldn't be an alternative to. It should in one way or another help to fundamentally address the problem and influence systems change. We want to get to a position where it's not needed*. (Stakeholder, Mental Health)

Key to this will be a change in thinking of and processes employed by commissioners of mental health and drug/alcohol services – with some interviewees emphasising that workers employed by those services need to be given licence to exercise the flexibility that is now widely acknowledged as necessary when supporting this client group.

> *The people we really need to reach are commissioners. It's all very well training staff in trauma-informed practice and things, but they need licence to exercise that flexible approach. Frontline workers in these agencies are often bought in to [work with] Housing First, but they cannot operate flexibly.* (HF Team Manager)

Recruiting, supporting, and retaining staff

Staff recruitment has been ongoing in the Pilots to build capacity as service user numbers have increased and to replace support workers lost to attrition. The experiences of recruitment in LCRCA had led to a rebalancing of weighting given to candidates' values vis-à-vis their professional experience over the past year. Earlier recruitment rounds in LCRCA had been heavily focused on ensuring that candidates had the right attitudes or 'mindset' to be a HF support worker. Interviewees reported that this had led to the appointment of some individuals who did not have all the right skills or experience. While subsequent rounds of recruitment have continued to include values-based questions, providers have paid more attention to knowledge and skills, for example by asking questions on issues such as safeguarding and risk management.

Critically, the experiences of the Pilots in the past year have underlined the imperative of providing adequate support for frontline staff. The demands of their role are significant, and some providers gave examples of staff members leaving after a short period in the role because *"they found it too intense*" or *"could not switch off"*, for example. Support worker interviewees generally described the role as rewarding but discussed the challenges and impacts on their own well-being of working with people who can, at times, feel 'difficult to help'. They described feelings of failure and frustration in trying to support

people with experience of trauma and complex needs. A number described feeling overwhelmed by the responsibility felt when a client went into crisis, and/or being 'heartbroken' when a client had passed away.

> *It's emotionally difficult for us as people you know. We have more contact with these people more than we do with our own families. For them to be doing well and then to go backwards is difficult to handle…* (Support Worker)

> *Sometimes you can just have a really bad week and try and do everything for someone and still haven't done anything and they're still telling everyone in town you've done nothing for them and it's quite emotionally draining.* (Support Worker)

> *You do get sort of attached and close to them [the clients] in some ways and it is hard when they pass away because you've worked so hard with them as well.* (Support Worker)

The challenges associated with support workers' roles had been compounded by the pandemic, particularly feeling isolated when working from home and/or missing the interaction with peers and informal opportunities to share experiences and offload. Some interviewees also noted that changes to working practices necessitated by the pandemic made it more difficult to identify early symptoms of stress experienced by colleagues

Staff morale had been negatively affected by the uncertainty over funding going forward given concerns regarding what this might mean for clients and their own job security. Further to this, staff attrition had led to higher than intended caseloads in recent months in some areas and an associated increase in staff stress levels with some feeling unable to cope. These issues were particularly acute in GM where the potential 'cliff-edge' of the Pilot ending in March 2022 was imminent at the point of fieldwork.

> *We had quite a lot of staff sickness when the caseloads went over seven. That was real learning … My advice? Whoever does Housing First, do <u>not</u> go over seven*. (HF Team Manager)

On this issue, some (but not all) provider interviewees in GM reported losing significant numbers of staff in recent months, with the increased rate of turnover largely being attributed to uncertainty regarding potential redundancies in March 2022. Backfilling those posts had proved to be very difficult given that they necessarily had to be advertised as short-term fixed contracts. The challenge of recruiting to fill vacant posts was also described as 'horrendous' in one WMCA local authority area where staff had been lost to more secure and in some cases better paid posts.

> *The lack of clarity over what is going to happen after March next year means we are losing excellent staff. And struggling to backfill those posts.* (HF Team Manager)

HF provider interviewees in these contexts were very cognisant of and concerned about the impact of higher than intended caseloads on the intensity and flexibility of support that remaining staff could provide (see also above).

That issue notwithstanding, there was consensus amongst senior provider interviewees in GM that whilst the provision of support to frontline staff has exceeded what is typically available to housing/floating support workers in the homelessness sector, further thought

was needed regarding how to support HF workers most effectively going forward. There was a particular call for greater focus on and potential development of something more structured to address staff wellbeing. The provision of reflective practice sessions in groups facilitated by DDPs in GM was being reviewed in consultation with support workers at the point of fieldwork. These had to date been delivered in cross-zonal groups by DDPs in what was described as a fairly 'prescriptive' fashion. It was widely agreed that this approach did not suit all GMHF, and consideration was being given to delivering this support to staff on a one-to-one and/or less formal basis. Some GM providers also reported shifting the balance of emphasis in supervision sessions away from staff performance more toward wellbeing.

In LCR, support workers receive clinical supervision and reflective practice sessions from the HF psychologists on a regular basis. Interviewees unanimously reported that they found these invaluable: *'I couldn't praise them enough'*, describing the psychologists as *'really flexible and approachable'*. These sessions were valued for allowing staff to 'off-load', share experiences with others and explore strategies for resolving challenges they face with clients. Support workers also noted that the input of the psychologists at MDT meetings was invaluable. Other less formalised measures to support staff have included, amongst others, daily catchups between staff and team managers, team managers operating an open-door policy for support workers, and providing practical hands-on support to frontline staff (e.g., joint visits and calls).

In WM, staff are offered monthly reflective practice sessions facilitated by a senior clinical psychologist where PIE is used to help problem solve as well as support staff well-being. The PIE offer extends to supporting managers to embed a PIE approach through supervision and to case consultations. Interviewees delivering PIE stressed that organisations that structure regular meetings and supervision sessions benefit most from a PIE approach but noted that time and resource pressures can make it difficult to prioritise these. They also noted that there was a wide disparity between providers in terms of how far PIE was embedded into their practice and that a recommended next step would be a bench marking and standards setting exercise. That said, there was a general consensus among frontline staff that the opportunity to engage in reflective practice sessions has been extremely useful; there was some appetite for these sessions to be delivered more frequently than monthly.

> *[Name of psychologist] helps you to understand how you are feeling and why you are feeling that way. She also helps us to understand how clients are thinking ...how their minds work…to understand what cycle they are on and breaking that cycle.* (Support Worker)

> *I think they [the PIE meetings] are good. I really enjoy that hour. It's just nice to reflect…I really enjoy talking to [name of the psychologist] ... but we only have them once a month, I wish we could have more.* (Support Worker)

Working to the HF Principles[9]

In this round of fieldwork provider and stakeholder interviewees were asked to reflect on their experiences of operationalising the core principles of HF over the course of the Pilot

[9] https://hfe.homeless.org.uk/principles-housing-first.

to date. Levels of understanding of the principles amongst external stakeholders in the homelessness and allied sectors were said to have improved dramatically since the beginning of the Pilots, but it was noted that there was still further work to be done given variability in levels of awareness regarding the remit and particular principles of HF.

