# Childhood Adversity and Homelessness in Northern Ireland

BREAKING THE CYCLE

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simon community
Ending Homelessness

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# Contents

# Introduction

***When Sarah was 12, her family lost their home. By 15, she had spent time in care. By her twenties, she was sleeping rough and moving in and out of hostels.***

***Sarah's story is not unusual. For too many people in Northern Ireland, the path towards homelessness begins in childhood, shaped by experiences of trauma, institutional care systems and family breakdown that follow them into adulthood.***

At Simon Community, we are committed to ending homelessness and creating a society where everyone has a safe and secure place to call home. As the largest homelessness charity in Northern Ireland, we provide over 480 temporary accommodation beds every night alongside a wide range of preventative and specialist services. This frontline experience gives us a unique insight into the realities behind homelessness - realities that go far beyond housing need.

Homelessness in Northern Ireland is at a record high, with one in every 31 people affected - that's over 61,000 people in a population of just 1.9 million. This is a crisis we should never accept as inevitable. At Simon Community we believe that housing is a human right - and more than that, it is the foundation on which health, education, family life and our wider communities all depend. Yet every day, too many people are left behind by systems that should protect them.

This report, *Childhood Adversity and Homelessness in Northern Ireland: Breaking the Cycle,* sets out to build a clearer picture of the links between early life experiences and adult homelessness. While international evidence shows strong links between early adversity and later homelessness, there has been little research to explore this in a Northern Ireland context. This study begins to fill that gap and provides two key insights.

First, it gives a snapshot of **who is currently living in single adult homeless hostels** across Northern Ireland. While this demographic data is important, it is only a starting point.

Second, it takes a detailed look at the **journeys and experiences that led people there.** It shows how childhood adversities - such as abuse, neglect, violence, family breakdown, or time in care - create pathways that make homelessness far more likely later in life.

This report paints a clear picture: people living in homeless hostels in Northern Ireland have faced significantly higher levels of trauma and disadvantage throughout their lives compared to the wider population. For many, homelessness is not rare or short-lived. It begins with childhood adversity and returns again and again in adulthood, marked by rough sleeping, repeated exclusions and long periods without stability.

In Northern Ireland, these challenges are intensified by our unique historical context. The legacy of the Troubles continues to shape patterns of exclusion through segregated housing, intergenerational trauma and community violence. The communities most affected by conflict remain those facing the highest levels of poverty and disadvantage today.

There is an urgent need to act differently. Too often, childhood trauma and time spent in institutions such as the care system, prison or hospitals set young people on a path towards homelessness. These early experiences, left unaddressed, turn into adult struggles with housing, health and stability.

If we are serious about breaking the cycle, we need to step in much earlier - supporting children, young people and families before crisis takes hold. That means tackling childhood trauma, giving proper support to people leaving care, prison or hospital, and making prevention a real priority – all backed with adequate funding.  Collaboration across all departments and public agencies is essential - no single department can prevent homelessness alone. Homelessness is a generational problem, and it demands a generational response. Now is the time for real leadership, a long-term vision and decisive action to break the cycle of trauma, poverty and disadvantage passed from one generation to the next.

This research is the result of close collaboration. We are deeply grateful to the people with lived and living experience who shared their stories and experiences - their voices are at the heart of this report. We also thank the advisory boards, voluntary organisations and hostel providers across Northern Ireland whose support and insight has been invaluable.

***Homelessness is not inevitable. By acting early, we can prevent childhood adversity from turning into adult homelessness and build a future where everyone has a place to call home.***

# Background to this research

## How Homelessness is Defined in Northern Ireland

Under Article 3 of the Housing (Northern Ireland) Order 1988, a person is legally homeless if they have no accommodation available to them in the UK or elsewhere. The Northern Ireland Housing Executive is responsible for assessing applications and deciding whether someone qualifies for **Full Duty Applicant (FDA)** status. This means that the Housing Executive has accepted a legal responsibility to provide housing for this person because they meet all the homelessness criteria set out in law.

To qualify for FDA, a person must meet four legal tests:

1. **Eligibility** – legally entitled to housing assistance
2. **Homelessness** – no suitable accommodation, as defined in the legislation
3. **Priority Need** – such as pregnancy, children, serious health issues, or risk of violence
4. **Unintentionality** – homelessness was not deliberately caused

If all four criteria are met, the Housing Executive must offer temporary accommodation and two reasonable offers of permanent housing.

## A Crisis Gaining Momentum

Homelessness pressures in Northern Ireland continue to escalate in 2025:

**1 / 31**

As of June 2025, **61,698 people in Northern Ireland had official homelessness status** – equivalent to 1 in every 31 people[3]

As of June 2025, **90,477 people** were on the social housing waiting list, with **70,923 in housing stress**[3]

As of June 2025, **19,420 children and young people under the age of 18** were officially homeless – around **one third of the total**[3]

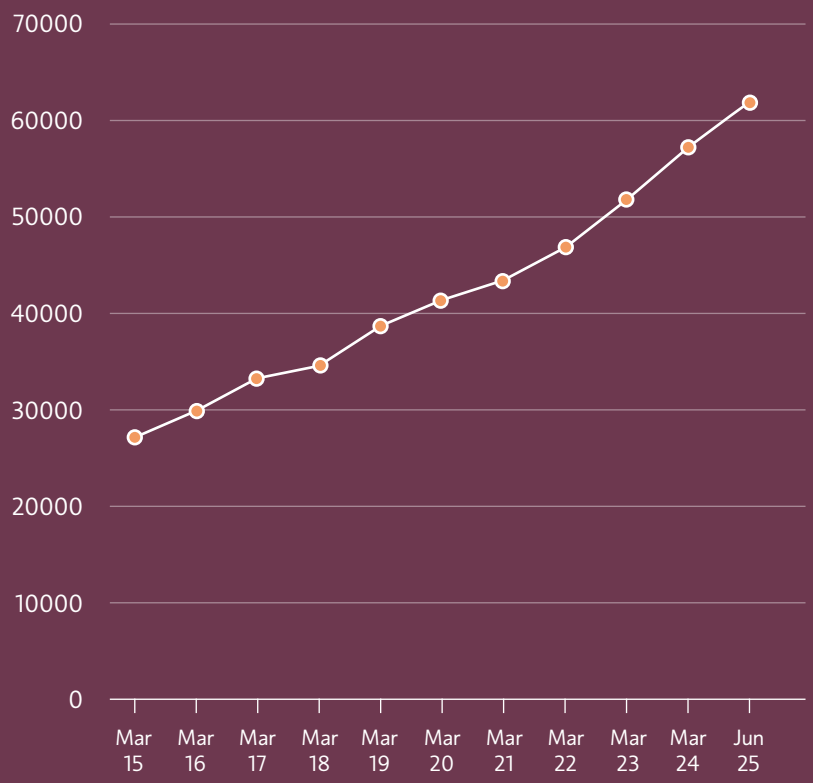
In 2024/25, **123 care leavers presented as homeless**[5]

The number of people who are **homeless in Northern Ireland has increased by 128%** over the past decade and by 20,000 in the past five years[4]

In 2024/25, **1,504 new social homes were started (against a target of over 2,000 per year).** In the three months between April and June 2025, only one new social home start was recorded[1]

On a typical night, **4,700 households are in temporary accommodation**, an increase of 3,000 since 2017[2]

## Number of People who are Officially Homeless in Northern Ireland




**More than DOUBLED in last decade**

The most common reasons for homelessness applications in 2025 were:

**24.8%**
**Accommodation deemed not reasonable**

**22.4%**
**Sharing breakdown or family dispute**

**14.8%**
**Loss of rented accommodation**

These figures reflect both structural pressures (housing shortage, welfare entrenchment) and interpersonal drivers (family breakdown).[6]

## Temporary Accommodation and Hostel Use in Northern Ireland

Between 2017 and 2024, the number of households that the Housing Executive had a legal duty to support increased by 80%. The demand for temporary accommodation has risen every year, with a sharp 115% jump between 2019/20 and 2020/21 during the COVID-19 pandemic.[2]

As a result, Housing Executive's expenditure has soared. In 2018/19, it spent £7.6million on temporary accommodation, rising to £38.6million in 2023/24 - a 408% increase.[7] The cost of "non-standard" temporary accommodation alone grew from £1.9million in 2019/20 to £15.5 million in 2024/25.[9]

Types of temporary accommodation include:


Hotels and B&Bs

Dispersed Intensively Managed Emergency (DIME) accommodation

Private single lets

Hostels

In theory, placements should be matched to people's needs. In practice, they often depend on whatever space is available. And too often, there is no space at all.

