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Evaluation of homelessness interventions: value for money

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Glossary

Glossary text

Acronym/Key word	Definition
COPD	Chronic Obstructive Pulmonary Disease
HF	Housing First
HF4Y	Housing First for Youth
PCSOs	Police Community Support Officers
VfM	Value for Money
YIF	Youth Homelessness Innovation Fund

1. Introduction

1.1 This report covers the Value for Money strand of an evaluation of homelessness interventions in Wales, which was commissioned by the Welsh Government to support homelessness services transformation. Imogen Blood & Associates were appointed to conduct the evaluation, which ran between February 2022 and February 2024.

1.2 The aim of the evaluation is to understand the impact and approaches of the interventions funded through 3 national programmes: Phase 2 approach to Homelessness; Housing First; and Youth Homelessness Innovation Fund (YIF). These programmes and the approach and findings to the wider evaluation are described in the main evaluation report.

1.3 The original specification for the evaluation included a cost benefit analysis of the three homelessness intervention programmes. However, the initial review of documents confirmed that, especially in relation to the Phase 2 funding, there was insufficient data available on expenditure and outputs to undertake this analysis. In addition, the document review highlighted it would be very difficult to disentangle this funding stream from others used locally.

1.4 It was agreed that the evaluation would focus Value for Money analysis on Housing First (HF) and, to a lesser extent, Housing First for Youth (HF4Y) since these are established models with an existing evidence base which can be used to assess costs and benefits. Additionally, there is recognition of a gap in HF cost benefit analysis within the Welsh context to date, which this project might begin to address.

1.5 The following table shows the actual spend of each of the 3 programmes:

Table 1 Actual spend of 3 programmes (rounded to nearest pound)

	2019-20 **Actual spend**	**2020-21** **Actual spend**	**2021-22** **Actual spend**	**2022-23** **Actual spend**	**Total**
Housing First	£1,109,879	£1,709,579	£1,814,766	£1,872,704	£6,506,928
Youth Innovation	£1,969,738	£3,008,232	£3,119,295	£2,823,349	£10,920,614
Phase 2 revenue	n/a	£4,195,285	n/a	n/a	£4,195,285
Phase 2 capital	n/a	£20,149,032	£16,469,081	n/a	£36,618,113

1.6 The next section contains a spotlight on HF, which discusses general considerations in assessing cost effectiveness, before presenting the findings of value for money analysis carried out on a series of diverse case vignettes drawn from HF projects within the sites selected for inclusion in the evaluation. Further case vignettes are then presented, drawn from Youth Innovation Fund (HF4Y) and Phase 2 examples to explore value for money in relation to these programmes.

2. Spotlight on Housing First

2.1 The evaluation considered 2 services funded by the Housing First Grant Programme (one of which included 3 projects) and 2 HF4Y services funded by the Youth Homelessness Innovation Fund (YIF). A viability assessment of the available data determined that it was possible to develop a series of vignettes and scenarios to explore cost effectiveness and cost avoidance to wider services, though with limitations.

Limitations

2.2 Using exact data for cost effectiveness analysis presents some challenges. Highly detailed trajectories through services are both hard to obtain and are likely to be individually identifiable. For that reason, the case vignettes used in this report are drawn from real life examples, but details have been omitted to protect the person's identity. Alongside this, actual service costs are commercially sensitive data, i.e., local authorities and homelessness service providers do not want to share exactly what resources have been agreed to when a service has been commissioned in a context where much of the funding of homelessness services is by competitive tender. This approach is also taken here, so that 'blurred' rather than actual costs and/or some estimation based on what is known about service costs elsewhere, are employed, rather than actual data. (Pleace and Bretherton, 2019).

2.3 Healthcare in Wales is paid for using a block contract. As such, the research team has not been able to identify Wales-specific health reference costs for individual health reference groups at individual patient level. Therefore, NHS England reference costs are used in the costing estimates in this report. It is likely that these slightly underestimate costs due to the economies of scale possible in English cities, which might not be possible in Wales. Some moves towards case level data in homelessness services have been started (Thomas and Mackie, 2021), and could potentially provide more precise estimates for the Welsh context in the future.

2.4 It is important to note that not all benefits are easily quantifiable. For example, a HF service may be able to help someone re-establish contact with a loved one having become estranged. Although evidence shows that connection is important in mental

health, and that loneliness can increase the risk of cardiovascular disease by 30% (WHO, 2023), it is not possible to put a numerical value on reconnecting with a parent or a child. Some of these benefits have been listed in this analysis; the fact that they have not been ascribed a monetary value is less because they are valueless and more because they are invaluable. The opposite is true of rough sleeping, which may not incur direct costs to local authorities (at least in the short term, for accommodation), but which has clear risks and disbenefits for individuals and can increase longer-term spending by the State.

2.5 In addition, it is hard to track people after interventions take place. NHS data is highly confidential, and it is not ordinarily possible to be sure whether an individual's gains in reducing their service use have been sustained. It is also important to be aware that some people manage to reduce their NHS use without intervention (British Red Cross, 2021). Due to these constraints, the analysis takes a relatively short-term window as the likely horizon rather than trying to ascribe lifetime or ten-year values to reduced service use.

3. Cost effectiveness in homelessness services

3.1 Cost effectiveness can be difficult to measure for homelessness services in several respects. Assessing homelessness service effectiveness over time can be difficult when contact with those services is quite short-lived and it is impractical to track outcomes over time. For example, if someone uses supported housing, exits homelessness through that route, but then loses a tenancy and presents as homeless in a neighbouring authority, there may not be any way of tracking that experience. People experiencing homelessness will also self-exit services, which may sometimes be because they have found their own way to exit homelessness itself or it could be a return to homelessness, but that may not be apparent unless further service contact of some sort happens at a later date. In addition, some low threshold services, like an informal emergency shelter operated by a local church on a charitable basis, may not keep records at all, which means that if someone who has unsuccessfully left a commissioned service turns up there, it will not be recorded. When it is difficult to track outcomes over time, unplanned exits from homelessness services and/or temporary accommodation can be difficult to interpret, e.g., the extent to which self-exits from homelessness may be occurring alongside possible returns to homelessness.

3.2 Alongside this, bringing administrative data together to explore costs from a multidimensional perspective can be challenging. Wales (Thomas and Mackie, 2021) and Scotland (Waugh *et al*., 2018) have both made significant progress in linking General Practitioner (GP), addictions service and other health service data with nationally collected administrative data from their statutory homelessness systems. However, the capacity to look at 'whole system' individual trajectories, across entire homeless populations, i.e., tracking all contacts with publicly funded services, ranging from social care/social work, health, mental health, addiction, police and criminal justice, alongside patterns of homelessness service use over time, which has been developed in Denmark (Benjaminsen *et al*., 2020) and at a smaller scale in the USA (Culhane, 2008) is not yet in place anywhere in the UK. This means that assembling a 'total cost' of homelessness and the cost offsets that homelessness services may generate is difficult to do across whole systems.