Further to this, a number of key challenges to delivering on fidelity were highlighted, including most notably the limited availability of appropriate housing stock, staff shortages, and uncertainties over longer-term funding. These affected the relative ease or otherwise with which each of the principles could be operationalised.

Pilot fidelity self-assessments (as used in GM and LCRCA for example) normally scored highly on the *separation of housing and support* given arrangements for the continuation of support when tenancies ended or managed moves were required, albeit that a need for clearer protocols re: how these are dealt with was identified in some areas. The *use of an active engagement approach* was also identified as being widely achieved, with staff reported as being persistent and creative when responding to client disengagement. A *strengths-based orientation* was also commonly identified as strongly shaping the Pilots' day-to-day delivery.

Whilst the principles of users having *a right to a home* and *choice and control* was at the forefront of providers' minds, it was noted that delivering on these to the extent that would be ideal was difficult in the context of a shortage of suitable housing (see also above).The lengths of time taken to offer some clients settled housing and constraints as regards the type and location of properties available – both of which affect non-HF tenants also – were noted as being particularly challenging. Some interviewees emphasised that there was a balance to be struck on the issue of choice and control, wherein frontline workers needed to have 'realistic conversations' with clients regarding the availability of properties and any potential risks associated with different options.

Whilst the Pilots have all been very invested in a *harm reduction approach*, the ability of staff to promote this was impeded by barriers in access to mental health services and to a lesser extent drug/alcohol provision, especially where service users were dually diagnosed. The clash of the flexible approach endorsed by HF and less flexible approach typical of statutory services in these areas fields was noted as being particularly problematic.

The principle that providers had found most consistently challenging overall was the provision of *flexible support for as long as it is as needed* given the lack of guarantees regarding the continuation of services post-Pilot. On this, funding uncertainties meant that providers had not been able to assure clients that they could support them indefinitely or for as long as needed. Furthermore, not being able to give this assurance to housing providers meant that some had become increasingly reluctant to offer properties to HF clients given concerns that HF support might be withdrawn given contracts ending in the not-too-distant future.

The issue of caseloads was central to conversations about fidelity. Whilst every effort had been made to keep caseloads at the level intended and previously maintained across the Pilots, a combination of factors had meant these were exceeded in some areas during the past year, to highly detrimental effect. In GM, the combination of staff resignations given uncertainty regarding the Pilot end-date and absences due to covid infection, self-isolation or stress dictated that worker: client ratios were reported to be 1:10 or even 1:12 on

occasion. Similarly, in WMCA funding insecurity and associated staff attrition coupled with the smaller than projected number of service user graduations meant that caseloads varied between 6 and 14.

Where intended caseloads had been exceeded, HF support worker interviewees reported that their work with clients had felt more 'crisis-focussed' than had previously been the case. This meant that on some occasions they were unable to deliver the intensity and flexibility of support intended (and previously offered). Furthermore, they were less able to support clients to achieve their goals beyond sustaining a tenancy (e.g. fostering social integration, employability etc.).

Where this had happened, senior manager and frontline staff interviewees alike were very mindful of and regretted the detrimental effect that high caseloads had on the Pilots' fidelity to the principles of HF. Some went as far as to suggest that in worst case scenarios support workers were able to deliver little if anything more than what would be typical of a mainstream floating support service.

> *I was given someone who had just lost two workers and it was just kind of walking into this chaotic situation … [I] just felt like walking out again to be honest…which is quite sad because I've always enjoyed Housing First and enjoy the job … I think … because of the situation at the minute we are just constantly firefighting … and doing crisis work, which is taking us away from the actual Housing First role.* (Support Worker)

> *It is impossible to stick to Housing First principles [under these conditions] … we are turning into more traditional floating support.* (HF Team Manager)

Where they had occurred, higher than intended caseloads had not only compromised fidelity, but also exacerbated stress levels amongst staff, some of whom reported feeling overwhelmed (see above). Staff absences due to stress or covid compounded the situation even further as support workers did their best to cover for absent colleagues.

Provider interviewees emphasised that these impacts served to highlight the imperative of keeping HF caseloads low if fidelity to the core principles is to be preserved as HF is scaled up elsewhere. This learning is especially notable given that external stakeholder interviewees, including housing providers, often identified low caseloads as a critical ingredient to the effectiveness of the Pilots to date.

> *I do think that a key element of the success of Housing First is that the caseloads are protected…You're able to work with those protected six or seven people and really spend time with people finding out what their goals, their aspirations are…it's not just the quick fix*… (HF Team Manager)

5. Client experiences of Housing First

This section sets out the findings from the most recent interviews with Pilot service users. Due to the pandemic, only two interviews were carried out face-to-face observing suitable precautions, while the remainder took place via telephone or online video conferencing. The interviews were conducted using a qualitative topic guide co-developed with lived-experience representatives. For the nine participants who took part in the previous round of interviews, a slightly different follow-up topic guide was used.

Interviewee characteristics and background

A total of 44 interviews were carried out across the three pilot regions, with 18 of the interviewees identifying as female, and 26 as male. Length of time on the programme ranged from four months to over three years. Interviewees were sampled on the basis that they had spent at least four months on the programme and were able to reflect on their experiences of support. Interviewees were invited to participate, and it should be noted that the achieved sample was not necessarily representative of the Housing First user group as a whole in terms of gender, age and ethnicity.
Some interviewees opted to have a support worker accompany them for the interview, while the majority took part on their own. The majority had been homeless at the point of acceptance onto Housing First, either rough sleeping, sofa-surfing, in shelters or in supported accommodation. Only a very slim minority had no experience of rough sleeping. The length of time spent precariously housed or homeless varied, from under a year to multiple decades. At the time of the interviews the majority of participants held one-bedroom tenancies, aside from those with children who lived with them.

Across the three pilots the interviewees disclosed a range of support needs, and almost all had multiple areas in which they required intense support. This included:

- Diagnosed and suspected/undiagnosed mental health conditions, ranging from mild to severe and enduring. The majority of interviewees experienced some form of anxiety and/or depression. Some participants also disclosed self-harm, learning disabilities, ADHD, and brain injuries.

- Substance misuse. Class A drug addiction, often crack cocaine and heroin, and issues with alcohol dependency were common amongst those taking part in the interviews. Some service users had made significant progress with their recovery and maintained sobriety for periods of several months to multiple years, and some noted that they remained dependent on their drug of choice.

- Offending. A significant minority of participants interviewed had served time in prison, and some had been imprisoned many times, were on probation, or had up-coming court cases.

