



social care  
institute for excellence

# A rapid evidence assessment of what works in homelessness services

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## About Crisis

Crisis is the national charity for homeless people. We are committed to ending homelessness.

Every day we see the devastating impact homelessness has on people's lives. Every year we work side by side with thousands of homeless people, to help them rebuild their lives and leave homelessness behind for good.

Through our pioneering research into the causes and consequences of homelessness and the solutions to it, we know what it will take to end it.

Together with others who share our resolve, we bring our knowledge, experience and determination to campaign for the changes that will solve the homelessness crisis once and for all.

We bring together a unique volunteer effort each Christmas, to bring warmth, companionship and vital services to people at one of the hardest times of the year, and offer a starting point out of homelessness.

We know that homelessness is not inevitable. We know that together we can end it.

## About the Social Care Institute for Excellence (SCIE)

SCIE is a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. Widely respected for our intellectual weight and clarity of approach, SCIE works closely with governmental and non-governmental organisations at national and local levels to improve the quality of care and support services for adults and children by:

- Identifying and sharing knowledge about what works and what's new.
- Supporting people who plan, commission, deliver and use services to put that knowledge into practice.
- Informing, influencing and inspiring the direction of future practice and policy.

The core focus of SCIE's work is to support policy and practice within health and social care. We wholeheartedly believe that further care integration is essential to improve access and quality of care – as well as wider health and wellbeing outcomes - in a cost-effective and sustainable ways. Working within and across social care, local government and NHS, SCIE have developed a deep understanding of the range of pressures faced by commissioners and providers alike. SCIE develops evidence based tools and resources for the social care sector.

## Acknowledgements

SCIE are grateful to Crisis for commissioning this study, which seeks to identify and review existing evidence on what works to end homelessness. The study is intended to inform Crisis's forthcoming plan to end homelessness and also to be a resource for those working to end homelessness in the UK. SCIE would like to particularly thank Francesca Albanese for her guidance and input at every stage in this review. SCIE would also like to thank the experts who gave their time freely to take part in the review's Advisory Group, which provided invaluable input.

**Disclaimer:** All views and any errors contained in this report are the responsibility of SCIE. The views expressed should not be assumed to be those of Crisis.

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## Acronyms

Acronym	Title in full	Explanation
<b>ACT</b>	Assertive Community Treatment	Assertive Community Treatment is a practice that offers treatment, rehabilitation, and support services, using a person-centred, recovery-based approach, to individuals who have been diagnosed with a severe and persistent mental illness. Assertive Community Treatment services - assertive outreach, mental health treatment, health, vocational, integrated dual disorder treatment, family education, wellness skills, community linkages, and peer support - are provided to individuals by a mobile, multi-disciplinary team in community settings.
<b>AH-CS</b>	At Home-Chez Soi project	The At Home-Chez Soi project was a four-year Canadian Housing First demonstration project across five cities including a range of populations: urban Aboriginal population, people with substance abuse problems and ethno-racialised populations including new migrants who did not speak English.
<b>CHAIN</b>	Combined Homelessness and Information Network	Combined Homelessness and Information Network is a multi-agency database recording information about people sleeping rough and the wider street population in London. The system, which is commissioned and funded by the Mayor of London and managed by St Mungo's, represents the UK's most detailed and comprehensive source of information about rough sleeping. Combined Homelessness and Information Network allows users to share information about work done with rough sleepers and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated.
<b>CTI</b>	Critical Time Intervention	Critical Time Intervention is an empirically supported, time-limited case management model designed to prevent homelessness in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in stable housing with access to needed support. Critical Time Intervention works in two main ways: by providing emotional and practical support during the critical time of transition and by strengthening the individual's long-term ties to services, family, and friends. Ideally, workers who have established relationships with clients during their institutional stay to deliver post-discharge assistance.
<b>MHCLG and DCLG</b>	The Ministry for Housing Communities and Local	The Ministry for Housing, Communities and Local Government was formally The Department for Communities and Local Government. The current department continues to be supported by 12 agencies and public bodies. Their

	Government formally the Department for Communities and Local Government	role is to create great places to live and work, and to give more power to local people to shape what happens in their area. When referencing the reports from the Department for Communities and Local Government we use their full name, as well as notating that the department has since been renamed.
<b>FUSE</b>	Frequent Users Service Enhancement initiative	A two year intervention, which involved the provision of Permanent Supportive Housing, operated by non-profits using housing subsidies alongside provision of intensive case management for people with mental health issues, clinical supervision and any other support needed, to offenders coming out of the criminal justice system.
<b>GED</b>	General Education Development	General Educational Development tests are a group of four subject tests which, when passed, provide certification that the test taker has United States or Canadian high school-level academic skills.
<b>HCP</b>	Homebase Community Prevention project	The programme consisted of a network of neighbourhood centres where families are assigned case workers who develop individualised family service plans which include both referrals to, and information about, a range of services providing welfare and consumer advice. The Homebase Community Prevention project also provides vouchers to pay rental or utility arrears, moving costs and security costs, to help stabilise families.
<b>HF</b>	Housing First	Housing First is a recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing, without preconditions regarding recovery from (or participation in treatment for) substance misuse or mental health problems. Person-centred support is provided on a flexible basis for as long as individuals need it. The approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues.
<b>HPCC</b>	Homelessness Prevention Call Centre	A call centre in Chicago which processes a large number of calls annually for access to the Emergency Rental Assistance Program which provides financial assistance to Chicago residents, directly related to the prevention of homelessness, to eligible individuals and families who are in danger of eviction in order to stabilise individuals and families in their existing rental units.
<b>IB</b>	Individual Budgets	An Individual Budget is a system for organising individualised funding where the person is told, upfront, how much they are entitled to spend. Support workers have access to a budget for each individual (£2,000-£3,000) which they can spend on a wide variety of items (ranging