3.3 There are however several ways in which it is possible to explore cost effectiveness of homelessness projects. One is through longitudinal analysis that tracks statistically representative groups of people experiencing homelessness over time, something that can be difficult to orchestrate and fund. Two other methods, which are explored here, involve:

- Looking at what administrative data that is routinely collected by homelessness services can tell us about changes in wellbeing, patterns of service use and the relative effectiveness of services and
- Using fairly detailed individual case studies on patterns of service use before and after engagement with a homelessness service.

3.4 Neither necessarily provides a full picture. However, administrative data can highlight things about effectiveness, e.g., do people keep coming back to a service in a 'revolving door' pattern, signalling that lasting solutions to homelessness are not being delivered. Alongside this, individual stories of service use can tell us quite a lot about the capacity of services to generate cost offsets, even if not being able to describe every detail. For example, an individual vignette might show that someone was receiving services costing £40,000 a year across all publicly funded service use while homeless, but HF then brought that down to £8,000 a year. (Pleace and Culhane, 2016; Pleace and Bretherton, 2019). In essence, it is still possible to get a good idea of what is and what is not likely to be cost effective in terms of homelessness service strategy, design, and management, even if a fully comprehensive administrative database, that would allow the tracking of all service use by people experiencing homelessness over time, is not available.

3.5 Where whole systems, such as hostel pathways that take referrals from street outreach and housing options teams, floating support and, where present, HF are working together, administrative data can provide important information on where challenges exist, and where resource use might be reviewed. For example, the Camden HF project, the first in London, stemmed in part from an interest in innovation, but was mainly driven by administrative evidence of a high cost, high risk cohort of people experiencing homelessness who were repeatedly using the Camden Hostels Pathway or becoming stuck long-term in what were supposed to be transitional supported housing services. The successful use of HF in Camden –

and its cost effectiveness – lay in providing an alternative route to the established homelessness services for those who needed it (Pleace and Bretherton, 2019).

3.6 There are 3 main ways of looking at cost effectiveness which will be explored in more detail in the next section, but in brief these are:

- Relative efficiency i.e., not cheaper necessarily but is more successful in terms of outcome and therefore a more efficient use of public finances to achieve targeted outcomes.
- One service model is consistently cheaper than another service model and has comparable or better outcomes.
- Total costs to the public purse are significantly lower when using one model of homelessness service compared to another.

Housing First

Introduction

3.7 The following illustrates the application of the above points in detail, and within the context of HF:

- Relative efficiency, e.g., if a HF service that typically works with someone for 4 years for a similar cost to supported housing that aims to resettle people and cease service contact after 12 months has better outcomes, it represents a more efficient use of public finances, but is not cheaper. Here, HF might be more cost efficient because it has a higher success rate in ending homelessness at similar costs and/or because people using those services report a better quality of life through HF than through supported housing pathways, again at a similar cost. This pattern has been found and used to support the case for HF in the US (Culhane, 2008).
- One service model is consistently cheaper than another service model and has comparable or better outcomes. For example, using HF again, there are those who argue and present research that says overall costs are typically lower than existing systems for its main customer group, i.e., people experiencing recurrent and sustained homelessness associated with multiple and complex needs, with comparable or (often) better outcomes than existing systems (Padgett, Henwood and Tsemberis, 2016).

- Total costs to the State are significantly lower when using one model of homelessness service compared to another. This means that there are meaningful reductions in spending for emergency health and mental health services, and the criminal justice system. These cost offsets are generated by a homelessness service supporting a pattern of transition from high frequency, high-cost emergency service use to lower levels of general service use. For example, if a homelessness service reduces a pattern of someone experiencing homelessness routinely attending A&E 60 times a year to nothing, replacing that with more active management of health and mental health conditions, supported by a lower number of lower cost visits to a GP or other health professionals working in primary care, it is benefitting both the people it supports and the wider public sector through cost offsets.

3.8 There is some need for caution here, since negative comparisons of the efficiency of supported housing, compared to HF, are often based on North American data (Pleace, 2018). Whereas most supported housing services operate on a very different basis, at a very different cost, in Wales. HF was initially compared to what could be expensive, strict, abstinence and treatment compliant based American services, using a staircase or linear residential treatment model. By contrast, Welsh and wider UK supported housing has been more likely to employ the person-centred approaches, choice and control and trauma informed support that is part of the innovation offered by HF for many years (Pleace, 1995).

3.9 Data from experimental randomised control trials in Canada (Lachaud *et al.*, 2021) and France (Aubry *et al.*, 2021) has suggested that HF can reduce frequency and duration of contact with mental health and other services. However, it has also been found that outcomes can be variable, both in the sense that HF does not end homelessness for everyone it works with and in terms of the extent of positive change in mental and physical health, addiction, offending and social support it is able to deliver (Aubry, 2020). The patterns seen in HF are also present in other homelessness services, i.e. what they can achieve can be variable in 4 main ways:

- For cost offsets to be maximised, someone must be using emergency health, mental health, addiction and other emergency services, including frequent contact with the criminal justice system at very high rates and see those rates drop drastically, or fall away to nothing, because of the effectiveness of a homelessness service intervention. If needs are high and there is little or no use

of current health and other services, connection with HF or other homelessness services using effective case management will cause costs to the public sector to spike. Equally, if someone has support needs, which are improved by a homelessness service intervention, but their wider costs to the public sector were not particularly high, something like HF may represent additional expenditure (for which there will still be a case as it is likely to end what would otherwise be long-term or recurrent homelessness, which may have longer term cost benefits1). The challenges here can be addressed by trying to establish broadly typical costs and cost offsets, then considering whether or not a service is reducing overall public expenditure or increasing it.

- Cost offsets may not be realisable in the sense of clearly demonstrating increases in capacity or creating space to reduce expenditure. For example, if a dozen people with complex needs who are routinely sleeping rough turn up at the A&E department of a hospital in a city like Cardiff or Swansea an average of 40 times a year each2, reducing or ending that behaviour through the right mix of support and case management will clearly increase capacity in A&E, potentially reduce some stress and strain on clinical and administrative staff and have other benefits. However, those hypothetical dozen people sleeping rough repeatedly turning up in the A&E will represent a tiny fraction of overall activity, i.e. stopping them turning up because their support and treatment needs are now being met by mainstream primary and social care does not create meaningful levels of additional staff time because of the scale of general demand for A&E. Stopping people experiencing homelessness with complex needs repeatedly using A&E does not mean there is suddenly a spare nurse or doctor, because any space their absence might create is instantly filled by other need. The same pattern exists in relation to criminal justice services, e.g., Police time might be saved, but such is the general demand that, again, resources cannot be reduced or redeployed in meaningful ways (Pleace *et al*., 2013). The challenges around measuring realisable costs can be met to some degree by alternative metrics, e.g., if a homelessness service is removing pressure from emergency services, given the strain on services like A&E, mental health teams or the Police, it can clearly be seen as broadly beneficial.

[1] In the sense that exit costs from long-term and recurrent homelessness tend to increase (alongside deteriorations in mental and physical health, social connection and life chances) the longer it is allowed to persist (Pleace and Bretherton, 2019; Pleace and Culhane, 2016).
[2] NB: These numbers are indicative and for illustrative purposes only; they are based on reasonable estimates from the authors' research elsewhere.