The growing use of hotels and B&Bs highlights the intense pressure on the system. In Northern Ireland, many people experiencing long-term homelessness now spend many months, even years, in temporary accommodation or hostels. Homelessness hostels were designed for short-term emergencies but have become the main option for people with complex needs. On average, someone stays in a Simon Community hostel for around 252 days - far longer than intended.

Hostels do provide safety and shelter, but with few housing options and overstretched support services, they are increasingly struggling to give people the best chance to recover or rebuild their lives.

At the start of this study in 2022:

There were 86 homeless hostels in NI (excluding care leaver and probation services).

Of these, 73 were run by voluntary organisations and 13 by Housing Associations.

31 hostels supported *Single Adults with Support Needs,* operated by 15 voluntary organisations, providing around 842 units of accommodation.

# Why this research matters

Until now, no study in Northern Ireland has systematically explored how widespread childhood adversity is among adults experiencing homelessness, or how it shapes their later experiences of exclusion. By exclusion we mean being shut out of everyday opportunities and resources – like work, education, community life or having a voice in decisions that affect you. Without this evidence, policies and services risk focusing only on the immediate crisis of homelessness rather than the deeper causes that drive it.

This report begins to address that gap. Phase 1 focuses on two key questions:

1. **What are the backgrounds, health issues and life experiences of single adults living in hostel accommodation in Northern Ireland and how do these differ by age and gender?**
2. **How common are Adverse Childhood Experiences within this population?**

The findings offer a new and detailed picture of who is living in hostels in Northern Ireland and the life experiences that have shaped their journeys into homelessness. They reveal the scale of disadvantage and trauma among this group and underline the need for services and policies that recognise and respond to these realities.

Phase 2, to be published in 2026, will go further by exploring how multiple disadvantages overlap and how chronic homelessness is experienced for people living in hostels in Northern Ireland.

# What we already know – previous research

## Homelessness, Adversity and Institutional Contact

Homelessness is rarely the result of a single event. It usually reflects the accumulation of poverty, trauma, poor mental health and gaps in support systems over time. These experiences are shaped by wider social and economic inequalities and by how institutions respond, or fail to respond, to people's needs.[10] [11]

## Health and Homelessness

People who are homeless have much poorer health than the general population. Research in the UK and Ireland shows higher levels of illness and a greater risk of dying early, especially for those who are homeless for long periods or repeatedly.[12] [13] In Dublin, a study found that homeless women were between six and ten times more likely to die than women in the general population and homeless men were three to ten times more likely to die than other men.[14]

Mental health is a central part of this picture. Poor mental health can increase the risk of losing your home, while homelessness itself often makes existing conditions worse. Northern Ireland has some of the highest rates of mental illness in the UK, affecting around one in five adults – about 25% higher than in England.[15]

Among people experiencing homelessness, mental health needs are especially widespread. A 2022 survey by Homeless Link[16] found that 82% of people experiencing homelessness had a mental health diagnosis, yet nearly half said they had not received the support they needed. In Northern Ireland, a joint study by Simon Community and Depaul (2023) found similar results: 70% of 170 hostel residents had a diagnosed mental health condition, most diagnosed before they became homeless.[17]

## Substance Use and Exclusion

Substance misuse can be both a cause and a consequence of homelessness. Some people use alcohol or drugs to cope with trauma, pain, or unsafe environments, but homelessness itself can intensify use and substance use can make it harder to secure housing.[13] [18]

High levels of substance dependency are common among people experiencing homelessness. However, many accounts overlook gender differences and the ways substance use is bound up with survival strategies and cycles of exclusion.[19]

## Institutional Contact and Homelessness Risk

Many people experiencing homelessness have had significant contact with institutions such as care, prison, or psychiatric services. These transitions, particularly when abrupt or unsupported, can increase the risk of housing loss.

Adults who were in care as children face higher risks of homelessness, poor health and justice system involvement[11] [20]

People discharged from psychiatric care into homelessness are more likely to be readmitted to hospital or rely on emergency services[21]

People leaving prison are more likely to become homeless and homelessness increases the risk of reoffending[22]

# Understanding Adverse Childhood Experiences (ACEs)

## What are ACEs?

Adverse Childhood Experiences (ACEs) are harmful events in childhood, such as abuse, neglect and household dysfunction, including domestic violence, parental substance misuse, mental illness, or incarceration. Exposure to violence outside of the family home is also considered, especially in areas of conflict.

ACEs are described as

> *'...a term used to refer to a collection of potentially traumatic exposures that individuals may experience during the childhood ages 0-18 years. Exposure to ACEs is related to increased risk for a host of negative health outcomes and can limit life opportunities, including educational attainment and employment, which can have far-reaching impacts beyond a single time period, person or generation."* [23]

## Prevalence of ACEs in the general population

To understand the impact of ACEs on people who are experiencing homelessness, it is useful to first understand their prevalence in the general population.

**UK:** Almost 50% of adults report at least one ACE and 9% report four or more [24]

**Northern Ireland:** 60% report at least one ACE; 17.6% report four or more [25]

## Long-term impact of ACEs

High exposure to ACEs, particularly four or more, has been consistently linked to poorer outcomes later in life. Research shows clear associations between multiple ACEs and mental health problems such as anxiety, depression and suicidality, as well as increased risk of substance misuse.

Physical health is also adversely affected, with higher ACE scores linked to chronic illness and overall poorer health outcomes and even reduced life expectancy, with evidence suggesting a loss of up to 20 years compared with those who had little or no childhood adversity.[24] [41]

In NI, adults with four or more ACEs[25] are:

**Almost 10 times** more likely to have a mental health diagnosis

**12 times more likely** to experience domestic or sexual abuse [20]

Previous studies outside of Northern Ireland show that almost all homeless adults have faced at least one ACE and more than half have experienced four or more.[25] These early adversities are strongly linked to poor mental health, substance use, suicidality and longer episodes of homelessness.

This research aims to understand these experiences among adults living in hostels in Northern Ireland. By understanding their backgrounds and challenges, we can better shape the support they need to recover and move forward.

# About the study

This is the first study in Northern Ireland to examine in detail the backgrounds and life experiences of single adults living in hostel accommodation.

Conducted across a number of hostels operated by 10 homelessness providers. These organisations were: Apex Housing, East Belfast Mission, Extern, NB Housing, DePaul, Mindwise, First Housing Aid and Support Services, The Salvation Army, Welcome Organisation and Simon Community.

Targeted single adults in Housing Executive-funded hostels designated as Single Adults with Support Needs under the Supporting People programme.

Used a confidential, digital survey covering demographics, health, housing history and adverse life experiences, both in childhood and adulthood.

Incorporated internationally validated tools: WHO ACE-IQ (childhood adversity), AUDIT-C (alcohol use), DUDIT-C (drug use) and Housing Executive's measure of chronic homelessness.

175 participants completed the survey.

The study was ethically approved by Queen's University Belfast and designed on a trauma-informed, voluntary basis, with participant wellbeing prioritised throughout.

The research forms part of a Doctoral thesis in Childhood Studies at QUB.

## Lived experience and participatory structures

The research was shaped by two advisory groups that embedded living, lived and learned experience into design and interpretation:

**Hostel Advisory Group:** people currently living in hostels who tested the survey for accessibility, informed question design and helped interpret findings.

**Research Advisory Group:** a mix of professionals and Experts by Experience who provided ethical oversight and interpretive guidance.

Together, these groups ensured the research reflected not just the data, but also the lived realities of homelessness. (Further details on Methodology in Appendix 1)

# Key findings and what they tell us

## Part 1:

### Who lives in hostels? A profile of single adults experiencing homelessness in Northern Ireland

This study gathered data from 175 single adults currently living in hostels across Northern Ireland. The findings offer a detailed picture of this population and their experiences of homelessness.

#### Demographics

**Gender:** The majority were male (73.1%), with just over a quarter female (25.1%).

**Age:** Participants ranged from 18 to 65 years. The largest age group was 18–26 years (31.4%), followed by 27–36 years (26.9%).

**Ethnicity and place of birth:** Most identified as White (92.6%) and were born in Northern Ireland (76.0%).

**Sexuality:** The majority identified as heterosexual (88.6%). Among those who identified as lesbian, gay or bisexual, half were young people under the age of 26.

**Family status:** Most were single (82.2%), though half (50.3%) reported having children. None had children currently living with them due to the nature of their accommodation.

**Education:** Over half had completed secondary school (55.7%), while nearly a third had completed higher education (32.8%).

**Employment:** The vast majority were unemployed (82.2%). Of these, two-thirds (63.4%) said they were unable to work due to health or other reasons, while one in five (19.4%) said they were able to work.