		<p>from a caravan to clothing) in order to help secure and maintain accommodation</p> <p>A key component is the ability of individuals to decide how funds are spent. It is a needs-based approach to setting budgets, instead of a service-driven approach.</p>
<b>ICM</b>	Intensive Case Management	<p>Intensive Case Management is a team-based recovery oriented approach that supports individuals through one-to-one case management, the goal of which is to help clients maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. The duration of the service is determined by the needs of the client, with the goal of transitioning to mainstream services as soon as possible.</p>
<b>NRCT</b>	Non Randomised Controlled trial	<p>A study where participants have been assigned to the treatment, procedure, or intervention alternatives by a method that is not random. The investigator defines and manages the alternatives and controls the exposure of groups to the intervention. There are different types of controls that can be used, for example, concurrent controls where treatment and control group participants are matched at the group level based on demographic and other characteristics, and receive different treatment conditions at the same time.</p>
<b>PSH</b>	Permanent Supportive Housing	<p>Permanent Supportive Housing combines rental or housing assistance with individualised, flexible and voluntary support services for people with high needs related to physical or mental health, developmental disabilities or substance use.</p>
<b>RCT</b>	Randomised Controlled Trial	<p>A randomised controlled trial is a type of experiment, which aims to reduce bias when testing a new treatment. The people participating in the trial are randomly allocated to either the group receiving the treatment under investigation or to a control group receiving standard treatment (or placebo treatment). Randomisation minimises selection bias and the different comparison groups allow the researchers to determine any effects of the treatment when compared with the no treatment (control) group, while other variables are kept constant.</p>
<b>RRHD</b>	Rapid Re-Housing Demonstration project	<p>The project offered families rapid rehousing and a package of temporary assistance. Twenty-three communities were awarded funds in 2009 by the U.S. Department of Housing and Urban Development (HUD) to implement the programme. Rapid rehousing is designed to enable households to exit shelter quickly by assisting them in finding a housing unit in the community and subsequently providing them with a short-term housing subsidy (not to</p>



		exceed 18 months) along with a modest package of housing-related services designed to stabilise the household in anticipation of the conclusion of rental assistance.
<b>SIB</b>	Social Impact Bond	Social Impact Bonds are a new form of financing social programmes which gather private investments to fund specific providers to deliver a service or programme. They are increasingly being used, or are at least being considered, in response to homelessness in a number of countries.
<b>SP</b>	Supporting People programme	The Supporting People programme funds housing related support services that a landlord (for example, a housing association or other provider such as a voluntary organisation) can provide. Support means advice and help to make it easier for vulnerable people to maintain their independence in their home. People can receive support in a hostel or in sheltered housing or other type of supported living. Support can also be provided to people in their own homes through floating support services.
<b>SR</b>	Systematic Review	A systematic review is an appraisal and synthesis of primary research papers using a rigorous and clearly documented methodology in both the search strategy and the selection of studies. This minimises bias in the results. The clear documentation of the process and the decisions made allow the review to be reproduced and updated.
<b>VHPD</b>	Veterans Homelessness Prevention Demonstration project	The programme was a three-year collaboration between the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Veterans Affairs (VA), and the U.S. Department of Labor (DOL). It was designed to include rapid rehousing, a combination of short- to medium-term housing assistance in the form of vouchers (up to 18 months), including security deposits, rent, moving costs assistance, and utilities, case management and access to health and employment services. It also involved working with housing providers, local agencies and veterans' medical centres, amongst others.

Note that Appendix 3 provides detailed explanation of services referred to in the table above and throughout the remainder of this report.