- Outcomes will have some inconsistency in even the most efficient homelessness service. At the individual level, outcomes for services like HF or intensive supported housing that are designed for people experiencing homelessness with multiple and complex needs have to allow for what is often very poor mental and physical health at the point of referral. One issue here is that people using services like HF will not necessarily get better, especially in relation to long-term physical or mental health conditions (which may also develop as a person 'ages in place' in their tenancy) even if service quality is excellent and that better support from HF may cause (appropriate) increases in costs across public services. However, outcomes may also simply be variable, as noted there is evidence that HF is more consistent in ending homelessness than in relation to improvements in mental health, addiction and reducing contacts with emergency services, albeit that it does deliver some improvements (Aubry, 2020). Again, when looking at service efficiency, either in terms of what an individual service is doing or when comparing it with others, understanding what it is typically doing and what the overall performance is like is important, i.e., being careful not to focus only on the most spectacular individual successes or failures. In some cases, people who have experienced homelessness may have health conditions which they were not receiving treatment for previously. In the short-term this may lead to rising costs, though preventing higher costs in the future by preventing conditions reaching severe levels. This is particularly important when exploring service effectiveness through individual case studies.
- Assessing the costs to individual wellbeing and to emergency and other services that homelessness services and systems may have prevented by stopping homelessness from occurring - particularly important in the Welsh context - is challenging because it means dealing in hypotheticals. However, previous personal trajectories that involved recurrent and sustained homelessness and high levels of emergency service use, if they have been altered by homelessness service contact, can serve as a proxy indicator for what services like HF might do in a preventative capacity (in the sense of stopping initial homelessness rather than the usual role of preventing recurrent or long-term homelessness).

Value for Money Case Vignettes

3.10 The cost scenarios for HF looked at in this section of the report are based on a real-life operational HF project in Wales. In this instance, actual costs are available and employed, but for the commercial reasons, the HF service and commissioning local authority remain anonymous. In addition, the costs are slightly 'blurred' in the sense that this section refrains from using exact amounts that might potentially identify where the commissioning local authority and HF service are in Wales.

3.11 6 case studies are employed, drawing on real-life examples shared by the HF service but with personal details left out to preserve anonymity. However, it should be noted they do not actually detail the real trajectories through services or the life experiences of specific individuals.

Value for Money: Case Vignette 1 Housing First

3.12 The first case vignette involves someone, who was living as a lone parent and whose experiences had led to addiction and subsequently, experience of trauma from a child being removed into care by social services. A stable social housing tenancy was lost, and they also lost contact with their child. They had no previous history of homelessness and their experience of it was not sustained.

3.13 Since engaging with a HF service, they have been able to bring their drug use under control and re-establish stable contact with the child who was taken into care. In this example, the person using HF is highly traumatised and has a range of emotional, social, practical and other needs. However, they are not within the 'high cost, high risk' group characterised by very frequent and sustained emergency service use. HF has produced a stable outcome, in that they are housed, their principal treatment and support needs around addiction have been stabilised and their social and emotional needs at least partly met by re-establishing contact with their child.

3.14 This case resulted in significant costs to the public purse prior to HF because of the loss of tenancy through eviction. The costs here, based on Welsh Government funded research, which includes an estimate of total costs by Shelter Cymru of £26,000 is not necessarily the cost that would be borne by an individual social landlord, which might be in the £6,000-£7,000 range (Welsh Government, 2019).

There is also the estimated cost of a 6 week stay in B&B homelessness temporary accommodation, following assessment by a housing options team, at around £500 a week. However, while they are homeless and has had a child taken into care, they are not making use of emergency services, nor NHS or (adult) social work services in the year before being taken on by HF. Necessary support around the addiction and trauma associated with the child having been taken into care and around preventing further homelessness is in place and the outcomes are positive, but they are costing the State more than before homelessness occurred because of being better connected to services through HF case management. However, without HF, there might be a risk of a further homelessness through tenancy breakdown and eviction and further stays in emergency and temporary accommodation and, very importantly, the human cost of homelessness on the family has been mitigated by HF.

Value for Money: Case Vignette 2 Housing First

3.15 The second case vignette is a person, whose trajectory through services has been shaped by a series of abusive relationships and having been both a victim and a perpetrator of crime. Their life involved frequent contact with criminal justice services, and they had been imprisoned multiple times. There were issues with depression and multiple experiences of hidden homelessness.

3.16 In the year before engaging with HF, they completed the last few months of a prison sentence and, being homeless on release, was temporarily accommodated in a B&B for 3 weeks, following an assessment by a Housing Options team. Shortly after leaving prison, they moved in with their then partner, the relationship was abusive and they left after 6 weeks, entering a domestic violence service for 2 months. From this service they were re-referred to housing options and placed in supported housing for people experiencing homelessness for a further 4 months, at which point they were accepted into and supported by the HF service. While they received support in the supported housing, treatment for ongoing mental health and addiction issues was not in place at the point HF began to work with them. Since engaging with HF, they have been placed in stable social housing and there has been

sustained engagement with community mental health and addiction services, they have not reoffended, and their mental and physical health has improved.

3.17 The tables below illustrate costs to the State associated with the year before entering HF compared to the cost of one year of receiving HF for the two case vignettes.

Table 2 Value for Money Case Vignette 1 for Housing First

VfM Case Vignette 1: Before Using Housing first	
Description of cost to State before entering Housing First	**Estimated cost to State (£)**
Social rented tenancy for 46 weeks[1]	£4,830
Eviction by social landlord[2]	£26,000
Assessment by Housing Options[3]	£1,090
Temporary accommodation for six weeks (B&B)[4]	£3,000
Total estimate	**£34,920**
VfM Case Vignette 1: One Year of Using Housing first	
Description of cost to State for one year of Housing First	**Estimated cost to State (£)**
Housing First support costs[5]	£13,000
Social rented tenancy for one year[6]	£5,460
Social worker engagement (child services) @40hrs[7]	£2,000
Addiction services @40 hrs[8]	£3,200
Total estimate	**£23,660**

1. Welsh Government (2023)[3]
2. Welsh Government (2019) [4]
3. Based on 2015 and 2016 prevention research, adjusted for inflation[5]
4. Estimate
5. Based on actual Housing First service total costs, including support and back office costs (anonymised) Pro rata average not that actual expenditure on each service user could fall or rise over time)
6. As 1
7. Source: Jones, K.C. et al (2022) Unit costs of Health and Social Care 2022 Manual.[6]
8. As 7

Case vignette 1 illustrates an estimated saving to the State of £11,260.