- Physical health issues. Issues with mobility, and long-term health problems such as epilepsy and chronic pain were commonly reported. Needs relating to mobility also sometimes caused delays with finding suitable housing (i.e., ground floor, wet room etc.)

- Family and relationship breakdown, for example children being taken into care/estranged from one or both parents, divorce, and parental disputes.

- Adverse childhood experiences, time spent in the care system, and trauma were also spoken about by some interviewees who were comfortable sharing this information.

Initial engagement and perceptions of Housing First

Initial engagement varied greatly between interviewees across all three regions. Some participants had not been aware of their referral to Housing First and did not know what to expect from the referral. For some interviewees, this lack of awareness was due to the situation they were in at the time, for example entrenched substance misuse or alcoholism affecting their ability to recall how they were referred. Outreach workers and hostel support staff were typically the referring agent.

When asked about their initial impressions of Housing First, and meeting their support worker, most service users were cautiously enthusiastic. One participant described how they interacted differently with Housing First support workers compared to previous services, '*When I was in jail, I got new workers and sometimes I don't interact with the new workers properly, but I've interacted with [names of both HF workers] a lot.'* One interviewee was so jaded by their previous experiences that they first engaged '*to prove them wrong!'* but has gone on to successfully work with the pilot and now has their own tenancy.

Relationships between support staff and service users were mostly positive and trust was built using a variety of methods in a service user-focused way and at their pace. One participant mentioned that '*Meeting Housing First was a relief because I knew from that point things were going to get better'* while another described the initial meeting as *'brilliant to be fair, to find out I could probably get a council flat.'* Support workers being able to follow through on promises, being '*on it'* and going *'above and beyond'* were common themes.

Across the three pilots, participants observed that the commitment and effectiveness of their workers' actions brought results from the beginning of their engagement with the service.

Finding a property and moving in

Finding a property

The process from initial engagement to moving into a tenancy varied considerably, with some participants being able to move in within 8 weeks and some not being matched with a property for 12 months. Therefore, the process was, for some, considerably quicker and more efficient than the traditional housing models (bidding etc.) and for some of those with specific requirements, the wait for suitable housing was often longer than participants had anticipated. These requirements were often to do with mobility, for example needing a ground-floor flat or bungalow, due to an inability to safely climb stairs. Other interviewees

had more complex mobility issues and had additional requirements, such as a walk-in shower and wheelchair accessible rooms/entrances.

Interviewees across the Pilot regions all felt they had a degree of choice when allocated their properties, and were able to refuse unsuitable properties, either due to disabilities or due to other factors that were important to them such as being near their support network, or conversely, far enough away from their 'old life' that they could continue to make progress in their recovery journey. The ability to choose and refuse properties was a novel experience for most service users, and one participant said he'd had the Housing First ethos explained to him in the following terms:

> *…if we're gonna offer you somewhere and you're gonna settle down and try and sort your life out, it's gotta be at least somewhere that you're gonna be comfortable, happy and want to be.*

There was also variation in the interim accommodation provided and/or accepted by the interviewees, with most being in either homeless hostels or supported accommodation before moving in, and some 'sofa-surfing' with either friends or family. A minority of those interviewed had elected to sleep rough rather than accept an offer of temporary accommodation, due to traumatic experiences in hostels/supported accommodation. In one region, the majority of interviewees who had stayed in supported accommodation described not receiving any meaningful support while they lived there (beyond the support provided by Housing First.)

> *They did offer me like, temporary [accommodation], but I refused…I was getting into trouble, and I couldn't be arsed with that.*

Before moving in, some of the interviewees had to wait for repairs to take place, as these could only be done after the previous tenant had vacated. Often these repairs would take 4-8 weeks, during which time the service users would remain in their interim accommodation or sleep rough.

Moving in

Moving into a tenancy, either for the first time, or the first in a long time, was an exciting, but daunting process for most of the participants interviewed. While the majority of interviewees were happier now than when they were homeless, this took time and was part of the process, rather than something that happened overnight.

> *It took me while. I had to dip my toe in and do it bit by bit. When I started staying there a friend stayed with me. But I'm settled in now, I feel like I've found my home… I can't stay in my bed yet. But I'll get there.*

A key theme across the Pilot regions was the intensity of assistance provided by Housing First when the participants first moved in, including:

- Practical support, such as acquiring white goods and furniture, setting up energy and water bills and discounts. '*The flat was set up and furnished for me, everything was done. Even my electric and gas and that. I don't know how to do things like that. I've been off the grid for so long that's it's all so mad for me now. It stresses*

me out.' 'I just need that little bit of help with appointments and bills, and budgeting money and that kind of stuff.'

- Benefits applications to maximise income, including Universal Credit and PIP for service users that qualified, described by one as a '*huge weight off my shoulders.'*

- Emotional support. One participant described having a 'wobble', where they wanted to relinquish their new tenancy, but was able to talk things through with their navigator and concluded together that it would be better for him to remain in the property. *'They've given me all the support I really need, they're there for me […] All I want is for them to not disappear.'*

    Support accessing other services/activities. Many service users described feeling isolated when they first moved in or required additional support from organisations for substance/alcohol misuse, mental health, or anger management now that their housing was 'sorted' and they time to focus on other issues.

Sustaining the tenancy

Support to sustain the tenancy across the three regions was holistic and service-user led and varied depending on the wishes of the service user. Due to the pandemic, many interviewees were receiving support by phone, alongside face-to-face visits. Broadly, participants felt supported to access help, but not pressured into it – for example, several participants would have been eligible for support with substance misuse but had decided not to tackle that issue at that point in time, and those wishes were respected by their support workers, rather than being a condition on which the support continued. That said, it is important to note that many of the interviewees had taken up the offer of substance misuse support, frequently via a methadone/Subutex prescription, and managed to maintain sobriety in their new home. One interviewee reported receiving counselling as well as regular nurse appointments to help reduce their alcohol intake safely, which was arranged by their HF support worker.

Many of the interviewees spoke about the pride they took in their new home, for example decorating it, and being motivated to maintain the property to a high standard. '[…] *This is our sanctuary'.*

Relationships with and role of support workers

Service users described their experiences of support received from HF in similar terms to the initial round of interviews. The value of the therapeutic aspect of the relationship with between service user and support worker was described with similar emphasis as the practical support interviewees had received, with activities such as going for a walk or for coffee given as examples.

Experiences of support

Whilst some interviewees described initial "wariness" of HF and the promises made during initial engagement, others felt enthusiastic about what the program offered and even sought it out themselves. Subsequently, they all went on to develop good relationships

with their workers in a relatively short space of time. Service users witnessed the promises being fulfilled and the support being delivered in a way that worked for them at a pace which felt right. For one individual it was the first time that they accepted support and developed a rapport with a worker.