#### What this tells us

The **gender** distribution in this sample was 73.1% male, compared with 49% in the general population.[38] The age profile was also younger, with 58.3% under the age of 36. Homelessness in single adult hostels in Northern Ireland is experienced much more by men, which is consistent with wider patterns. The younger age profile points to early life disruption and difficult transitions out of care, education, or other institutions, showing how exclusion often begins at a young age.

*Experts with Living Experience confirmed the predominance of younger men in hostel provision, though noted that age distribution can vary by hostel location due to move-in patterns and local service configurations.*

**Ethnic diversity** was limited, with 92.6% identifying as White, consistent with national figures.[38] Whilst not a feature of this study, 76% of participants were born in Northern Ireland which may suggest that homelessness in this context is shaped primarily by local structural conditions, rather than being driven by recent migration. Among those born elsewhere, the most common origins were Great Britain (8%), Europe (5.7%) and Ireland (5.1%), which suggests that exclusion is largely rooted in regional socio-economic dynamics, affecting people who are already part of the community as well as those who have come from nearby.

**Sexuality** emerged as a significant factor: 10.9% identified as lesbian, gay, or bisexual, over five times the rate recorded in the 2021 Census.[38] This overrepresentation aligns with international evidence on the heightened risk of homelessness among sexual minorities, often linked to family rejection, discrimination and minority stress.[26]

*Experts with Living Experience noted that while sexuality and ethnicity were rarely discussed openly within hostels, a shared ethos of acceptance existed, grounded in the common experience of homelessness.*

**Family status** showed a mixed picture. Even within single adult hostels, half of participants were parents separated from their children. This highlights how homelessness fractures family life, with lasting consequences for both parents and children.

**Economic inactivity** was pronounced: 82.2% were unemployed, with 63.4% saying they couldn't work due to health problems or other reasons. This is very different from the national average, where about 70% of people are in work or looking for work,[38] and reflects well-established associations between labour market detachment, homelessness and exclusion. These findings underscore the need to understand homelessness not only as a housing issue but reflects a much bigger picture of economic and social disadvantage.

**Education levels** in the group showed a more mixed picture. While low education levels are often linked to homelessness, this wasn't always the case here: 55.7% had completed secondary education and 32.8% had completed higher education, including college or university. Despite participants remaining in education, homelessness still happened. Other challenges and barriers clearly play a role.

*Experts with Living experience described how trauma, addiction and mental health crises disrupted otherwise strong educational and employment histories.*

*"People have brains to burn, but trauma can shut you down."*

Later school-leaving has previously been evidenced to reduce homelessness risk, but no such protective effect emerged here.[11] This anomaly may reflect structural and relational factors specific to Northern Ireland, including intergenerational trauma, labour market conditions and institutional contact. It warrants further exploration in future research.

## Health profiles

Poor health was widespread among participants. More than half (56.6%) reported a condition or disability that limited their daily activities:

- **32.6%** said they were limited **'a little'**
- **24.0%** said they were limited **'a lot'**

Women were more likely than men to report a limiting condition. Over a third of women (36.4%) said they were limited 'a little' and almost a third (29.5%) 'a lot'. Men were more likely to report no condition affecting daily life (46.9% compared with 34.1% of women).

Younger adults (18–26) were the least likely to report health-related limitations, with more than half (56.4%) reporting no restriction. Older participants had the highest levels of severe limitation, with one in three (33.3%) describing themselves as 'limited a lot'.

In terms of the types of conditions reported:

- **Emotional, psychological,** or **mental health difficulties** were by far the most common, affecting **62.0%** of participants.
- **Nearly a third (31.0%)** reported having a **learning disability.**
- **Long-term pain** or **discomfort** was reported by **21.1%.**
- **Shortness of breath** or **breathing difficulties** affected **20.6%.**

### What this tells us

These findings show that poor health and disability are not side effects of homelessness; they are central to it. Over half of participants reported a long-term condition that limited daily life (56.6%), which is more than double the rate in the Northern Ireland population, where only 24.4% reported any limitation.[38]

Emotional, psychological or mental health difficulties were reported by 62% of participants, compared to just 8.7% in the general population. Learning disabilities, including autism, were also much higher than Census rates (31% vs. 5.9%). Physical health conditions such as chronic pain (21.1%) and breathing problems (20.6%) were nearly twice as common.

Women and older adults were more likely to report serious limitations, suggesting that exclusion and poor health accumulate over time.

*Experts with Living Experience reflected this challenge, describing being caught in a 'revolving door' of services, where health issues often went untreated, not through neglect, but because care was inaccessible or inconsistent.*

*"It's not just the trauma, it's how you get passed around."*

Tackling homelessness requires addressing these structural health inequalities by removing systemic barriers to care and designing services that recognise the deep connection between mental health, disability and lifelong exclusion.

## Mental health

Mental health needs were widespread and severe among people living in hostels:

**73.9%** had been diagnosed with a mental health condition

**52.8%** had been hospitalised for mental health reasons

**61.4%** were on prescribed medication

**54.6%** had a history of self-harm



**79.8%** had experienced suicidal thoughts

Gender differences were striking. Women reported higher rates across every measure:

**84.1%** had a diagnosis (vs. 69.5% of men)

**72.1%** had been hospitalised (vs. 46%)

**81.8%** were on medication (vs. 53.2%)

**67.4%** had self-harmed (vs. 50%)



**90.7%** had suicidal thoughts (vs. 76.4%)

### What this tells us

Mental health needs in this population are not occasional or mild; they are widespread, acute and often life-threatening. Nearly three-quarters (73.9%) of participants reported having a diagnosed mental health condition. **This is almost four times higher than the general adult population in Northern Ireland.**[15] Over half had been hospitalised due to their mental health and most were on medication. More than half had self-harmed and nearly 80% had experienced suicidal thoughts.

Women's experiences of homelessness in Northern Ireland often follow sustained trauma, particularly domestic and sexual violence and relational harm that damages mental health and access to support. Recent research from Heriot-Watt University[28] underscores how violence, including intimate, familial and even paramilitary threats, drives women into homelessness and deepens exclusion. Services must respond to this reality; housing loss is not just a practical problem, but also a psychological crisis, especially for single women living in hostels.

The highest rates of self-harm and suicidal thoughts were found among younger adults (18–36 years), showing that distress is intense even in the early stages of homelessness.

*Experts with Living Experience suggested that suicidal thoughts are linked to long-term stress, a response to feeling stuck and unsupported. As one person explained:*

*"Homelessness is the start of hopelessness."*

Overall, these findings make two things clear:

1. **Mental health need is a central feature of homelessness,** not a side issue.
2. **Gender-sensitive, trauma-informed support is essential,** especially for those facing long-term exclusion and deep psychological harm.

## Experiences with care, justice and health systems

Many participants had significant contact with institutions over their lifetime, showing how homelessness is closely linked with wider systems of care, justice and health:

**21.3%**

had been in care as children.
**Higher among women (30.2%) than men (18.0%)**

**52.9%**

had been admitted to hospital for a mental health issue.
**Much higher among women (72.1%) than men (46.0%)**

**32.0%**

had been in prison or a young offenders' centre.
**Higher among men (34.1%) than women (25.6%)**

### What this tells us

Our findings show that many people experiencing homelessness have spent time in institutions such as care, prison or hospitals. For some, these experiences began in childhood and have shaped much of their adult lives. Women are especially affected.

These aren't one-off experiences. They often repeat and overlap, creating a cycle that makes it harder to build stability. **Time in care, prison, or hospital can both lead people into homelessness and result from the exclusion they face. These patterns are closely linked to early adversity, poor mental health and struggles with substance use.**

Patterns varied by age and gender. Mental health hospitalisation was the most common institutional contact, affecting over half of participants and was especially high among women, where rates exceeded 70%. Over one in five participants had been in care as children, with rates higher for women. Prison experience was reported by almost a third, peaking in the 27–36 age group, where nearly half had been incarcerated. The data suggests that the late twenties to mid-thirties may be a critical point where disadvantages accumulate and institutional contact intensifies.

Women's homelessness is frequently shaped by histories of care and mental health, in contrast to men's pathways, which are more often connected to criminal justice. Evidence from the *Hard Edges: Women study*[29] shows that women affected by severe and multiple disadvantage commonly experienced childhood trauma, removal into care and ongoing mental health crises, often linked to domestic and sexual violence. The high levels of hospitalisation among women in this study highlight the entanglement of trauma, gender and mental health, raising questions about whether mental health services function primarily as crisis interventions rather than as sustained recovery support.

*Experts with Living Experience told us that time in care, prison, hospital and hostels often isn't just a one-off — it happens again and again. Each return makes life less stable and recovery harder. Many described feeling trapped in a system that was supposed to help but often felt more like being held in place than being supported to move forward.*

## Addiction and survival

Substance use was a feature of life for some people living in hostels, but it was not as widespread as is often assumed and was not simply about addiction.