Table 3 Value for Money Case Vignette 2 for Housing First

VfM Case Vignette 2: Before Using Housing first	
Description of cost to State <u>before</u> entering Housing First	**Estimated cost to State (£)**
Last 4 months of a prison sentence[9]	£15,230
2 assessments by Housing Options[10]	£2,180
3 weeks in temporary accommodation (B&B)[11]	£1,500
6 weeks in former partner's house	£0
2 months in refuge service[12]	£3,416
4 months in a hostel[13]	£5,238
<u>Total estimate</u>	**<u>£27,564</u>**
VfM Vignette 2: One Year Using Housing first	
Description of cost to State <u>for one year</u> of Housing First	**Estimated cost to State (£)**

[3] Stats Wales: Average weekly rents in stock at social rent by dwelling type, number of bedrooms and provider type
[4] Understanding Social Housing Evictions in Wales Note that this is an estimated total cost from Shelter Cymru and actual costs borne by social landlords may be in the £6-7,000 range.
[5] Pleace, N. (2015) and Pleace, N. and Culhane, D. (2016) as above (adjusted for inflation using the Bank of England calculator)
[6] Unit Costs of Health and Social Care 2022 Manual

Housing First support costs[14]	£13,000
Social rented tenancy for one year[15]	£5,460
Six GP visits[16]	£287
Total estimate	**£18,747**

9. Source: Statista (2022)[7]
10. As 3
11. Estimate
12. Based on Pleace and Bretherton (2019)[8]
13. As 12
14. As 5
15. As 1
16. As 7

Case vignette 2 illustrates an estimated saving to the State of £8,817.

3.18 Value for Money case vignette 2 represents something of an archetype of the potential cost effectiveness of HF because of the combination of complex needs and use of emergency services. The person also has chaotic use of multiple, expensive insecure homelessness services and temporary accommodation, and contact with the criminal justice system that brings a high financial cost to the State. Individuals with these sorts of trajectories exist and when, as can and does happen, HF brings about a marked shift in wellbeing, engagement with support and treatment and stable housing, the financial costs to the public purse associated with that individual can fall significantly. Here, HF is delivering both better outcomes in addressing the human cost of homelessness and reducing the risk of further homelessness occurring. Thus, it is reducing overall public expenditure.

3.19 As noted above, some of the criticism aimed at HF in North America has used the argument that the 'right' combination of high and complex needs and frequent use of emergency and homelessness services has to be present for HF to save money, i.e., claims that whenever HF ends homelessness, it will also reduce the bill for taxpayers as well, are exaggerated, because not everyone has these patterns of

[7] Average annual overall resource expenditure per prison place in England and Wales from 2015 to 2022
[8] Pleace, N. and Bretherton, J. (2019) as above.

high emergency service use. This argument rather neglects the human dimensions of homelessness and the wider socioeconomic benefits of reducing the presence of long-term and recurrent homelessness, including rough sleeping, but also takes little account of evidence around relative cost efficiency i.e., public expenditure on some forms of homelessness services, like HF, reduces homelessness more effectively. In other words, even if, on balance, services like HF cost about the same, that expenditure brings about greater and more sustained reductions in homelessness.

Value for Money Case Vignette 3: Cost implications of late support for drug use, antisocial behaviour and severe infection

3.20 The research team were provided with information relating to the case of someone who had been homeless for over twenty years. They were using alcohol, and occasionally crack cocaine and heroin. They had a history of COPD and of problems with their feet. In addition, they struggled with emotional regulation, often abandoning temporary accommodation placements resulting in them being evicted repeatedly. Information shows multiple rotations through homelessness services in recent years. The person in this case vignette had also had a history of antisocial behaviour, in particular fighting. As a result of their issues, they had lost contact with their child.

3.21 The HF team began to engage them whilst they were sleeping rough and sofa-surfing. They could not maintain good hygiene and an injection site wound became severely infected. They resisted going to the hospital, despite the infection being very obvious to the support workers and likely painful. The team took several weeks to persuade them to go to hospital. This attendance resulted in emergency surgery, one week in the ICU and 6 weeks on a general ward.

3.22 After hospital, they were housed via HF and are now in regular contact with the community addiction unit, with the support of the HF team. They have not needed acute medical services at all and have had no further contact with the police.

3.23 There are 2 possible cost comparisons in this case; one would be to compare the costs of the intervention at this time with the cost of not intervening. However, it is likely that without the dedication of the team supporting them, they may have died of

the infection. The delay in accessing treatment indicated extreme reluctance to attend, and the infection would have continued to advance had they not been helped to attend.

3.24 The more useful comparison therefore is to compare the costs of this intervention with what would have happened if they had not become so severely infected. Although the analysis cannot state with certainty that access to housing earlier would have prevented them from either fighting or from having an infection in the injection site, it is likely that secure housing and a trusting relationship with the HF support workers would have reduced the risk (and these inputs have now significantly reduced the risk of this happening again in future). Given that they are also no longer involved with the police, the costs of antisocial behaviour have also been included.

Table 4 Value for Money Case Vignette 3

VfM Case Vignette 3: Comparative cost before and after Housing First intervention		
Description of estimated cost to State before HF intervention	**Estimated cost to State before HF intervention (£)**	**Estimated cost to State after HF intervention (£)**
2 assessments by Housing Options (per instance)	£2,180	£0
Placement in TA/ hostel per night x 20	£1,400	£0
Anti-social behaviour further action necessary (cost of dealing with incident) (per occasion)[1]	£780	£0
Emergency Department Attendance[2]	£86	£0
1 week in a hospital ICU[3]	£16,267	£0
6 weeks on a general ward[4]	£19,970	
Estimate for an emergency admission for an uncomplicated bacteraemia, an infection associated with injection site injuries[5]	-	£826
HF support costs as in Case Vignettes 1 and 2	-	£13,000
Total estimated costs to State	**£40,683**	**£13,826**

Source information:
1. GMCA (2022) Unit Cost Database (v.2.3.1)
2. Hope *et al*. (2008)
3. Betsi Cadwaladr University Health Board (2020) 55/19/FOI – this is used as a reasonable comparator since there is no national data published on this in Wales.
4. As 3.
5. As 3.

Focus on incalculable costs

3.25 In addition, the person in Case Vignette 3 reconnected with their child, for which it is not possible to calculate a value, but we can assume has benefits to their physical and mental health. Their HF worker noted that a change has occurred in how they no longer perceive themselves as homeless, their self-esteem has increased, and they are feeling more positive about their future.

Focus on health and social care costs

3.26 It is worth noting the cost of managing COPD at the level of a hospital visit or stay compared to the cost of the likely scenario of a HF worker supporting the person to attend GP appointments to manage the condition. Using NHS England's reference costs for treatment of COPD (NHS England, 2023), the cost to the State before HF intervention is £3,723. During the intervention, where the condition can be managed through support, a GP appointment for COPD management is £36 (NICE, 2018). Costs are significantly reduced depending on the severity of the condition, for cyclical visits to health care professionals to manage the disease costs range from mild COPD (£26) per cycle, Moderate COPD (£28) and severe COPD (£189) (NICE, 2018).

3.27 The following examples focus only on the potential costs and cost avoidance for the NHS arising from HF interventions, i.e., they differ from case vignettes above in that they do not attempt to estimate or include the costs of housing, support or other services (including the HF intervention itself) outside of healthcare provision.

Accessing treatment for cancer

3.28 An individual was receiving support from the HF team. They were experiencing a considerable amount of pain due to an ongoing health condition and were using heroin to manage the pain; however, they were reluctant to engage with health services due to the shame and stigma they associated with their condition. After a period of ill health, HF support workers persuaded them to seek medical help, and they were diagnosed with cancer. Their HF support workers felt that there was 'no way', they could have managed the radiotherapy for this on the street and that they would have died if the team had not been able to take them to daily radiotherapy for 6 weeks.