> *When I first met Housing First because I'd been let down so much, I thought it was another let down. The more I got to know them the more I began to trust [HF worker] and I began to believe there was hope... We got to know each other a bit. All I know and recall really is that there was this lovely person that had come into my life and who was telling me there was hope. And I got to know them more and eventually I came down a bit, stopped being so feisty with them and all that.*

Accounts of being able to open up for the first time, or in a long time, were common when interviewees spoke about the impact of the relationship on how they felt.

> *Imagine you're locked in a room on your own and you're scared to open the doors or the windows […] now I can open up and speak and talk about things with them.*

> *I'd say they're more of a friend than a support worker.*

Openness, honesty, and transparency, as well as rapport building were the keys to participants' positive experience with HF support staff. Developing trusting relationships in which they felt like they were treated with respect and like 'an adult' were important to service users who largely felt that the approach their support workers took with them was effective and non-judgemental.

> *The honesty I was getting – straight answers, honesty and there was always effort put in.*

> *They actually treat me like an adult. [...] They [Housing First] are coming with no judgement, they come to be here for you. They sit with you; they listen to your voice. And take your words as accountable instead of talking to third parties about you.*

Non-conditionality and 'stickability' of the support offer appeared to be crucial. Interviewees described situations when support workers calmly talked them through moments of crisis, created a space where they could take a step back to avoid escalation of frustrations or steered them towards getting the right support without "jumping through hoops". Knowing that someone was there for them no matter what the situation was a significant factor contributing to the quality of relationship between individuals and HF.

> *I get angry very easily and have a bad trait that I just walk off if I think someone is getting pissed off with me … But [name of worker] never made me feel that way. I don't understand a lot of things, I get so muddled up, [but] [name of worker] will let me take a step back and explains everything in a way that I don't get frustrated.'' ''My life's pretty chaotic, do you know what I mean, and they don't give up on me. They help me the best they can.*

Interviewees felt listened to and reported that their support workers made an effort to understand them while also helping them understand and tackle things with which they struggled.

> *What they've done for me and how they helped is amazing. They listen, they take the time to understand each individual. They don't just say 'This is what you need, this is what you need to do'. They ask you, they find out about your problems and your issues, and how we go about it, you know?*

Consistency of support worker

Not all interviewees had the same support worker from the start, with two having had five different staff working with them within the space of 2.5 - 3 years. This reportedly impacted on how close they could become with their workers, but it did not impact on the support received. In situations when service users requested a change of a support worker or declined such proposed change, this was felt to have been handled quickly and respectfully by HF.

Issues with staff shortages were reflected in some of the interviewee's accounts. For example, one service user observed that they had to do more for themselves as a result of their support worker having seemingly less time available for them.

Having a 'second' main worker was a valuable and reassuring resource to some of the service users during the times when they needed extra support, or their 'main' worker was on leave, and could receive support from someone they were familiar with. The GM Pilot area offers a 24/7 helpline which provided reassurance to people that they were never fully 'on their own'.

Shared life experience was again something which service users valued about their support workers, with one exception of an unwelcome disclosure from a staff member with lived experience.

Frequency of contact

At the time of the interviews service users felt that the frequency and type of contact with support workers was on the right level and that they were able to decide about this. Some participants received daily phone calls and visits from their support workers whereas for others face-to-face contact happened on a weekly basis with phone calls in-between, or less frequently, depending on need.

> *I get a call every day, even at the weekend. I can say things to them and they're not judgemental, or over reactive.*

Increased support and contact usually took place during times of crisis or difficult periods but also when interviewees required assistance with their appointments. One participant highlighted how daily visits contributed to them developing trust after years of negative experiences associated with homelessness and institutional care. The frequency of contact often decreased after the initial period of intense work and once interviewees were set up with necessary arrangements in place.

Ongoing support

Satisfaction with ongoing support was almost uniformly expressed by interviewees who reflected on the 'distance travelled' and the changes in their lives which had occurred since working with HF.

> *I've felt supported from the moment they started working with us, to, well, to now. I look forward to [Support Worker's] visits.*

A focus on problem solving was described in some of the interviews.

> *I didn't believe it at first, but they've changed my point of view. I couldn't wish for anything more.*

Exceptions included a participant who expressed dissatisfaction regarding the time it took for an accommodation offer and how this affected their relationship with HF detrimentally. A second person reported a decrease in the amount of time which their support worker could offer to them.

The attributes of the support workers and their approaches (see above) contributed to the participants' confidence in the service. A number of interviewees reflected that they did not feel the need to work with other services in order to progress on their path of recovery because of HF support. Moreover, none reported feeling pressurised to attend any other service if it was something they did not want or feel ready for.

Practical support

Levels of support varied between interviewees and depended on the need and aspirations of the individual. Those who were in their own tenancies described receiving support with different aspects of managing a tenancy which proved challenging at times for some. Areas commonly identified as problematic included making and keeping appointments, paying bills, managing phone calls and finances, safety issues due to antisocial activity in the area, property damage or cuckooing. When deemed beneficial and/or necessary some service users had received assistance with managed moves.

During periods of transition prior to moving into a permanent tenancy interviewees could access temporary accommodation or remain on the streets while still being able to receive all the assistance they needed from HF.

> *I felt like I had like, some support people who were actually there for me.*

Holistic Support

Those service users who felt more settled gave accounts of a greater focus on areas such as social integration and the ability to commit to working towards their aspirations and future plans, as well as re-engage in former interests. Some interviewees had developed positive relationships with neighbours and built up the confidence to interact with the wider community.

Having a house and support has changed my lifestyle completely. I've reduced my drug taking and I'm volunteering. I'm going out and speaking to people, "normal people" who aren't on drugs.

Being able to reconnect with family members, especially children, scored high on the list of achievements for interviewees who considered support from HF as a catalyst.

I'm back in touch with my [child] because of Housing First.

In one case HF were able to help an individual to set up a recovery group by providing meeting space and a small budget for the endeavour. The support given to make choices was integral to promoting recovery from mental health and substance misuse issues.

This is working a lot better for me. I feel more relaxed.

Reflections on Housing First and reported benefits

Housing First compared to previous experiences of service provision

Despite several participants sharing some negative issues they had had with Housing First, all participants across the three Pilots shared positive reflections of Housing First in general. Some participants reported that they were referred to HF through services they were engaged with at the time and that the trust they had with the staff there had led them to approach HF with an open mind.

Others reported receiving support from services other than HF and found that these services were working well together. However, many participants reported that their experience of the HF was different to those they had had with other homelessness services throughout their time in "the system". Some participants were very sceptical of HF and their promises of housing and support when first encountering it.

I just wanted to prove [..] that it couldn't help… but it did help me!