- **A quarter of participants (25.7%)** scored in the range associated with probable alcohol dependence. This was most common among older adults.
- **One in five participants (21.1%)** were in the high-risk category for drug use, meaning their patterns were consistent with drug dependence or serious harm. Drug use was more common among younger participants.

*Experts with Living Experience reflected that for many, drug and alcohol use was not about choice but about managing pain, disconnection and the absence of support. As one Expert with Living Experience put it:*

*"Alcohol is easier to get than help."*

Many participants told us that they had used street-based survival strategies:

**21.3%**
**had engaged in street drinking or drug use**

**38.7%**
**reported shoplifting**

**21.3%**
**reported begging**

These behaviours were not confined to men. Women were equally, and sometimes more, likely to report survival activity, especially begging, where 27.9% of women compared with 20.1% of men said they had done so. This challenges the idea that women's homelessness is always hidden and highlights their visibility and vulnerability in public spaces.

*Experts with Living Experience described these actions as part of an "economy of survival," driven by a lack of safe options, rather than individual failings. As one member put it:*

*"You survive to live."*

### What this tells us

These findings remind us that substance use and street-based behaviours are **not only risk factors to homelessness,** but **a response to it.** For many people living in hostels, addiction isn't just about dependency. It is about surviving trauma and exclusion and is a way of coping when other forms of support have failed or disappeared.

If services focus only on treating substance use without addressing the deeper structural issues that drive it, such as lack of housing, mental health support and economic opportunity, the cycle is likely to continue.

Alcohol and drug use in this population should not be viewed simply as risky individual behaviour. Instead, these patterns reflect a response to long-term harm, trauma and disconnection from care systems. Substance use is often a way to cope with difficult conditions, not a cause of them.

## Experiences of Violence

Violence was a common experience in participants' lives, both in personal relationships and in the wider community:

**52%** had been a victim of violence in adulthood

**36.1%** had been threatened with community or paramilitary violence

**28.7%** had been directly victimised by community or paramilitary violence

**15.4%** had perpetrated violence themselves, though this was often complex and linked to wider contexts

### What this tells us

Violence is not a one-off event in homelessness but a persistent reality. These findings show that violence, especially threats and assaults tied to community and paramilitary groups, is a defining feature of homelessness in Northern Ireland. For many, it added another layer of trauma on top of childhood adversity, mental health struggles and exclusion.

Violence appeared in this study through victimisation, threats and in some cases perpetration, cutting across gender, age and life stage. Violence in homelessness contexts is rarely isolated and often blurred with survival and safety. More than half of participants had been victims of violence in adulthood, including domestic and sexual violence, with prevalence similar for men and women. Rates were highest in early-to-mid adulthood (27–36), suggesting this period may carry heightened vulnerability as exclusion deepens and people become more exposed to high-risk environments.

Paramilitary and community violence remain deeply present in Northern Ireland, decades after the Good Friday Agreement. Over a third of participants had been threatened and almost one in three had experienced actual violence from such groups. These harms, most concentrated in the 27–46 age range, reflect the continuing impact of territorial control and coercion.[40] [41]

*Experts with Living Experience reflected on these findings, highlighting coercion through drug debt, manipulation and forced involvement in illicit activity. They stressed that participation was "not always voluntary" and sometimes came from simply being "in the wrong place at the wrong time."*

## Homelessness Pathways

The study shows that homelessness often begins early in life and is rarely a one-off crisis. For many, it is repeated and long-term.

### First experience of homelessness

- **61.2%** became homeless before the age of 26
  **22.9%** as children or teenagers
  **36.2%** between 18–26
- Women were more likely than men to have experienced homelessness before 26 **(70.5% vs 59%)**

### Repeat homelessness

- **58.9%** had experienced homelessness more than once
- **22.9%** reported five or more separate episodes
- Even among the youngest group (18–26), **18.2%** had already faced five or more episodes

These findings show how homelessness can become entrenched very quickly, often beginning in childhood or early adulthood.

### Rough sleeping

- **63.8%** had slept rough at some point
- The highest prevalence overall was in the 27–36 group **(76.6%)**
- Men were more likely than women to have slept rough **(69.5% vs 49.8%)**
- Among 18–26 year olds, **nearly nine in ten** young men had slept rough compared with just over one in ten young women

### Duration of homelessness

- **45.3% of men** and **27.2% of women** had been homeless for over a year in their current episode
- The most common current episode lasted 1–6 months **(30.3%)** or 6–12 months **(24.6%)**
- Long-term episodes were most common among older adults **(37–66: 44–46%)**

These findings show that temporary accommodation does not always provide stability. For some, it is marked by repeated moves and exclusions, reinforcing insecurity.

### Housing and homelessness applications

- **93%** had submitted a housing application
- **89%** had made a homelessness application
- **Around 11%** had not applied, or were unsure if they had, more common among men

This shows that most hostel residents are engaged with the housing system, but gaps remain, especially among men.

FDA status is the highest level of homelessness recognition under Northern Ireland's homelessness legislation.

- **65%** of participants reported having FDA status
- **18%** said they did not have it
- **17%** were unsure
- Men were more likely than women to lack or be uncertain about FDA status **(40.6% vs 15.9%)**

### What this tells us

Homelessness in this study was rarely short-term or one-off. It often began early, recurred many times and was marked by rough sleeping, instability and cycling through systems. These patterns show that **homelessness is both a product of exclusion and a mechanism that deepens it.**

Over six in ten participants first became homeless before the age of 26 and nearly a quarter before 18. Women were especially likely to experience early homelessness (70.5% before the age of 26).

*Experts with Living Experience reflected that early exclusion often set people on trajectories that were difficult to reverse. As one member explained:*

*"I was in this hostel when I was 17, now back again."*

Homelessness was recurrent for most participants. Nearly 60% more than once and almost a quarter had been homeless five or more times. Even among the youngest adults, repeat homelessness was already evident.

Sleeping rough was a reality for many people in this study, almost two-thirds (63.8%) had experienced it at some point. It was most common among those aged 27 to 36, with over three-quarters (76.6%) having slept on the streets.

There were clear differences between men and women. Men were more likely to have slept rough than women (69.5% compared to 49.8%). Among the youngest group (18–26), the contrast was even starker: nearly nine in ten young men had slept rough, while just over one in ten young women had.

These numbers show how rough sleeping isn't rare or exceptional - it's something many people go through, especially young men. It's a sign of how deep the crisis runs and how urgently we need better support before people reach that point.

*Experts with Living Experience emphasised that rough sleeping was rarely a "choice" and for men was linked to feelings of shame and not being able to ask for help.*

Although most participants had applied to the Housing Executive, with 93% submitting a housing application and 89% making a homelessness application, only two-thirds reported FDA status. Men were much less likely to receive this recognition than women (40.6% vs 15.9%). This points not only to gaps in understanding of the system, but also to the reality that some people are refused FDA status even while living in homeless hostels, having failed one or more elements of the statutory tests.

Recognition also appeared linked to time thresholds, with those who had been homeless for either a very short or very long period less likely to be recognised.

*Experts with Living Experience suggested that for many the process is unfair:*

*"We don't understand the system, but we know it's unfair."*

Homelessness for people living in hostels was not rare, brief, or non-recurrent. It often began in youth, repeated across adulthood. These findings show how early exclusion, through childhood homelessness or care, can set trajectories that are reinforced over time. Homelessness appears not as an isolated event but as a life course process, shaped by the intersection of housing shortages, welfare conditionality and repeated instability.

*Put simply, homelessness is not an isolated event, but an ongoing struggle for stability.*

# Part 2:

## Adverse Childhood Experiences (ACEs) among single adults experiencing homelessness in Northern Ireland

### Overall prevalence

Childhood adversity was almost universally experienced by the people we spoke to in this study.

- **96%** had experienced at least one ACE
- **66%** had four or more
- **40%** had seven or more
- **11%** had eleven or more

#### What this tells us

These figures show the depth of early harm among people currently living in hostels. Childhood adversity was not a one-off event but a common foundation in people's lives, shaping health, stability and relationships long before adulthood.

In the general Northern Ireland population fewer than 18% of people report four or more ACEs.[25] The fact that 66% of hostel residents had reached this threshold underlines the strong link between childhood trauma and later homelessness.

International research reinforces this pattern: high levels of ACEs are consistently found among people experiencing homelessness[30] [31] and having four or more ACEs is associated with much poorer health and well-being in later life.