3.29 In this example, the mean costs associated with cancer treatment are estimated to be around £12,000 (Bending *et al*., 2010). Saving their life would also have required a very high level of HF staff time. They needed to be taken to and from radiotherapy every day for 6 weeks and supported at home between treatments. Aside from the hourly rate for the workers, there would have been opportunity costs in as much as they would not have been able to manage their usual case load as easily whilst helping this person, although it is undoubtably the right thing for them to do.

3.30 Marie Curie (Marie Curie Cancer Care, 2012) estimates the cost of a day of palliative care in the community to be £145, compared to the upper end cost of £425 in a specialist palliative unit. Although the care in this vignette was not palliative, it is possible that without a safe home to return to the person would have had to be admitted to hospital and incur similar costs. However, ultimately, the cost argument here is less important than the likelihood of the person dying without the intervention of the housing workers in persuading them to go to hospital and then helping them manage the radiotherapy.

Frailty in people with housing needs

3.31 A further example illustrates the complex issue of frailty in people with housing needs.

3.32 Frailty is a serious issue in healthcare for people experiencing sustained and recurrent homelessness. For example, one study (Rogans-Watson *et al*., 2020) indicates that 55% of the residents of one London homelessness hostel were assessed as clinically frail, though it is notable that physical frailty associated with old age is less common amongst those experiencing sustained homelessness since mortality rates are high for this group. In the UK, ‘the average age of death is 46 years for men, and 44 years for women’ (Blood, Birchall and Pleace 2021, p.22). The specific patterns of need characterised by frailty are more often associated to HF target groups consisting of high cost and high-risk individuals.

3.33 In this case, an older person had been homeless for over 25 years and moved into accommodation, initially in a hotel, during the COVID-19 No one Left Out approach. They had no history of interacting with the police and were described as ‘delicate’ and a ‘gentle personality’, taking a long time to become comfortable with interaction

and being indoors. Sometime after they had been supported into settled accommodation by the HF team, it emerged that they had care and hygiene needs, and – with advocacy from the HF team - have been assessed as requiring three visits a week from a carer arranged by Adult Social Care. It is unlikely that the person would have thrived in a mainstream care home environment. They valued quiet and needed a gentle, individualised approach and the freedom to go to familiar places. It is also hard to secure care home places for homeless people. This can be because of ongoing difficulties with drugs or alcohol use, although this individual was not using either. It can also be because of different lifestyles, scarce places, and the perception that someone who is pre-retirement age would not be appropriately accommodated with much older people.

3.34 Even if a suitable residential care placement could be identified, the cost of this to the State would be much higher than the cost of the HF support combined with domiciliary care. Domiciliary care typically costs the local authority £20-£22 per hour (Swansea Council 2023; Carmarthenshire County Council, 2023)9. Depending on how long the visits are, the annual cost would be in the region of £1,600 to £3,300 per year and we have estimated HF support costs at £13,000 per year. By contrast, the average residential care home in Wales costs £760 a week (Munson, 2014) (£39,520 per year) and, given the person's needs and lifestyle, a smaller, more specialist, and hence more expensive setting may be needed.

3.35 Being safely housed and having facilitated access to a range of services may have prevented a raft of problems associated with frailty, which may in turn have resulted in Emergency Department or hospital admissions. Frailty is associated with:

- Bone fractures
- Muscle weakness
- Fatigue
- Malnutrition and unintentional weight loss
- Poor sight or hearing
- Deteriorating memory and mental health.

[9] For example, at the time of writing, Swansea Council's rate is £21.84 per hour; Carmarthenshire's is £20 per hour. These authorities have been chosen randomly and because their costs are published, to give an indication.

3.36 Social care costs (at 2022 prices) estimate that for community dwelling older people, per annum costs are £2,895 compared to £321 for those without frailty. Extra annual healthcare costs for those with frailty in England (Han *et al*., 2019) range from £561.05 to £1,208.60 depending on whether frailty is mild, moderate or severe. Emergency admission figures for England are also higher for those with frailty, £3,147 compared to £2,128 for those who are not frail (the Strategy Unit, 2023).

Focus on costs to the Criminal Justice System

3.37 Costs to the Criminal Justice system in relation to HF are also worthy of note. For example, one individual who was known to services before receiving HF, had a personality disorder and mental health challenges, was using alcohol and was in frequent trouble with Police Community Support Officers (PCSOs) in the city centre. The individual picked fights with people and struggled with authority. Once settled housing had been found in a small block in their preferred area, their interactions with PCSOs dropped from '6 days a week' to none. In addition, when they had a dispute with a neighbour, they were able to ask the PCSOs to help mediate this. During the evaluation period, the individual had developed a positive relationship with two HF support workers and was able to regulate their feelings and feel less overwhelmed than when in the city centre.

3.38 A report for the Wales Violence Prevention Unit (Jones *et al*., 2020) indicates that for people involved in physical violence, the average cost of treating injuries from assault was £1,254 (2018/19 prices) for those who needed treatment.

3.39 Though based on the UK context, the Greater Manchester Combined Authority Unit Cost Database (GMCA, 2022) estimates that an incident of anti-social behaviour where further action is necessary costs £780. The cost of arrest if detained is an additional £826.

3.40 Without detail on how often this person started fights with people who fought back or the precise number of arrests they had a month, it is hard to estimate the costs saved by housing and supporting this person. However, there are clear financial benefits in terms of avoidance of PCSO time being used, and potentially in terms of reduced injuries from assault, both for this person and for others. It is also likely that

there was a public benefit in terms of them no longer becoming stressed and causing a nuisance in the city centre.

Value for Money Case Vignette 4: One HF service: aggregated data on wider service usage

3.41 Returning now to a fourth HF case vignette in which one HF service sampled for the evaluation, was able to supply aggregated and anonymised data on wider service usage relating to:

- Nights in police custody
- Nights in hospital or outpatient visits
- Visits to an Emergency Department
- Nights on the street.

Nights in police custody

3.42 Having reviewed available unit cost estimates for a night in police custody suite, the research team assume a cost of £300 per night10.

3.43 Before HF interventions, a total of 246 nights were spent in custody. This was generated by 8 individuals, with the remaining people not having any police custody stays. This means that of those people who were in police custody, the pre-intervention average cost of custody per person was £9,225 ((246 nights*£300)/8 people), or a total cost to the police of £73,800.

3.44 After the intervention, this dropped to 163 nights amongst the same cohort. This included decreases for most of the 8 people, a small increase for one person, and one person who had not previously stayed in police custody having 90 days in custody. This was, overall, a saving to the police; the total spend was £48,900 (163 nights *£300). The number of people in police custody also dropped from 8 people to 5 people. This meant an increased average cost per person, to £9,780. However, most of this is attributable to one individual. This represents an estimated saving to the State of £24,900.

[10] This figure is based on Welsh figures reported by the BBC News (2017) of £260, which factoring for inflation to 2022 prices, would produce around £300, using the Bank of England UK inflation calculator Inflation Calculator (Bank of England)

Hospital and Outpatient contact

3.45 Unfortunately, the data provided by the HF project aggregates overnight stays in hospital and outpatient visits. This makes it impossible to comment meaningfully on costs or on NHS usage, as these are very different metrics. Before HF, there were 78 nights in hospital or outpatient visits amongst the cohort. Of these, 56 were attributable to one person, and afterwards there were 33. However, without disaggregating outpatient care (which is generally elective and relatively low cost) from inpatient care (which may be elective or emergency, and is much higher cost, varying by cause), it is not possible to work out if this represents a more appropriate use of NHS resource.