I've got bad experience of all different types, and I thought at first that they [HF] would be like the others. Get bored of me, I'd be too much, and I'd have to move on, but it wasn't like that, and I have full faith in them.

The following sentiment was echoed by many of the interviewees:

HF is a support network I've never had. It's better than any service I've ever had. They seem to have it down, treat you as an individual and really see you that way. It's made really easy for me.

Interviewees described a lack of faith in other services – some of which they described as "useless", but were happy to find that HF, *'just made me feel really comfy'* and *'went above and beyond.'* Some participants shared that they had heard of HF through friends who were already on the programme who encouraged them to get a referral as they '*give you more help'.* One participant was enthusiastic in spreading the word about HF to others who might be eligible for the service: '*I'm proof that it works*'. These recommendations helped participants to trust in HF and believe that HF would deliver on promises made.

Many of the participants had positive experiences of HF compared to other services they had received in the past. This hinged on receiving the right level of support for the individual, and the genuine effort HF put into acquiring a property for them - even if waiting times for those properties were fairly long in some cases. Participants shared that the level of support they received was suited to them and their needs as individuals, rather than having a support plan set out for them that they must try and stick to. One participant reported that in the past, other services were *"setting goals that [they] couldn't achieve,"* but that they *"never had any of that with Housing First."* A second explained:

> *In other services I've had rules and you must do this and that and with Housing First I've never felt under threat. No one forcing you, do you know what I mean? Everything that gets mentioned as far as I'm concerned is in my best interest.*

Participant accounts suggest that the flexible, person-centred approach to support taken by HF had been effective for them. Participant perspectives also suggest that support workers are there when they need them and have time to source resources that service users need, as well as being able to build relationships with other services they might be engaging with. The time in which support workers must perform all these tasks relies on manageable support worker caseloads.

With HF's smaller caseloads and flexible approaches to support, service user and support workers are afforded the opportunity to work together with more focus and time to get the service user the things that they require to progress towards a tenancy and tenancy sustainment. It should however be noted that in some areas caseloads were growing and this was having a detrimental effect on the amount of time support workers could spend with individual service users (see above). That said, from the service user perspective HF is different to other services in that they are able to build trusting relationships with their support workers, had choice and control over their support, and they receive this support without conditionality.

Reported benefits

Participants were able to give many examples of the benefits of being on Housing First. The most frequently reported benefits were being offered the opportunity to accept a tenancy in an area chosen by the participant, and the level of flexible, ongoing support received from HF. These were reported to affect other areas of a participant's life, such as being able to seek help and support with physical and mental health and had led to a number of participants reducing their drug and/or alcohol intake:

> *Obviously, number one would be the physical property, but number two would be the support I've got from [Support Worker] – knowing that I was going to become homeless, but knowing there was someone there to help me, to support me.*
>
> *It was the support that was telling me "Look, that's not gonna happen here, we are gonna help. Yeah, we are gonna get you somewhere." And they followed through with the property.*
>
> *Having my own place really does help me to get back up when I do fall down [figuratively]. And living on the streets my health was bad all the time. Since I've*

been indoors my health seems to be just getting better. Everything is getting better. I'm a lot happier… I'm fitting right into the community here. I've made loads of friends around the area. It's nice to know that I fit in around here. Normally people are too quick to judge you, all they see is an addict. I'm not getting that so much around here. My neighbours are great, they do a lot for me.

Housing First has enabled many participants to make progress in several areas of their lives. Some of that progress is down to working directly with HF and building partnerships with other services such as mental health teams. While for others simply having their own home to feel settled, alongside robust support, has given them the space to reach out and address issues within their personal lives.

HF has made a huge difference to my life. It's been a massive, massive difference to my life. Having my own place, my own space, my own time to be who I want.

Participants reported receiving help and support with the following:

- Sourcing a property
- Help in moving into and furnishing property
- Help with making and keeping important appointments that are essential to different areas of progress for the individual, and essential to maintaining a tenancy
- Making phone calls and getting in touch with authorities
- Getting assessments, support, and treatment for mental health conditions
- Getting assessments, support, and treatment for physical health conditions
- Being able to set realistic goals and working towards them
- Seeking drug and alcohol addiction treatment
- Reduction in drug and alcohol intake
- Finding voluntary work
- Help with the process of getting on the correct disability benefits
- Financial management, including paying bills
  Moral and emotional support, or "just knowing someone is at the end of the phone when you need them."
- Beginning the process of being reunited with children
- Getting a pet for companionship, something to care for, and to aid in better mental health
- Help with food shopping and the use of foodbanks when needed
- Help in finding meaningful activities such as the gym or accessing services that provide a social space for people with certain needs.

Next steps

Many participants described different goals and aspirations for their future, while some were more uncertain. The most common responses focused on stability and maintaining tenancies. Many also expressed the belief that for them to remain stable or progress they would need continued support from HF. No participants expressed any desire to return to rough sleeping, and several were enthusiastic about their plans for the future, including employment, education, and volunteering.

In the next six months I want to get settled in properly. Get over this year and start a fresh new one. I want to set up my own business. I want to own a food truck. A Caribbean food truck.

In 12 months, I will definitely be working […] I think I'll probably get construction or landscaping jobs.

Some clients expressed a desire to "graduate" from HF but for others planning for the future made them anxious or they explained that their futures depended on things like the outcome of court cases, reducing their drug use or improving their physical health.

In the next 12 months I want to get better, to get my detox. To reinvent myself. To see my kids, to have them knocking on my door. I am back in touch with my child because of HF.

I'm not really in a dark place now. I'm in a lighter place now […] I'd like to draw again, get back to normal, stay off the drink, get off the pregabalin, and get stronger again… I'd like to write as well, a creative writing course or something.

Knowing HF are there helps a lot. At the moment I don't need much, apart from getting my health back. I'm looking into voluntary work to try and get back into things. I'd like to work with dogs. I've always had dogs. I can't have a dog in my accommodation at the minute, but I want to apply to have a therapy dog. Take it out for walks and that, give me something to do, to go out for.

In the next 12 months I'd like to be drug free and either working full time as a drug worker or working with the homeless. But giving back to society. If I could work alongside HF that would be great. Whatever I can do to make things better for people.

My next six months is to get myself settled in here properly and to be able to say everything's done and dusted. Everything's in place, all my bills are paid and get on with my new life.

Some participants were anxious about HF support possibly ending soon (at time of fieldwork). People who felt particularly anxious about this appeared to be those who received a high level of support from HF. Participants who rely heavily on HF for help with getting access to statutory services were particularly worried. One interviewee, for example, reported having five community psychiatric nurses (CPNs) in the past year. This participant relies heavily on their HF support worker so that they do not have to keep '*repeating my story*'. In these cases, service users were very worried that without a HF worker advocating for them, other services would no longer provide the support that they needed and that this would jeopardise their tenancy.