### Prevalence of 4 or more ACEs by age group

*Comparison with the Northern Ireland General Population ACE study[25]*

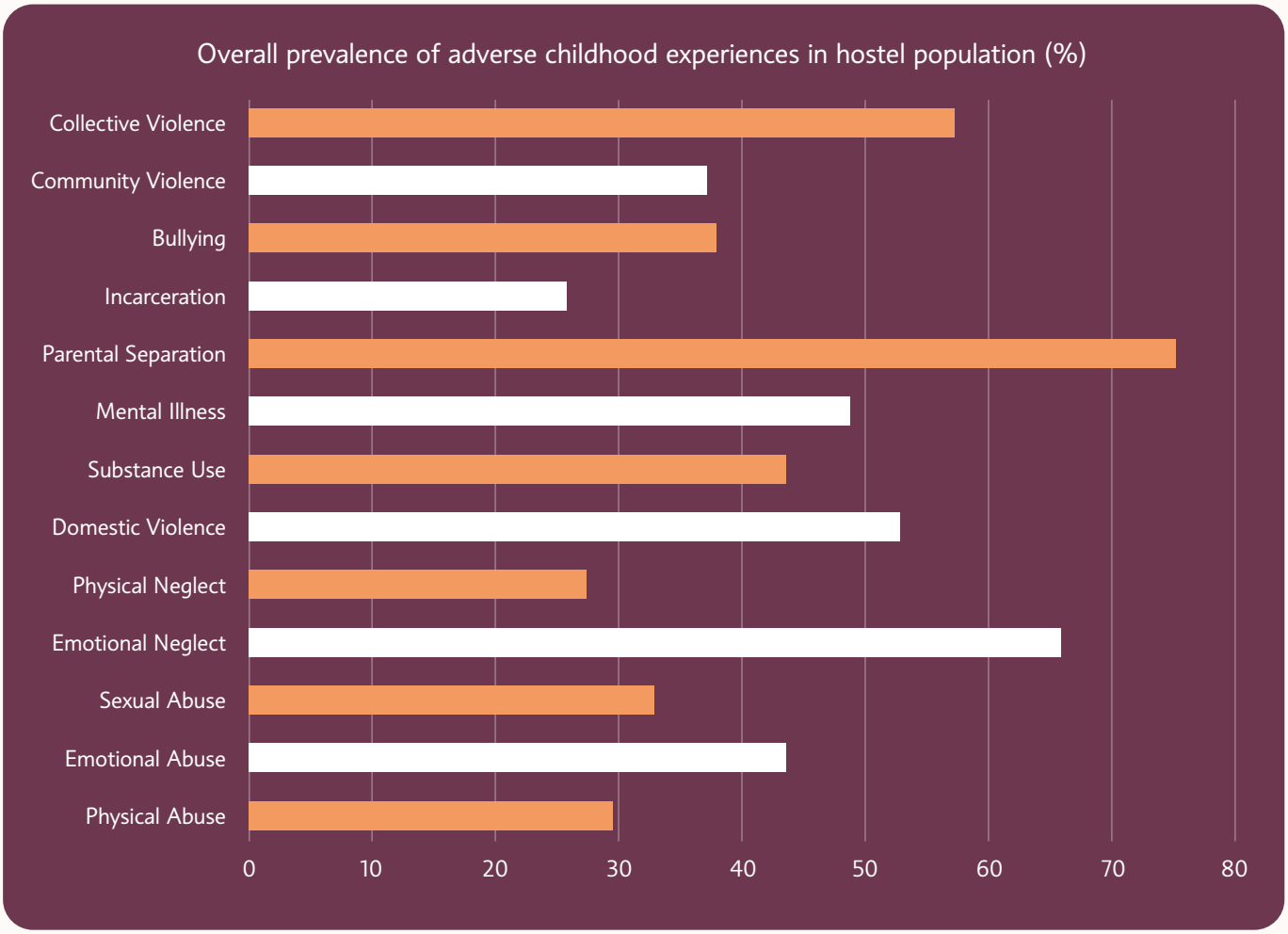
| Northern Ireland general population | | Hostel residents | |
|---|---|---|---|
| 18–24 | 11.4% | 18–26 | 67.3% |
| 25–35 | 17.8% | 27–36 | 74.5% |
| 35–44 | 24.1% | 37–46 | 69.4% |
| 45–64 | 18.4% | 47–66 | 51% |

#### What this tells us

Across all age groups, people in hostels were far more likely to have experienced four or more ACEs than their peers in the general population. This gap is particularly stark for younger people: nearly three quarters of hostel residents aged 27–36 had four or more ACEs, compared with fewer than one in five in the wider population.

## Prevalence of individual ACEs

Looking at individual childhood adversities, some experiences were especially common among hostel residents:




(see Appendix 2 for full breakdown)

- **Parental separation** was the most frequently reported, affecting three-quarters of participants (75.2%).
- **Emotional neglect** was also widespread, reported by around two-thirds (65.9%).
- **Exposure to collective violence**[1], reflecting the legacy of conflict and community unrest, was reported by over half (57.4%).
- **Domestic violence and Mental illness** were also reported by around half of participants (52.9% and 48.8%).

Other adversities, though less common than separation or neglect, were still significantly widespread. Emotional abuse was reported by almost half (43.6%). Around one in three had experienced sexual abuse (33.7%) or physical abuse (29.7%). About one in four had lived with a parent in prison (25.9%) or experienced physical neglect (27.5%).

[1] **Collective violence** refers to organised violence linked to political, sectarian, or military conflict. In Northern Ireland, this includes harm or threats from paramilitaries, armed forces, or police during or after the Troubles.
**Community violence** refers to local violence not driven by politics, such as assaults, threats, or witnessing violent crime in the neighbourhood.

### What this tells us

Adversity was not limited to one type of harm. Family disruption, neglect, household mental illness, violence in the home and wider community violence were all significant features of childhood for people living in hostels. The concentration and overlap of these experiences show how deeply rooted and wide-ranging early adversity was for people now living in hostels.

Significant levels of harm and instability were a common part of growing up for many in this group.

## Gender patterns in ACE Exposure

Both men and women in hostels experienced high levels of childhood adversity, but some differences stand out. Women reported more than double the rate of sexual abuse compared with men (54.1% vs 26.1%). They also faced higher levels of emotional neglect (72.7% vs 63.5%), physical neglect (36.6% vs 24.5%) and household mental illness (54.8% vs 47.2%).

### What this tells us

The most significant gender difference is the much higher rate of sexual abuse among women. Women also carried greater burdens of neglect and household adversity, pointing to different pathways of harm compared with men. These findings reinforce wider evidence that sexual and relational violence play a central role in women's homelessness pathways.[28] [29] Responses must therefore be both trauma-informed and gender-responsive, recognising the distinct and enduring impact of sexual violence.

## ACE Exposure by age group

The types of childhood adversity reported varied by age. For younger residents (18–26), the most common experiences were parental separation (73.5%) and emotional neglect (68.5%), with around half also exposed to domestic violence or household mental illness.

In the 27–36 age group, adversity was even more concentrated. Nearly four in five (76.6%) reported emotional neglect and more than seven in ten had experienced parental separation (73.2%) or collective violence (70.5%). High levels of domestic violence (60.9%) and household mental illness (59.6%) were also reported. This group also recorded the highest prevalence of many other adversities, including sexual abuse, neglect and household substance use, marking them as the most heavily exposed overall.