Emergency Department visits

3.46 Emergency department visits vary from £86 for attendance alone with no treatment, to £418 (The Kings Fund, 2023). Before engagement with HF, this cohort of people attended 15 times, and after engagement with HF, 3 times. This gives a range of impact from a low estimate of £1,032 to £4,915 in direct NHS savings. These savings are unlikely to be cash-releasing but are more efficient and reduces the waiting times and bed unavailability for other people.

Nights sleeping rough

3.47 Crisis states that the average cost to society per annum for someone who is sleeping rough was £20,128 in 2015 (Pleace, 2015). This could be averaged out to a daily cost of £55.15 per person, centred primarily on service contact, although clearly the costs are not accrued on such a steady basis in real life, sometimes there would be no costs as such.

3.48 The HF cohort evaluated here had a pre intervention total of 1,545 nights sleeping rough, and a post intervention total of 3 nights. This would represent a potential indicative saving of £85,041.30 (1,545 nights *£55.15 – 3 nights* £55.15). Again, this may not be cash releasing; it is unlikely that this amount of money could be redistributed to other services. There is also a risk of double counting, as this figure includes some healthcare provision (where individuals were sleeping in healthcare

settings). However, it is indicative of potentially greater efficiencies possible in a number of services, including police, health and outreach services.

Case Vignette 4: Overall Conclusions

3.49 This spotlight on cost effectiveness in relation to HF highlights the complexity of individual trajectories and the challenges of drawing overall conclusions.

3.50 Cost avoidance is greatest where individuals with previously frequent use of emergency health, criminal justice and homelessness services are supported by HF to stabilise within a settled tenancy, reduce any offending and access timely, and where possible, preventative health treatment.

3.51 However, there are many variations of this trajectory, as the diverse vignettes have shown. Many individuals are already very unwell by the time they reach HF in Wales, some are frail (or will age and may become frailer whilst supported by HF), and some are enabled by HF support and advocacy to access treatment such as radiotherapy, or regular care visits which they would not have been able to do without support and a stable home. Without HF, it is possible that much more expensive care interventions would have been needed by these individuals. It is equally likely that they would have died, though it is worth noting that one of the largest drivers of HF endings in the UK is premature death (Blood, Birchall and Pleace, 2021). Whilst there are many examples of HF customers with reducing numbers of arrests, ‘recovery’ for people with lifelong complex needs, trauma and homelessness is unlikely to be linear and, as highlighted in this analysis, one individual with spiking numbers of arrests can skew the overall trend.

3.52 For these reasons and given the limitations of the data, the research team has been able to collect in this exercise, it does not feel defensible to aggregate these cost savings to produce total or average cost savings. However, the analysis has demonstrated the different contexts and mechanisms through which HF might generate cost savings both for local authorities and for health and criminal justice systems. Even in cases where costs have increased or remained the same, public funds have been spent more effectively and with better outcomes for individuals, families, communities, and with reduced pressure on professionals working in crisis response services.

Youth Innovation Fund

3.53 As explained at the beginning of this Value for Money section of the report, it has not been possible to explore in detail the potential case level cost savings attributed to the Youth Innovation Fund without longitudinal assessment and/or disclosing the identity of individuals. However, the evaluation found one interesting case illustrating the limitations of the fund with reference to age limits and potential inefficiencies created through service transitions.

Value for Money Case Vignette 5: Housing First for Youth (HF4Y) and the costs of an age 'cliff edge'

3.54 This worked example of cost effectiveness is based on a hypothetical individual but mirrors the direct experience of a HF4Y service in Wales. The HF4Y service, which works with people aged 16-25 is delivered through 5 self-contained flats and an office, with some communal areas with one additional 'move-on' flat also being available, all within. This model operates a modified form of HF; HF models tend to be open ended, whereas HF4Y is time limited (CACTI, 2014). There are also some differences with the original HF model (Pleace, 2016) which has an emphasis on dispersed housing, whereas this project is largely congregate (an approach that has been used elsewhere).

3.55 Some issues have been reported with the ability of this service, which is operating a hybrid form of HF, reflecting the practice of CTI (critical time intervention) approaches which mirror HF in many respects, but is time-limited, rather than open ended (CACTI, 2014). There are also some differences with the original HF model (Pleace, 2016) which has an emphasis on dispersed housing, whereas this project is largely congregate (an approach that has been used elsewhere, e.g., Finland).

3.56 Prior to beginning operation, this HF4Y service had been envisaged as being able, after offering support in independent housing, to move young people on to a settled, independent home. The evaluation found that 'move-on' from this hybrid service had proved challenging, due to a lack of appropriate housing supply. One issue has been that the HF4Y service has been 'silting up', i.e., young people are pooling in

the service which was reporting doing a great deal of work over long periods before young people using the service are typically able to move on.

3.57 Whilst an assessment of model fidelity was beyond the scope of the evaluation, it should be highlighted that these factors – the time-limited, age restricted support offer, combined with congregate housing which is provided as a package with the support, and a lack of access to stable move-on housing end up being much closer to a transitional supported housing staircase model than true HF.

3.58 An issue identified is that where move-on has not occurred and someone reaches the upper age limit for funded support from this HF4Y service, they could face recurrent homelessness. It is this possibility, again drawing on lived experience of young people using the service, but not reporting the actual trajectory of a real individual, that is explored here.

3.59 Assume that someone has been using HF4Y for 2 years and in that time:

- Contact hours have reduced as they became more confident and able to manage independently, so that in month one of service use, their cost (in terms of total contact with the HF4Y service) was much higher than it was after 2 years. They were stably housed and not using any other accommodation.
- Treatment and support needs were being met through stable use of standard NHS Wales and local authority social work/care services, plus the ongoing support from their HF4Y service.

3.60 And assume that, on leaving HF4Y at age 25:

- The young person has not successfully been connected to another HF service (there is a service for adults run by the local authority, but they have not been able to access it because it is full).
- They enter emergency/temporary accommodation which is sufficiently distant from the health and social care/work services they have been using to make ongoing access difficult, e.g., transport is too expensive and/or they have moved to another administrative area.

3.61 In this scenario, a young person with complex needs including a history of mental illness associated with trauma and contact with child protection services, addiction centred on illegal drug use and a history of low-level offending and short-term imprisonment, has been largely or wholly stabilised through two years' contact with

HF4Y. They are stably housed; they are engaged with treatment and support services and their offending behaviour has ceased.

3.62 On leaving HF4Y, a combination of living in low quality, but expensive, emergency accommodation which faces challenges around safeguarding and disconnection from their support worker in HF4Y, combined with breaks in contact with social work and NHS Wales services has caused a rapid deterioration. Addiction issues resurface, as does mental illness and offending behaviour resumes, with the end result being ejection from temporary accommodation and rough sleeping. If this scenario occurred, costs might shift in the sorts of way illustrated by the hypothetical scenario summarised in Table 5 below.