Interviewees also reported that their support needs might evolve, or their need for support might lessen. However, many still felt they would require some level of on-going support from HF:

> *To stay in my flat, I need the support I have at the moment to continue. I didn't think it would be so soon getting my own flat and seeing my own son. If you said to me, I'd have been able to see my kid so soon I'd have laughed at you. In the future I want to be more settled, see my son more, and get my flat how I want it. Reduce crack use. I smoke weed but that sorts my head out. I want to keep myself busy and spend my money more wisely… the main aim is to not go back to prison.*

> *I would like to be a support worker in the future… [the future] depends on what I will need. There's a lot going on in my life at the minute. It will depend on what happens with all that kind of stuff. I do feel I can pick the phone up straight away and get onto HF.*

6. Outcomes and benefits

For service users

Provider and stakeholder interviewees endorsed service user accounts of outcomes and benefits achieved. They gave examples of clients experiencing positive impacts across the full range of outcomes typically measured for HF programmes (e.g., housing retention, substance misuse, health, criminal activity, social support etc.). What was notable in these accounts was the 'distance of travel' experienced by these clients many of whom had been homeless for long periods of time due to a combination of childhood trauma and other adverse life events. These journeys were often described in terms such as 'astonishing', 'amazing', 'remarkable', 'incredible' and 'miraculous'.

> *They've had some absolutely miraculous outcomes with customers … for example one … within the first 10 weeks of being supported on Housing First he had zero hospital admissions as opposed to 54 in the 10 months prior to that.* (Stakeholder, Housing)

> *We've had some people who have actually gone through recovery, have worked on their addictions, and recovered from those which has been incredible. There're people that we've seen real changes in their mental and physical health from [working with HF], being in a home, a stable environment.* (HF Team Manager)

For some interviewees housing outcomes were highlighted as the most significant and a number of accounts were given of individuals who had been housed after very long periods of rough sleeping – in some cases as long as 20 years.

> *It's enabled people that we've seen rough sleeping or have very transient lifestyles or where they might have had several tenancies over a number of years, a number of decades…We've seen people finally settle down, and this has worked for them…it'd be a travesty to lose that.* (Stakeholder, Housing)

Even when clients had sadly passed away it was pointed out that '*at least they died in their own home and not out on the streets'* and/or that they had been afforded a greater level of dignity at the end of their life than would otherwise have been the case. This was noted to have been a comfort to bereaved family members in some cases.

For some service users outcomes had been life changing and examples were given of individuals who had totally 'turned their lives around':

> *I had a lady that was very high on heroin and was an alcoholic. She's now completely clean. She's still on script but she's not taking drugs. I think that's a really good thing for her because she was on it for years. She's transferred from her property because she had some violence at the property; someone broke and threatened her so we had to get her transferred. She's very happy where she is now, and she's really settled. She's doing really well, paying all her bills. It's just the simple things isn't it just to get her settled and happy. I'm referring her onto bike riding classes and things and she's doing well socially.* (Support Worker)

> *I've got his lad... He was smoking heroin, cocaine, whatever he could get his hands on really, just smoking. He had anger issues. I think it was who he was hanging around with and being on the streets. But since we've housed him, he's doing absolutely amazing. He loves it. He doesn't stop tidying. I referred him to an agency because he was interested in going back into work. He went and did it all himself, went into the agency, is now working full time, nights. He does have a bit of a wobble now and again with neighbours but if I go around and have a word with him… he's okay. He's doing absolutely fantastic. He now picks up his script fortnightly whereas [previously] it was supervised daily.* (Support Worker)

Interviewees also commonly emphasised the significance of developments on service users' journeys that could not be captured by traditional outcomes measures. By way of example, one housing provider reported that from amongst the modest number of people her organisation had accommodated: one tenant had celebrated their birthday with a cake for the first time ever, another visited a GP for the first time in over 35 years, someone else had cataract treatment after suffering impaired vision for many years, another had received dental treatment after living with tooth pain for years, and someone else learned to ride a bike after never having had the opportunity to do so as a child.

Interviewees also noted however that for some clients, measurable success had thus far been limited but that without HF they would be in a far worse situation. The following account reinforces the message that HF needs to be delivered as a long-term programme of support.

> *It's easy to look at the clients and see loads of barriers…. But if Housing First wasn't in place for a lot of our clients they would literally be on the street and in a worse state than what they are in now. So, although, we're going round in this massive circle and coming back. I think that in itself - there is something positive in that because if Housing First weren't there, there would be… nobody to chase the mental health team and get them on board. And keep on at the doctor to see the client because it took, I think, about five weeks for the client to get to the doctor…So without Housing First would that client had gone to the GP and got checked over? Probably not…. it's about having the energy, the motivation, the willpower, to actually fill out a referral form and the condition that some of our clients are in, they don't have that motivation for themselves and the willpower just yet. They are at the stage where they need someone to help them to kind of push them up, and when they fall that you're there and you say, 'don't worry if you can't make that, we will make you another appointment, please don't worry'. It's a case of keeping their head above the water, maybe not as much as we'd like, but it's still progress. It still success. They are still keeping afloat somewhat'.* (Support Worker)

For organisations

Housing First has reportedly been well-received by the homelessness sector overall in all three Pilots, primarily because it offers a solution for the vast majority of those with multiple and complex needs who take up an offer of HF. Demonstrable successes with individuals who had been known to services for long periods of time and for whom solutions had been wanting had contributed to growing appreciation of the value of the HF approach:

> *Housing First are able to offer support to a cohort that have been very difficult to engage, house, sustain a property in the past because of their multiple and complex needs. Normally the sector would be looking to house them in TA [temporary accommodation] and this role is now reduced because of Housing First.* (Stakeholder, Housing)

> *There have been key successes with clients that they have been through that revolving door several times, and so it's very well received.* (Stakeholder, Local Authority)

Stakeholders across all three Pilots observed that HF had improved awareness of the needs of the experiences and needs of homeless people, and contributing to heightened understandings of the value of working in more person-centred, flexible and trauma informed ways:

> *One of the outcomes is that it's helping agencies to understand that people who have been through significant trauma will view things completely different to people that haven't been.* (HF Team Manager)

HF providers also reported learning from their engagement with external services, with staff reporting a greater understanding of how mental health provision works and how to navigate associated processes more effectively.

In WMCA one provider reported extensive learning for them as an organisation both in terms of effective working with the HF client group and working with partners in the homelessness sector. They were hopeful that this would have a legacy effect for their organisation enabling them to grow into a wider role in delivering services to people who sleep rough.

In both GMHF and LCRCA the role played by people with lived experience in HF was reported to have heightened awareness of the importance and value of their involvement in service design, staff recruitment, training, and quality assurance exercises.