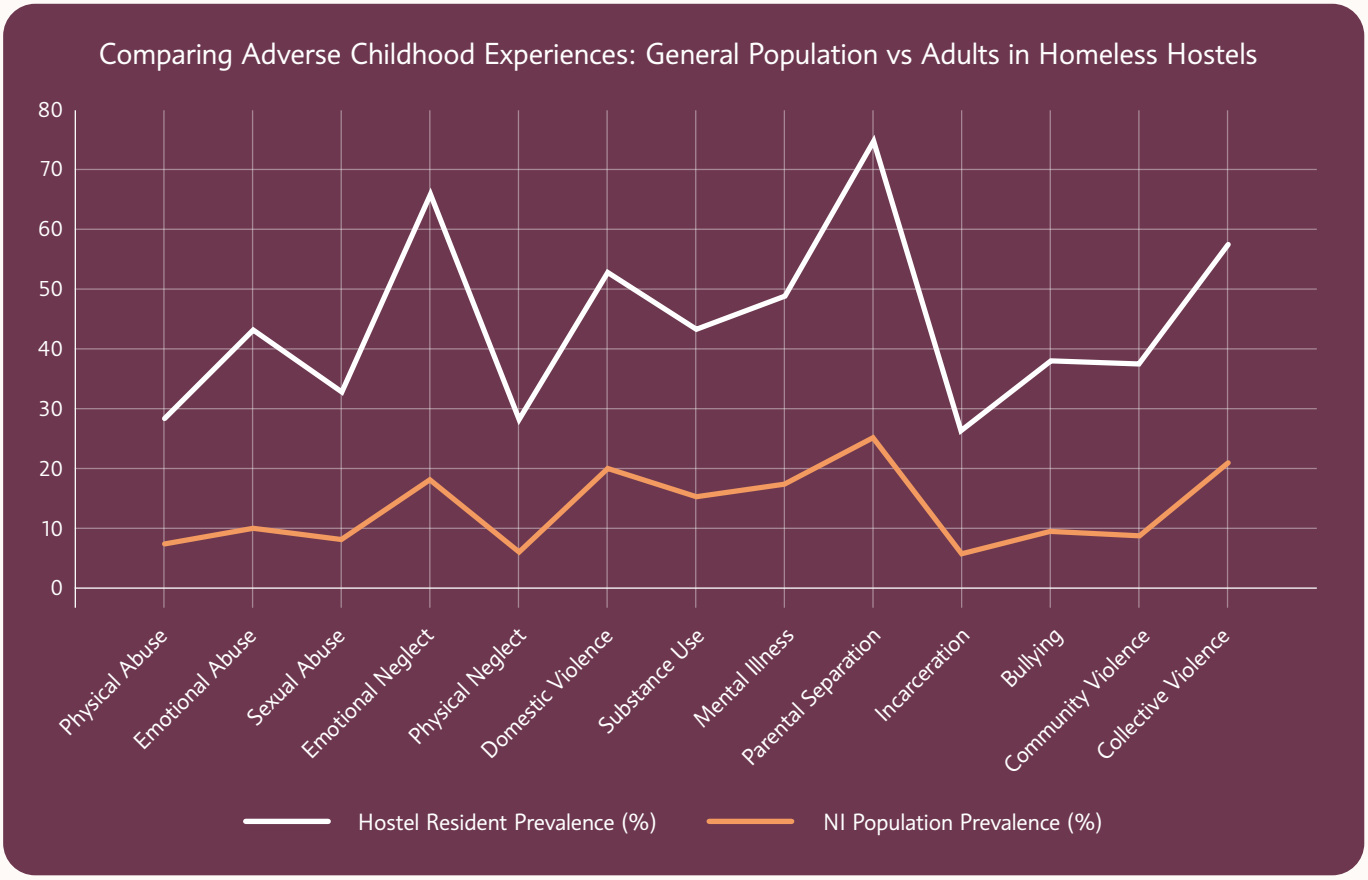
For those aged 37–46, collective violence (66.7%) was the most common adversity, while parental separation dominated in the 47–56 (92.6%) and 57–66 (87.5%) groups.

### What this tells us

Patterns of childhood adversity shifted across generations, with older residents more likely to report conflict-related violence and younger groups more exposed to household mental illness, substance use and neglect. The 27–36 cohort stands out as carrying the heaviest burden across multiple forms of harm. At the same time, the findings show that adversity was intense across all age groups, underlining how deeply rooted early harm is within the hostel population.

## Comparing childhood adversity in the general population and hostel residents

What stands out in this study is not only the high levels of adversity, but also its pattern. The types of childhood adversity experienced by people in hostels - like parental separation (75.2%), emotional neglect (65.9%) and exposure to violence (57.4%) - are similar to those experienced in the wider Northern Ireland population.[25]




The differences between hostel residents and the general NI population are stark. In every category, prevalence was higher among hostel residents and several adversities were many times more common:[25]

- **Sexual abuse** was about four times more common **(32.9% vs 8.1%)**
- **Domestic violence** was more than two and a half times more common **(52.9% vs 20.2%).**
- **Household mental illness** was nearly three times more common **(48.8% vs 17.3%).**
- **Collective violence** was also nearly three times more common **(57.4% vs 20.9%).**
- **Parental separation** was around three times more common among hostel residents **(75.2% vs 25.4%).**
- **Emotional neglect** was also around three times more common **(65.9% vs 18.2%).**
- **Emotional abuse** was over four times more common **(43.6% vs 10.2%).**

### What this tells us

- **Adversity is concentrated among people who become homeless** – as in other countries, people experiencing homelessness are far more likely to have faced multiple childhood adversities.
- **Adversity reflects Northern Ireland's context** – the types of childhood adversity reported mirror the region's history, including the legacy of conflict, family breakdown and neglect within close relationships.

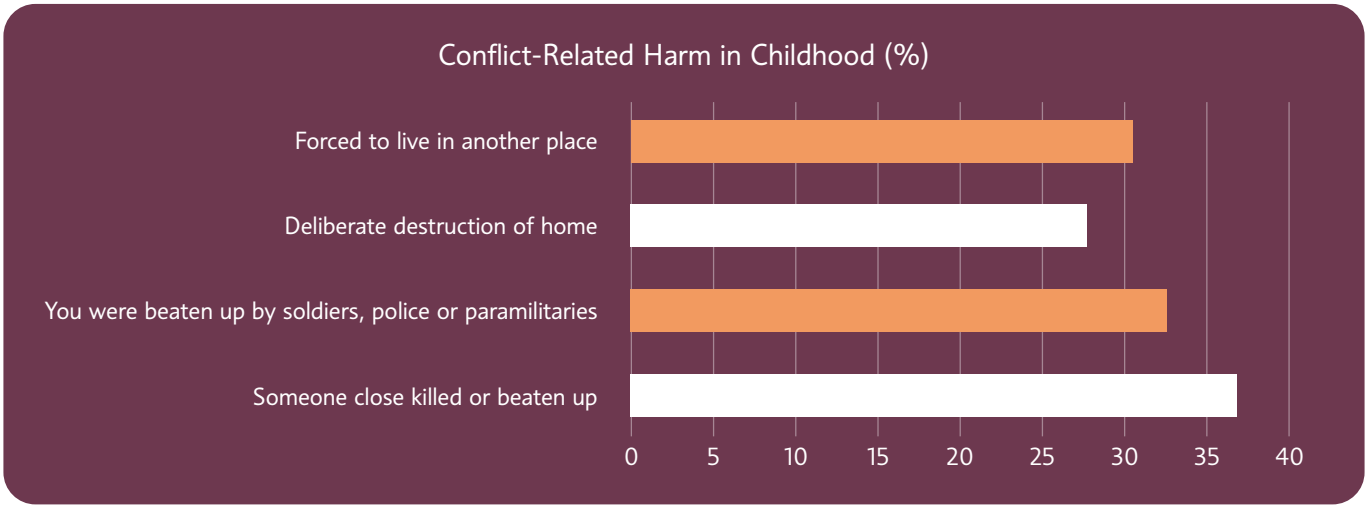
The kinds of adversity people in hostels faced as children are not unusual in Northern Ireland. What's different is how often these experiences happened in this group. These weren't rare or isolated events. **They were part of everyday life for many children who later became homeless as adults.** The same types of harm seen across the wider population were present here — just more frequent and more concentrated.

This suggests that homelessness isn't always the result of extreme or unique circumstances. Often, it's the result of common adversities piling up over time, shaping lives in ways that reflect broader social patterns across Northern Ireland.

## Conflict-Related Childhood Adversity

There are four key findings that show how the Troubles and related community conflict affected this population, either through direct or indirect exposure to violence in childhood.

- Someone close killed or beaten up was reported by over a third of participants (36.8%).
- Being beaten up by soldiers, police, or paramilitaries as a child was reported by one in three (32.6%).
- Deliberate destruction of the home was reported by over a quarter (27.7%).
- Being forced to live in another place was reported by nearly one in three (30.5%).



## Gender and Conflict-Related Violence

Patterns of conflict-related adversity also varied by gender. Men were nearly twice as likely as women to report being beaten up by soldiers, police or paramilitaries (38.1% vs 19%). Women, meanwhile, were more likely to report displacement (37.2% vs 28.1%) and the deliberate destruction of the home (34.9% vs 26%).

## Conflict-Related Violence Across Generations

Conflict-related violence was reported across all age groups, with clear generational patterns:

- Nearly half of those aged 27–46 had been assaulted as children, showing the extent of harm during the Troubles.
- Among those aged 27–36, who were very young at the time of the Good Friday Agreement, almost half still reported violence in childhood.
- Even in the youngest group (18–26, all born after the Agreement), conflict-related harms persisted:
  - Almost one in three were forced from their home or lost someone close to violence.
  - One in five had been personally assaulted.

### What this tells us

Conflict-related violence was not peripheral but a significant part of childhood for many people now living in hostels. Experiences ranged from personal assault to displacement and the loss of family members, with especially high levels among those who were children during the height of the Troubles.

Conflict-related harms were experienced by both men and women, but in different forms. Men were more exposed to direct assault, while women were more affected by the destabilisation of home and community. Both types of harm undermined stability in childhood and contributed to the pathways into later homelessness.