Table 5 Value for Money Case Vignette 5 HF4Y 'Age Cliff Edge' Scenario

Estimated cost of an individual being in a Housing First for Youth service			
Description of costs to State at one month of using HF4Y	**Cost to State at one month (£)**	**Description of costs to State at two years of using HF4Y**	**Cost to State at two years (£)**
HF4Y contact for 20 hours	£399	HF4Y contact for 8 hours[1]	£160
3 GP visits	£123	One GP visit[2]	£41
8 hours contact from social worker	£400	2 hours contact from social worker[3]	£100
Rent	£800	Rent[4]	£800
Approximate monthly costs	**£1,722**	**Approximate monthly costs**	**£1,101**

Estimated cost of an individual having left a Housing First for Youth service			
Description of costs to State one month after leaving HF4Y	**Cost to State after one month (£)**	**Description of costs to State one year after leaving HF4Y**	**Cost to State after two years (£)**
Temporary accommodation	£1,200	Temporary accommodation[4]	£0
No use of health services	£0	3 attendances at A&E (with investigation)[5]	£1,254
No hospital stay	£0	Admission for 3 nights[6]	£2,244
No contact with addiction services	£0	Contact with addiction services (3 hours)[7]	£240
No contact with social worker	£0	8 hours contact with social worker[8]	£600
Approximate monthly cost	**£1,200**	**Approximate monthly cost**	**£4,338**

Source information:

1. Based on current range of advertised HF worker roles in Wales, plus 13.8% employer NI contribution and assuming £5 in back-office costs.
2. Source: Jones *et al.* (2022).
3. As 2.
4. Estimated
5. Source: The King's Fund (2023)
6. Source: Guest, J.F. *et al.* (2020) (Adjusted for inflation)
7. As 2.
8. As 2.

3.63 In this example, which as noted is based on real case scenarios and the issues being faced by a HF4Y service, an effectively unplanned exit from HF4Y produces increases in cost to the State. This arises because the costs of the support offered by HF4Y have dropped to low levels for this young person after 2 years of service use compared to the level of support and service contact they would have had during their first month of HF4Y service use (Pleace and Bretherton, 2019). In this scenario, disconnect occurs from a stable pattern of mainstream NHS and social work services, which has been orchestrated through the housing related support offered by HF4Y. Initially, costs are similar, because there is a legacy effect from

the HF4Y contact, but the young person's mental health deteriorates and issues with addiction reappear after one year. This results in spikes in emergency service use. Costs of temporary accommodation may drop to nothing during any periods in which the young person is rough sleeping or making their own arrangements (e.g. sofa-surfing, squatting, etc); however, where people are cycling in and out of temporary accommodation and other services in this way, the total annual cost to public services has been estimated at £20,128 at 2015 prices (Pleace, 2015) , as well as the poor health outcomes and increased risk of contact with criminal justice, discussed above.

3.64 Costs might, of course, shift in other ways. For example, the young person might shift to adult homelessness services in one of two ways, one scenario is a smooth transfer to adult HF, where costs might continue on a similar basis to before (and would probably come down over time). Alternatively, they might be referred to supported housing (specifically hostel) services which could have operating costs in the range of £400 to £800 a week, depending on the nature and intensity of the support on offer and what sort of accommodation is being provided.

3.65 If, for example, the young person leaving HF4Y was in supported housing at £400 a week, but that was ensuring their needs were still being met and offering a good mix of support, costs would be around £1,200. However, their situation would be one of (legally defined) homelessness, not one of being stably housed in an independent home, which H4FY was offering for a similar level of spend. Of course, if the supported housing was not able to offer the right mix of support, other costs might start to appear. Another scenario might be that their mental health, addiction and homelessness combine to increase the risk of offending, resulting in imprisonment, which would cost around £3,889 a month, depending on the nature of the sentence and type of prison (Clark, 2023).

3.66 A key point here is that if there is not continuity of HF support, the risks are twofold. First, support and treatment needs, as well as the broader practical and emotional support needs might not be met in the same way and what were effectively managed treatment and support needs could reassert themselves as unmet needs, heightening the risk of recurrent or sustained homelessness. Second, if a supported

housing service steps in and fills the gap, costs might not necessarily be greater (particularly if it is effective). Yet the investment in HF4Y has been at least partially undermined and the person has still returned to homelessness particularly if that supported housing faces multiple barriers to securing move-on housing and support and the young person becomes 'stuck' in the service, which is not an uncommon situation.

Phase 2 funding

3.67 One local authority described how the relative flexibility of both revenue and capital funding provided through Phase 2 had enabled them to accelerate their transition to a rapid rehousing system. They had, for example, been able to convert a large hostel for families into self-contained flats for single people, which now provide a non-time limited supported accommodation model for those with ongoing needs which cannot be met within short-stay, transitional models. Meanwhile, they were able to create additional modular temporary units, and develop permanent 'managed schemes' for different cohorts: single households, families and over 55s with higher and lower support needs. Phase 2 funding allowed them both to test and expand innovative models – such as the multi-disciplinary team which works across these pathways - and to cover the costs of transition, such as operating two models at once and covering voids, as people are re-located, and refurbishment works carried out. Here we describe in more detail, the 'managed scheme' model which has been developed by this authority as part of their work to transform to a rapid rehousing system. Although not directly funded by Phase 2 monies, it represents a radical move towards rapid rehousing, and generates significant cost savings, even though it may be too early to evidence outcomes for individuals longitudinally.

Value for Money Case Vignette 6: Managed schemes

3.68 The 'managed scheme' model was developed as part of the wider system transformation described above. Specifically, it was designed to respond both to high numbers of rough sleepers in the area and evidence of people with complex needs caught in a 'revolving door' of homelessness service use. A review conducted by the local authority had reportedly identified 387 people as having been through the homelessness system ten times or more.

3.69 One of the managed schemes in Wales offers 62 self-contained flats (most 1-bedroomed, though there are some flats with a second small bedroom, which were included to meet planning requirements, but have been useful where individuals have complex healthcare needs or are working towards re-unification with their children). This was a newly built scheme, developed by a Registered Social Landlord (RSL), in partnership with the local authority. Flats are provided with white goods and a furniture package – depending on the social landlord's policy and the tenant's circumstances and preferences, this is sometimes gifted, sometimes re-charged and (in the case of white goods) maintained by the landlord. Tenants are on standard occupation contracts (tenancy), as they would be in any social housing. The model can therefore offer a home for life, though the intention is that individuals or couples who have children or are re-united with children are helped to apply for more suitable family housing.

3.70 A housing support worker is on site at the scheme between 9am and 5pm and, outside of these hours, a concierge service is provided. Individual tenants can access additional support as and where needed from the wider housing, care and support service offer. This might, for example, include floating support, assistance from the multi-disciplinary team or a HF support offer, as well as ongoing support from statutory and voluntary sector services, such as community mental health services or adult social care. The commissioner explained that they can flex the amount of support going into the scheme as a whole: for example, as people have settled into their tenancies, they have been able to reduce the scheme-based housing support offer to about three-quarters of that commissioned initially. At February 2024, there had been one managed move (requested by the tenant) back into supported housing, but no evictions from the scheme.