> *They have changed as a combined authority. In terms of recruitment and direct delivery. They are much more focused on people with lived experience being a part of the combined authority employment* (Stakeholder Combined Authority)

In GMHF there is now a requirement for the involvement of people with lived experience in new service specifications as a consequence, at least in part, of learning from the Pilot, while in LCRCA the lived experience group is increasingly asked to input into wider strategy development.

7. Looking ahead and sustainability

The primary issue at the forefront of stakeholders' minds at this point in the Pilots' maturation is the longevity of funding to support existing clients and, by extension, implications for the long-term sustainability of (these and other) HF programmes in England. The lack of assurance regarding the continuation of funding had been extremely anxiety-provoking for service users and staff alike at the point of fieldwork in those areas where the Pilot end-date was imminent. This had contributed directly to the loss of valued frontline staff in GM and WM; a similar situation was anticipated in LCRCA further down the line (given the later end-date in place at the point of fieldwork).

Uncertainty regarding the continuation of funding had also made housing providers reticent to offer (more) properties for HF clients, thereby compounding the difficulties support providers already faced in sourcing suitable housing.

At the point of interview, serious concern was expressed by providers and external stakeholders alike regarding the risk that the achievements of the Pilots may well 'unravel' should funding end and the care of existing service users be handed over to providers who were less well-resourced and/or insufficiently equipped to provide the level and nature of support required.

Frontline workers especially were very worried about the likely impacts of 'abandoning', 'letting down' and potentially (re-)traumatising service users should HF support end. These anxieties were echoed by service user interviewees, many of whom doubted their ability to cope should HF support be withdrawn.

> *I'd be really concerned if we took the model and then try and place it on an existing [local authority] team and expect them to do this because…the efficacy in this work has been about those small caseloads and that intensive approach.* (Stakeholder)
>
> *We don't want to traumatise people by promising the continuation of support and then disappearing*. (Provider)
>
> *They've given me all the support I really need, they're there for me … All I want is for them to not disappear.* (Service user)

In this vein, experiences during the past year have lent substantial weight to a growing call for the provision of much longer-term commissioning arrangements for services supporting people with multiple and complex needs. This, interviewees argued, is essential if providers are to be able to operationalise the principle of offering flexible support for as long is needed (see also above), which a growing body of evidence from the Pilots and other HF programmes in the UK indicates will exceed the length of the Pilot by some way for the vast majority of clients[10].

[10] Blood, I. et al. (2021). *Reducing, changing or ending Housing First support*. Available at: https://hfe.homeless.org.uk/sites/default/files/attachments/Reducing%2C%20changing%20or%20ending%20Housing%20First%20support.pdf. Johnsen, S. (2021) *Scotland's Housing First Pathfinder Evaluation: interim report*. Heriot-Watt University, Edinburgh. Available at: https://researchportal.hw.ac.uk/en/publications/scotlands-housing-first-pathfinder-evaluation-first-interim-repor-2.

What demoralises me [is] the short-term nature of the thinking ... You need long term thinking, not 2- to 3-year pilots and an extra 12 months here and there…it just doesn't work. (Provider)

This highlights a critical imperative for stakeholders within the homelessness sector, including central and regional governments, to consider what open-ended support 'looks like' practically in terms of procurement as HF programmes are scaled up. Allied with this is a growing call for a change of mindset amongst the commissioners of mental health and drug/alcohol services, such that staff within these have licence to exercise the flexible approach that is widely recognised as being necessary in work with this client group[11].

Importantly, whilst a very small minority of senior stakeholder interviewees (all in WM) suggested that the principles should be 'revisited' when delivering HF at scale, the much stronger weighting of opinion across the board was that fidelity to the principles is pivotal and should be promoted. There was very strong appetite amongst provider and stakeholder interviewees for fidelity to be monitored systematically in the longer term given anxieties regarding the risk of 'dilution' post-Pilot. On this issue, interviewees expressed particular concern regarding the possible imposition of limits to the longevity of support offered and/or conditionality regarding engagement with treatment as HF is scaled up given the resource pressures affecting local authorities.

The preservation of low caseloads will need to be central to any attempt to safeguard fidelity, given evidence that support workers' ability to deliver the intensity and flexibility of support HF users require is severely compromised if they take on additional clients during periods of staff shortage, for example. Attention will also need to be paid to the prevention of staff attrition, not least by avoiding the situation wherein staff move on to new roles elsewhere because of a lack of communication regarding their job security at contract transition points. Moreover, investment in appropriate levels of supervisory and clinical support for frontline staff will be essential going forward if high quality staff are to be retained and their wellbeing protected (see Section 4.).

[11] Luchenski, S. et al. (2018) What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *Lancet, 391:10117): 266-280.* https://doi.org/10.1016/S0140-6736(17)31959-1

8. Conclusions

During the past year, the Pilots have continued to grow in scale such that by the end of November 2021 they were supporting a total of 998 individuals with histories of homelessness and with multiple and complex needs - 78% of whom were housed. The vast majority of individuals being supported had sustained their tenancies with nearly half (48%) having done so for between one and three years. The vast majority continued to require support with only a very small number (32 individuals) 'graduating' because they no longer required HF support. Service users spoke highly of the support they had received from HF, valuing its non-conditionality and 'stickability' in particular.

In addition to housing outcomes, qualitative interviews with service users, triangulated with discussions with support workers and other staff, provide evidence of a range of other positive outcomes and benefits. These include outcomes typically measured by HF programmes such as reduced substance use, better health and increased social integration as well as outcomes that are difficult to quantify but nonetheless very important. Non-quantifiable outcomes were often highly individualised and included things such as eating a cooked meal for the first time in years, baking a cake and learning to ride a bike. Some individuals had ambitions for future employment while others were looking ahead to achieving short-term goals such as maintaining contact with previously estranged family members or reducing dependence on drugs or alcohol.

Beneficial outcomes for organisations and the homelessness sector more widely were also in evidence. First amongst these was that HF has offered a solution to people for whom other service interventions have had limited success. A heightened awareness among partners of both the needs homeless people and the value of working in more person-centred, flexible ways was also highlighted.

A number of valuable lessons have been learned in the past year which build upon those documented in earlier interim evaluation outputs. Key learning highlighted by interviewees during this past year has included:

Commissioning and monitoring

- The scale, characteristics and needs of the target group and nature of the housing portfolio can vary substantially at the local level between local authorities within the same city region. This variability should be borne in mind when HF services are commissioned and/or targets developed going forward.
- There are benefits in commissioning HF services from an external provider, with the combined authority providing oversight and support. This enables HF to be better integrated into the mosaic of homelessness and other services locally thereby facilitating local ownership and buy-in.
- The incorporation of healthcare specialists within HF partnerships helps to overcome many of the barriers to healthcare affecting clients. On this issue, the inclusion of psychiatry as well as psychology input alongside the DDP contribution has proven beneficial in GM.