While patterns differed by gender and age, the overall picture shows how political violence left a deep and lasting mark, adding to family and relational harms.

Importantly, **conflict-related adversity did not end with the peace process.** It continues in the form of paramilitary activity, community intimidation and intergenerational trauma. Other research has found similar patterns, showing that paramilitary violence remains a significant adversity for young people in Northern Ireland, creating cycles of trauma, disrupted education and exclusion.[32]

The displacement, destruction of homes and exposure to violence created instability in childhood that directly foreshadowed later homelessness. Unlike other adversities, these harms often involved the loss or damage of housing itself, making their relevance to adult homelessness especially clear.

This adds a distinctly Northern Irish dimension to ACEs. Conflict-related violence compounds family-based adversity, producing cumulative trauma that reverberates into adulthood. It reinforces the need for trauma-informed responses that address political as well as interpersonal harm, highlighting the contextual specificity of adversity in Northern Ireland's social fabric.

## Association Between ACEs and Exclusion

When we compared ACE scores between people with and without different experiences, clear differences emerged.

## Early exclusion in childhood

- **Care experience** – people who had been looked after as children had much higher ACE scores than those who had not.
- **Childhood homelessness** – those who had been homeless as children also carried significantly higher ACE scores.

## Adversities in adulthood

- **Mental health** – higher ACE scores were linked with self-harm, suicidal thoughts and being prescribed medication or admitted to hospital for mental health reasons.
- **Street drinking or drug use** – those engaged in street use carried significantly higher ACE scores.
- **Violence** – people who had been victims of violence, or who had perpetrated violence, had much higher ACE scores.

### What this tells us

Our findings align with a much wider body of evidence[24] [25] [41] - that the more ACEs a person experiences, the greater the risks to their health and wellbeing across their whole life. High ACE exposure has been linked to physical illness, poor mental health, substance use, shortened life expectancy and suicide attempts.

This study shows the same pattern among hostel residents. **Childhood adversity did not remain in the past:** it set in motion early exclusion (care, homelessness) and carried forward into adult life, where it was tied to violence, poor mental health and survival behaviours.

*People with the highest ACE scores were those who had been in care, homeless as children, or later faced violence and poor mental health as adults.*

## Drivers of Exclusion

To move beyond simply counting adversities, this study used cluster analysis (a statistical method that groups people together based on shared experiences). Instead of pre-defining categories, the analysis identified natural groupings in the data. These clusters highlight patterns of similarity, but they are not fixed categories. Given the high levels of adversity across the population, there was considerable overlap between groups. The findings are therefore best read as showing common pathways rather than neat divisions.

Two main drivers of exclusion were identified:

### 1. Trauma-driven

- Rooted in high levels of interpersonal harm during childhood – including domestic violence, emotional abuse, neglect, household substance misuse and community violence.
- These early adversities often cascaded into adulthood, with higher risks of victimisation, severe mental health difficulties and reliance on survival strategies such as rough sleeping and street drinking.

### 2. Institutionally embedded

- Driven more by institutional contact than by family trauma.
- Many had been looked after as children and experienced prison or youth justice centre, repeated hospitalisation for mental health crises also common.
- Even with fewer family ACEs, repeated institutional involvement created instability and exclusion.
- Survival strategies such as begging and shoplifting were frequently reported.

### What this tells us

Childhood adversity alone doesn't explain why some people end up deeply excluded or homeless. In this study, we can see two different paths leading to long-term homelessness.

One began early, rooted in family and community trauma, things like neglect, separation, or violence during childhood. The other was shaped by repeated contact with institutions - such as care systems, prisons, or hospitals - over time.

**Both paths led to the same place: entrenched homelessness.** But they got there in different ways, showing that exclusion can come from different starting points and that people's journeys are shaped by a mix of personal experiences and system responses.

It is important to stress that these drivers overlap. High adversity across the population meant many people showed elements of both trauma-driven and institutionally embedded exclusion. The analysis highlights patterns that help explain different routes into homelessness, rather than drawing hard boundaries between groups.

For policy and practice, recognising these drivers is crucial. People in hostels are not a single group with the same history or needs. While trauma-informed approaches are essential, responses must also address the role of institutions in producing exclusion and ensure support is tailored to different pathways.

## In Summary: The Patterns Behind Homelessness

People living in hostels in Northern Ireland face multiple layers of exclusion and disadvantage. Their stories show that pathways into homelessness are rarely simple but are shaped by early adversity, health and mental health needs, repeated contact with institutions and survival strategies. The findings highlight both the depth of personal harm and the structural barriers that keep them trapped in homelessness.

**Homelessness pathways:** For many, homelessness starts young, repeats over time and is marked by rough sleeping, long durations and instability within temporary accommodation.

**Childhood adversity and conflict legacy:** Almost everyone had experienced childhood adversity, with two-thirds reporting four or more ACEs. This includes not just family-based harms but also conflict-related violence and displacement, showing how political as well as interpersonal trauma shapes homelessness.

**Institutional contact:** Many have been in care, prison, or hospitalised for mental health issues, often experiencing repeated system contact. These encounters both reflect and reinforce exclusion.

**Health and mental health:** Over half live with a limiting health condition and nearly three-quarters have a diagnosed mental health problem. Rates of self-harm and suicidal thoughts are alarmingly high, showing that mental health need is widespread and severe.

**Substance use:** Alcohol and drug use are significant, but not as widespread as many people assume. For some, substance use is part of their story, but it did not define them.

**Street activity and violence:** Activities such as street drinking, shoplifting and begging are common survival strategies. Violence, including paramilitary threats and actual violence, is a recurring theme, both in childhood and adulthood.

***Almost everyone living in hostels had faced serious adversity in childhood. This reflects a global pattern — high levels of ACEs are always linked to homelessness — but also tells a local story, shaped by Northern Ireland's legacy of conflict, family breakdown and wider social disadvantage.***

# What needs to be done

**Homelessness in Northern Ireland is not about personal failure.** It comes from poverty, trauma, time spent in institutions and the lasting impact of conflict. People living in hostels are not all the same, but many share a history of disadvantage that began in childhood and carried through into adulthood.

To respond well, we need to move past stereotypes and see the reality: mental health struggles, trauma and exclusion are central to people's experiences. Housing is vital, but it cannot stand alone – the support we offer must also take account of people's experiences and the barriers they face.

Homelessness is not a short-term issue. It is a generational problem, and it demands a generational plan - one that spans mandates, outlives political cycles and delivers a lasting vision for ending homelessness in Northern Ireland.

Now is the starting point to doing things differently. This means:

### Prevention must be prioritised

Stopping homelessness before it starts saves resources, reduces trauma and breaks cycles. Government must start to shift resources upstream. We must provide adequate funding for housing stability programmes, family support and mediation, and mental health services. The development of the new Ending Homelessness Strategy presents a pivotal opportunity for Government to demonstrate genuine commitment and set out a generational plan for a generational problem. Too often, homelessness is described as something that should be brief, rare and non recurrent, yet the actions and resources required to make this a reality have consistently fallen short.

A statutory duty for prevention must be introduced - not only for the Housing Executive, but across all public agencies that support people at risk of homelessness.

### Collaboration is vital

Preventing homelessness cannot be the responsibility of one department alone. It requires collective responsibility across government and public services to spot risks early and provide joined-up support. Homelessness is never caused by a single issue, and this research shows how the factors that lead to it cut across health, education, justice, housing and wider community services. It also shows that, for many people who become homeless, there were multiple missed chances to step in sooner. Every department has a part to play, but lasting change will only come when we work together.

**Communities:** Increasing the supply of social and affordable homes is essential to preventing homelessness. We need a more ambitious programme of social housing development, combined with cross-departmental planning to ensure every young person leaving care has a secure home and the support needed to move confidently into adulthood.

**Health:** Investment in mental health and dual diagnosis services must be delivered in partnership with housing and community supports, ensuring people get timely, trauma informed care. The Mental Health Strategy provides the framework for delivering this but it urgently needs adequate resourcing.

**Education:** Schools can help spot children at risk by working with families, health and community services to connect them to support before problems escalate.

**Justice:** People leaving prison or youth justice institutions need coordinated plans across justice, housing and health so that no one leaves without a safe place to live.

## Final word:

*Recent commitments in the Programme for Government to prevent homelessness for care leavers and new school initiatives to identify young people at risk of homelessness are promising steps forward. They show what is possible when we work together and give us hope for the future. But we cannot stop here. We must go further to break the cycle of homelessness in Northern Ireland and give the next generation the chance of a brighter future.* ***Homelessness is not inevitable – prevention is possible but only if we work together.***

# Appendix 1 Methodology details

## Sampling and Recruitment

A purposive sampling strategy was used to recruit adults (18+) living in Housing Executive-funded hostels for *Single Adults with Support Needs.* At the time of fieldwork, there were around 820 beds across 30 hostels managed by 15 voluntary-sector providers. All 15 organisations were invited to participate, with 10 agreeing to support the research. These organisations were: Apex Housing, East Belfast Mission, Extern, NB Housing, DePaul, Mindwise, First Housing, Salvation Army, Welcome and Simon Community.