3.71 Rents are set at around the Local Housing Allowance level, so they are affordable for people. The cost of the concierge service, and housing management, alongside costs to maintain lifts, entrances, corridors, and grounds are included in a service charge, which is eligible for Housing Benefit, where the individual can claim this. Tenants are responsible for their own utilities, Council Tax, etc as they would be in mainstream housing.

3.72 The example shown in Tables 7 and 8 on the relative cost effectiveness draws on a real-life model of service provision are costs and the example trajectory which are designed to illustrate how cost effective an approach like managed schemes can be, i.e., they simulate realistic costs and a realistic trajectory based on experience. Tables 7 and 8 are vignettes, an illustrative rather than actual example, though, costs are based on actual figures unless otherwise indicated.

3.73 Here, a care leaver with a history of contact with mental health and criminal justice services is in one of two scenarios. In the first (Table 6), they spend a year in and out of different services and institutions, including a fairly short prison sentence and has limited contact with mental health services. In the second (Table 7), is the individual is stably housed in a managed scheme with individual floating support offered on top of the scheme-based offer and has better and more sustained contact with mental health services, probably accessed through the specialist Multi-Disciplinary Team.

3.74 The complexities that can arise around determining cost effectiveness are illustrated by the scenarios shown in Tables 6 and 7. The managed scheme and the package of NHS Wales and social (care) services being consumed (Table 7) is significantly more cost effective than a chaotic journey through the homelessness system (Table 6), temporary accommodation, stays in mixed forms of supported housing (hostels), imprisonment and living rough. The differences in how the money is being spent can be summarised as follows:

- Emergency services and the criminal justice system are incurring costs which may not arise to the same extent if the example person is living in the managed scheme service.
- Costs to health and mental health services still arise, but in a stable environment, there is use of a GP surgery rather than A&E and support from Community Mental Health Team (CMHT) is more expensive because contact is more stable.
- The cost of resolving homelessness and preventing further rough sleeping is significantly cheaper than allowing homelessness to persist. Since rent and service charge in the managed scheme have been set within Local Housing Allowance levels, this can be fully funded through benefits and should remain affordable if the person is or becomes employed. This is in contrast to

supported housing models where rents and service charges are typically much higher than Local Housing Allowance rates, making it very difficult for people to work and afford to pay their own rent, and meaning that anyone no longer assessed as needing support would need to move on.

Table 6 Value for Money Case Vignette 6 Before Entering Managed Schemes

Before entering managed scheme with Multidisciplinary Team	
Description of estimated costs to State before entering managed scheme	**Estimated cost to State before entering (£)**
2 assessments by Housing Options[1]	£2,180
6 weeks in temporary accommodation[2]	£2,400
15 weeks in a mid-range hostel (including rent, service charge and support)[3]	£3,570
10 weeks in a higher intensity supported housing (including rent, service charge and support)[4]	£4,270
5 visits to A&E (with investigation) [5]	£2,090
5 missed health appointments (based on cost estimates shared for the evaluation for the avg. cost of Emergency Unit attendance)	£1,309.75
12 contacts with community mental health team (CMHT)[6]	£2,760
Arrested and detained[7]	£1,090
12-week prison sentence[8]	£10,668
3 weeks living rough	£0

6 weeks hidden homelessness	£0
Total estimate (including rent and service charge)	**£30,337.75**

Table 7 Value for Money Case Vignette 6 in Managed Schemes

In managed scheme with Multidisciplinary Team	
Description of estimated costs to State for one year in managed scheme	**Estimated cost to State for one year (£)**
Rent and service charge (around £150 per week) – NB covered by Housing Benefit while man is receiving support but is in line with LHA levels, so that it is affordable longer term should he gain employment or move to Universal Credit housing component.	£7,800
Housing Support offer (scheme level, covers 1 daytime worker supporting 62 tenants)	£1,354
Housing Support offer (individual level, – we have assumed that the man would need a floating support offer (1: 15 caseload) for the whole of this first year at a cost of £55.50 per week.	£2,886
7 GP appointments[10]	£287
40 contacts with CMHT (NB: this may be provided initially via the MDT)[11]	£9,200
Total estimate if rent and service charge included	**£21,527**

Total estimate if rent and service charge is NOT included	£13,727

Source information for tables 6 and 7:

1. Based on Pleace, 2015; Pleace and Culhane, 2016
2. Estimated
3. Based on Pleace and Bretherton, 2019
4. As above
5. Source: The King's Fund, 2023
6. As 1.
7. As 1.
8. Source: Clark, 2023
9. Based on typical costs for intensive supported housing (Pleace and Bretherton, 2019)
10. Source: Jones *et al.*, 2022.
11. As 1.

3.75 One final point here is around the medium to long-term costs of recurrent and sustained homelessness among people with multiple, high and complex treatment and support needs. Costs are, based on current evidence, likely to increase over time as homelessness persists (Pleace *et al.*, 2013). In addition, while people experiencing these forms of homelessness, including sustained periods of rough sleeping, are much more likely to die before they reach 50 than the general population (Heerde *et al.*, 2023), the financial costs of what may still be 2 or 3 decades of homelessness can still be very high. By contrast, as is evidenced by some data on the use of congregate HF models internationally, stable housing and support is likely to have two effects over time. It may mitigate if not reverse the effects of serious illness and there can be some reduction in support use over time. As a result, costs may drop to some extent as residential stability and better access to treatment and support, alongside other positive outcomes appear over time. Again, the caveat around cost effectiveness here centres on how ill someone is at the point they start to use services like managed schemes. This is something that has been an issue for the HF model more generally - if referral is too late because the hurdles to eligibility are set too high, HF may find themselves quite often case managing what is essentially palliative care, rather than a sustained end of homelessness (Blood, Birchall and Pleace, 2021).

4. Conclusions

4.1 The evaluation has identified many examples in which housing stability, combined with the right support (i.e., a rehousing approach) has enabled individuals to reduce their avoidable use of emergency services, and access primary health and community mental health services in a more timely and preventative way. Often individuals with multiple health needs and histories of trauma have, with these interventions, been able to reduce their substance use and offending, and re-build protective relationships with family and friends. It is clear from both HF and Phase 2 examples, that it is more cost effective and often much cheaper for the state to support someone into stable, high-quality housing then it is to keep them circling around homelessness services. There can be significant cost avoidance for health, criminal justice, adult social care and children's services from a rehousing approach which combines stable and suitable housing with the right support.

4.2 However, it is also clear from the case vignettes and examples presented here that, where service or funding-led 'cliff edges' in support provision occur (as in the HF4Y example in case vignette 5, where a person became ineligible for the YIF-funded support offer due to age) risk destabilising individuals and returning them to, at best core homelessness, if not actual rough sleeping, especially where they also incur a loss of tied accommodation.

4.3 There are implications here for decisions about future funding programmes, including the length of funding cycles, the need for flexibility around the application of upper age limits, and the importance of ensuring funded projects are better integrated into local systems and pathways – a key recommendation of the main Homelessness Interventions Evaluation report that accompanies this VfM piece.

4.4 The Phase 2 example demonstrates how a local authority which already has a good strategic plan for the transformation of homelessness services can benefit from additional flexible funding to support the costs of making this transition.

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