- Pilot experiences suggest that key performance indicators need to be formulated very carefully if they are to be genuinely meaningful given the complexities and needs of this client group. Data collection processes need to be designed so that they are logistically feasible for the same reasons.

Fidelity to principles

- Key challenges to adhering to the key principles of HF have included the limited availability of appropriate housing stock, staff shortages, and uncertainties over longer-term funding.
- Some HF principles are more challenging to operationalise than others. The commitment to long-term flexible support is particularly difficult to implement given the short-term contract culture that prevails in the UK homelessness sector.
- Levels of awareness of HF principles amongst external stakeholders have improved substantially overall but understanding regarding the remit of HF and parameters of the HF support worker role remains variable in some places.
- Sufficiently small caseloads need to be protected if fidelity to HF principles is to be preserved. Exceeding the intended maximum threshold causes support delivery to become reactive and 'crisis-focussed', thereby compromising the quality of care that staff can offer.

Recruiting and supporting staff

- Consideration of candidates' values is extremely useful when recruiting frontline staff, but care should be taken to avoid placing too much weighting on values vis-à-vis professional experience.
- The provision of support for frontline staff is critical. Reflective practice is invaluable: it helps support workers to meet clients' needs and cultivates their own resilience. There is a need for further reflection and development in this general area, particularly regarding the most appropriate means of offering clinical support.
- Higher than intended caseloads can have a severely detrimental effect on staff members' health and wellbeing, leading to a high level of stress-related absence and limiting the capacity of staff to engage in activities aimed at promoting their wellbeing.

Supporting service users

- It is important that HF providers be 'honest' with service users regarding the potential time it may take to secure suitable housing so as to avoid jeopardising their trust in support workers.
- Support workers need to be able to exercise the flexibility required to capitalise on windows of opportunity when clients express willingness to engage with support. This is not possible when caseloads are too high.
- The period immediately after a service user moves into their tenancy presents a key window during which conversations about goals and interests might usefully

be (re)initiated, with a view to promoting community integration and combating social isolation.

Working with other agencies

- Establishing robust service level agreements with housing providers at the outset is advisable. These should set out clearly the type and level of support provided by HF staff and the steps that would be taken should problems with a tenancy arise.
- There should ideally be an agreed pathway for rehousing tenants when a move is necessary, most notably when there is an incidence of cuckooing and a service user's safety is threatened. A rapid response involving police input is essential in such circumstances.
- Whilst joint working with housing officers is to be fostered, housing providers should be discouraged from asking HF support workers to pass on messages when enforcement action (for rent arears or anti-social behaviour for example) is being threatened or pursued.
- In some areas there is scope to articulate more clearly the role of HF workers when service users are resident in temporary accommodation prior to accessing settled accommodation or transitioning between settled properties.

Sustainability

- The strength of case and level of appetite for longer-term commitments to funding for HF (and indeed other services supporting people with multiple and complex needs) are growing ever stronger. As previously reported, these should ideally involve cross-sectoral contributions.
- There is a strong level of appetite for the promotion and ongoing monitoring of fidelity to HF principles as the approach is scaled up nationally so as to avoid programme dilution. The preservation of sufficiently low caseloads will be essential in this endeavour.
- Whilst incorporation of healthcare specialists within HF partnerships are very helpful in the short- to medium-term, broader systems change is nevertheless still required if the barriers to healthcare affecting HF's clientele are to be addressed sustainably going forward.

Appendix 1. Housing First fidelity review: summary

The most recent assessment of fidelity[12] was undertaken between October 2021 and January 2022 by Homeless Link. Due the West Midland's devolved model, for the purposes of this review three different local authorities (Birmingham, Solihull, and Walsall) were examined individually, while Liverpool and Greater Manchester were each reviewed in their entirety.

Fidelity ratings across the seven Housing First Principles range from low to high and, in this review, two pilots received ratings between medium and high, while some local authorities in the West Midlands received lower ratings in some areas. The review included: interviews with strategic leads, housing providers, and commissioning managers; separate focus groups with team leaders and support workers; and follow up questions, as required.

Across most of the programme, there continues to be high adherence to the Principles in areas where support teams have direct control over delivery. This was particularly evident in the use of active engagement, strengths-based, and harm reduction approaches (Principles 5, 6, and 7). This included how services were able to highlight many of the creative ways they adapted during times of higher levels of pandemic-related government restriction.

In addition to the impacts of the pandemic on service users' mental health and feelings of isolation, it also helped create opportunities for increased partnership and joint working. While challenges still exist with external agencies' understanding and adherence to the Principles of Housing First, some services have worked incredibly hard to continue providing training and raise awareness across their local areas and with partner services. However, across all three regions there continue to be important systemic factors impacting fidelity that can only be resolved with government support and leadership. These include:

The impact of funding uncertainty
One of the greatest challenges that emerged across all three pilots was the impact of funding uncertainty. This has been one of the main contributing factors to areas of lower fidelity across this review and demonstrates the inherent tension between offering a flexible, ongoing service (Principle 2) when funding is only allocated for a short time period.

Staff described housing providers not being willing to offer properties due to the lack of confirmed funding. As ongoing government funding remained unconfirmed at the time of writing, some staff described extreme anxiety around the potential loss of support for service users they have been working with. Many also described feeling that they had no choice but to look for a job with greater stability.

[12] 'Fidelity' refers to how closely the service align to the key Principles of Housing First, as outlined by Housing First England: https://hfe.homeless.org.uk/principles-housing-first

As graduation rates have been very low across all three regions, these fidelity reviews have increasingly found the presence of an imminent funding end date to be discrepant with the need for ongoing support.[13]

Housing supply

Throughout the duration of the Housing First pilots, staff have worked incredibly hard to find creative strategies to increase housing offers. These include working to increase the number of social and PRS landlords pledging to HF, new housing pathways through direct matches with housing associations, and adjusting providers' policies (e.g., reference requirements or requests for rent in advance).

Challenges with the undersupply of social and affordable housing in this country are well documented. Many cases were described of clients needing to wait several months, including a small number of cases where clients had to wait up to or over a year before receiving housing offers. This situation is exacerbated for clients needing accessible properties. Along with funding uncertainty, staff described this as the key barrier and an ongoing struggle that, if left unaddressed, will be a significant inhibitor to the ability to offer Housing First to service users moving forward, and which may be more problematic over time as the need for homes increases.

[13] At the time of completing this evaluation round, there has been funding earmarked for an additional two years of HF provision. Programmes have submitted plans but this has yet to be formalised into agreed allocations.