Organisations supported recruitment by introducing the study to people living in their accommodation, sharing information sheets and enabling residents to access the survey; this could be done with the support of a staff member.

Fieldwork took place over six weeks (22 August–2 October 2023). Of the 180 individuals who began the survey, five withdrew at the consent stage, leaving 175 completed responses.

## Sampling and Recruitment

To address the research questions, the survey combined validated international instruments with measures tailored to the Northern Ireland context.

Validated instruments

- Adverse Childhood Experiences International Questionnaire (ACE-IQ): Developed by the World Health Organisation, measuring childhood trauma and adversity across 13 domains.[34]
- Alcohol Use Disorders Identification Test – Consumption (AUDIT-C): A short, internationally used screening tool for hazardous or dependent drinking.[35]
- Drug Use Disorders Identification Test – Consumption (DUDIT-C): A parallel tool for identifying harmful or dependent drug use.[36]

Additional measures

- Chronic Homelessness: Defined using Northern Ireland Housing Executive (Housing Executive) criteria.[37]
- Demographics: Collected in line with NI Census[38] categories for comparability
- Multiple Exclusion Homelessness (MEH): Measured as the overlap of homelessness with other domains of exclusion, including institutional contact (care, prison, psychiatric hospital), survival behaviours (street activity) and health harm.[10]
- Gender: Retained as an active variable to capture gendered dimensions of exclusion, addressing the under-representation and misclassification of women's homelessness in administrative systems.

This combination of measures provided a comprehensive picture of exclusion, enabling analysis of how different forms of adversity and disadvantage intersect across the life course.

## Substance Use – how it is measured.

Substance-related exclusion was assessed using two internationally recognised screening tools:

- AUDIT-C (Alcohol Use Disorders Identification Test – Consumption): A short 3-item tool developed by the World Health Organization to measure frequency and quantity of alcohol consumption. Scores range from 0–12. In this study, a score of 5 or more indicated potentially harmful use, while 8 or more suggested probable dependence. This higher threshold was chosen to focus on more severe patterns of alcohol use linked with exclusion.
- DUDIT-C (Drug Use Disorders Identification Test – Consumption): A 4-item tool used internationally to screen for risky drug use. Scores range from 0–12. A score of 5 or more indicated potentially harmful use, while 9 or more suggested probable dependence or severe harm.

## Data Collection

Fieldwork was conducted over a six-week period (22 August–2 October 2023). The survey was administered in digital format (Microsoft Forms) within participating hostels.To maximise accessibility, data collection was supported by workers in the hostels, who introduced the study, explained the information sheet and assisted residents where requested. Surveys were completed in private with staff trained in safeguarding and distress protocols.

Each participant received a £10 unconditional token of appreciation in recognition of their time.

## Data Analysis

Survey responses were anonymised at submission and analysed using SPSS statistical software.

- Descriptive statistics summarised demographic characteristics, health profiles, housing histories and experiences of adversity.
- Comparisons were made by age and gender to highlight inequalities and patterns.
- Cross-tabulations and statistical tests were used to examine associations between ACEs and adult exclusionary outcomes.
- Cluster analysis was employed to explore distinct pathways into and through homelessness, identifying groups with shared profiles of adversity and exclusion.

Findings are presented at the population level, with anonymity protected. Interpretive insights from the advisory groups were integrated throughout the analysis to ensure that patterns were understood in light of lived experience.

## Ethics and Safeguards

The study was conducted with robust ethical safeguards:

- Approvals: Ethical approval was granted by Queen's University Belfast, SSESW SREC, on 25 May 2023 with organisational governance approval from participating providers.
- Trauma-informed design: Safeguards included a distress protocol with pause points, grounding strategies and support contacts. Surveys were completed in private, or with staff if preferred.
- Voluntary participation: Participation was confidential and voluntary, with no impact on accommodation or support. Consent was captured digitally and participants could skip questions or withdraw before submission.
- Safeguarding: Clear limits to confidentiality were explained. Disclosures of immediate risk of harm were managed under organisational safeguarding procedures.
- Data protection: Data were anonymised at submission and securely stored in line with the UK Data Protection Act 2018 and UK GDPR.

# Appendix 2 ACE breakdown

| | ACE CATEGORIES | | | | | | | | | | | | | ACE COUNT | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Childhood Abuse | | | | | Family Dysfunction | | | | | Violence | | | 0 | 1 | 2 or 3 | 4+ | 7+ | 11+ |
| | Physical Abuse | Emotional Abuse | Sexual Abuse | Emotional Neglect | Physical Neglect | Domestic Violence | Substance Use | Mental Illness | Parental Separation | Incarceration | Bullying | Community Violence | Collective Violence | | | | | | |
| Overall Prevalence (%) | 29.7 | 43.6 | 32.9 | 65.9 | 27.5 | 52.9 | 43.7 | 48.8 | 75.2 | 25.9 | 38 | 37.3 | 57.4 | 4 | 12 | 17.7 | 66.3 | 40 | 11.4 |
| **Age Group (%)** | | | | | | | | | | | | | | | | | | | |
| 18-26 | 25.5 | 45.5 | 28.6 | 68.5 | 29.6 | 54.5 | 40 | 52.7 | 73.5 | 20 | 47.3 | 45.3 | 47.2 | 7.3 | 7.3 | 18.2 | 67.3 | 40 | 12.7 |
| 27-36 | 36.2 | 52.2 | 46.3 | 76.6 | 34.8 | 58.7 | 57.4 | 60.9 | 73.2 | 36.2 | 43.5 | 44.4 | 70.5 | 0 | 8.5 | 17 | 74.5 | 48.9 | 17 |
| 37-46 | 25.7 | 44.4 | 34.4 | 62.9 | 25 | 50 | 47.2 | 47.2 | 62.5 | 30.6 | 31.4 | 40 | 66.7 | 5.6 | 13.9 | 11.2 | 69.4 | 44.4 | 5.6 |
| 47-56 | 26.9 | 26.9 | 20 | 50 | 11.5 | 46.2 | 25.9 | 25.9 | 92.6 | 11.1 | 15.4 | 7.4 | 48.1 | 3.6 | 17.9 | 28.6 | 50 | 17.9 | 7.1 |
| 57-66 | 44.4 | 33.3 | 25 | 55.6 | 33.3 | 44.4 | 33.3 | 37.5 | 87.5 | 33.3 | 44.4 | 33.3 | 44.4 | 0 | 33.3 | 11.1 | 55.6 | 44.4 | 11.1 |
| **Gender** | | | | | | | | | | | | | | | | | | | |
| Male | 29.4 | 44.1 | 26.1 | 63.5 | 24.5 | 52 | 43 | 47.2 | 76.8 | 25.8 | 37.6 | 37.4 | 58.9 | 3.9 | 11.7 | 18.8 | 65.5 | 37.5 | 10.9 |
| Female | 30.2 | 42.9 | 54.1 | 72.7 | 36.6 | 57.1 | 46.5 | 54.8 | 71.4 | 25.6 | 39.5 | 34.9 | 54.8 | 4.5 | 11.4 | 15.9 | 68.2 | 47.7 | 11.4 |
| **Religion** | | | | | | | | | | | | | | | | | | | |
| Catholic | 25.4 | 38 | 30.2 | 70.8 | 29.6 | 50.7 | 45.8 | 52.1 | 72.3 | 29.2 | 34.8 | 38.6 | 51.4 | 5.5 | 11 | 20.6 | 63 | 38.4 | 12.3 |
| Protestant | 31.9 | 43.5 | 30.2 | 54.3 | 21.3 | 41.3 | 42.6 | 41.3 | 75.6 | 27.7 | 34 | 28.3 | 56.5 | 4.3 | 14.9 | 17 | 63.8 | 31.9 | 10.6 |
| None | 35.6 | 58.7 | 46.3 | 73.9 | 36.4 | 67.4 | 45.7 | 56.5 | 81.4 | 21.7 | 47.8 | 45.5 | 65.2 | 0 | 6.5 | 15.2 | 78.3 | 54.3 | 13 |
| Other | 22.2 | 11.1 | 0 | 44.4 | 0 | 55.6 | 22.2 | 22.2 | 62.5 | 11.1 | 33.3 | 33.3 | 71.4 | 11.1 | 33.3 | 11.1 | 44.4 | 22.2 | 0 |

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