# Executive summary

## Introduction

According to Heriot-Watt University<sup>1</sup>, nearly 160,000 households, estimated to represent just under a quarter of a million people, are experiencing the worst forms of homelessness across the United Kingdom and, assuming a status quo, rough sleeping is forecast to rise by 32 per cent by 2026. Crisis, in its 50th anniversary year, is developing a plan to end homelessness and to inform this the charity has embarked on a large evidence-gathering programme to understand what is needed to end homelessness across the United Kingdom. As part of their evidence-gathering, Crisis have commissioned this rapid evidence assessment (REA) to understand what services<sup>2</sup> work to address and end homelessness, and assess the quality of evidence that exists in published studies. The REA has been framed around Crisis's five definitions of ending homelessness:

1. No one sleeping rough.
2. No one forced to live in transient or dangerous accommodation such as tents, squats and non-residential buildings.
3. No one living in emergency accommodation such as shelters and hostels without a plan for rapid rehousing into affordable, secure and decent accommodation.
4. No one homeless as a result of leaving a state institution such as prison or the care system.
5. Everyone at immediate risk of homelessness gets the help they need that prevents it happening.

Overall, and in relation to each of the five definitions above, the review addressed the following questions:

- What **services are effective** in addressing, reducing or preventing people from becoming homeless?
- What are the **features of effective** services that address reduce or prevent people from becoming homeless?
- What are the **barriers** to addressing, reducing or preventing people from becoming homeless?
- What is the **quality of evidence** about the effectiveness (including cost effectiveness) of what works in addressing, reducing or preventing people from becoming homeless?
- What **approaches to evaluation** have been used to evidence the success of services aimed at preventing people from becoming homeless?
- What works in **preventing homelessness, rapidly responding to people with low level needs** and in **sustained support** for people with complex needs?
- What works for specific groups of people?

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<sup>1</sup> Homelessness projections: Core homelessness in Great Britain (August, 2017), Crisis.

<sup>2</sup> We use term 'services' to include all efforts to address homelessness, including interventions and types of intervention.

## Review methods

We employed a REA approach for this review which is based on SCIE's review methods and adapted from the Government social research services **rapid review toolkit** for use within social care<sup>3</sup>.

REAs provide a quick and clear examination of the evidence informed by a review protocol, but are limited by their resources and timescale. Crisis and SCIE worked in partnership along with the support of an Advisory Group (AG), to formulate the protocol and subsequent review (see Appendix 1) and to agree review goals and questions, sources and inclusion/exclusion criteria.

SCIE undertook scoping searches prior to the development of the protocol to gather a cross-section of data and test search approaches. The scoping confirmed that evidence on homelessness is both vast and far-reaching across international sources. Working with Crisis and the AG, we agreed an approach that sought to narrow the focus of the work and limit our review to studies published 2007 – 2017, identifying what services work in preventing, reducing or addressing homelessness using peer-reviewed journal sources and independent evaluations.

SCIE carried out searches for articles and published grey literature using a range of sources including databases, search engines and a prescribed set of relevant organisations which were identified in the development of the review protocol. A core search approach was defined and translated across a variety of platforms and the results were managed in a reference library (Evidence for Policy and Practice Information (EPPI) Reviewer 4) where we removed duplicate studies, undertook screening, committed inclusion criteria and conducted coding along with final extraction. A full description of the search approach, sources and search terms is included in the review protocol (see Appendix 1).

The review protocol describes the different types of study we examined and the key factors we looked for in terms of relevance. References were screened using the criteria described in our protocol in two stages of inclusion, Stage 1 identified 2,197 studies based on the title and abstract, with 332 studies making it through to the second stage, where they were screened on the basis of full text. This resulted in 120 studies being included in the third and final stage of selection, where a best evidence approach was applied to make the final selection of studies for inclusion. Only studies initially rated as high quality at Stage 2 were considered for final inclusion<sup>4</sup>. All studies rated as high quality at this stage were sorted within themes using a hierarchy of evidence, which ensured we included a range of types of study in our final selection. Selecting a maximum of 35 studies, our best evidence approach included:

- **Themes.** 120 were coded against Crisis's five definitions of ending homelessness.

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<sup>3</sup> Government Social Research Service (no date) Rapid evidence assessment toolkit, available via the National Archives, archived on 2 Apr 2014, viewed 9 May 2018, <http://webarchive.nationalarchives.gov.uk/20140402164155/http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment>.

<sup>4</sup> Note that a further more detailed assessment of quality was applied at stage 3, which is explained in Appendix 1.1.

- **A selection of study approaches.** We selected studies against each theme to include a range of study designs (Systematic Review, Randomised Controlled Trials, Quasi Experimental, mixed methods and case studies).
- **Quality of study.** Where, in each theme we had more than one type of study to select from, we applied the quality tests described in the protocol. Taking a best evidence approach and with the input of Crisis and the AG a number of studies, while not considered as high quality, were selected, for example, those involving cost-benefit content from the United Kingdom. Hence, this review included studies not graded as high quality, which highlights the need to improve standards of evidence.
- **Housing First.** There were 25 high quality studies of Housing First, which made it through Stage 2 screening. In order to ensure that a greater range of types of services were included in the review, we agreed with Crisis to select up to 4 Housing First studies on the basis that they were of most comprehensive, recent and of high quality.
- **Referrals from Crisis and the Advisory Group.** We have included 11 studies that were recommended by the AG and Crisis.
- **A mix of service/prevention types.** We selected studies to align where possible to Crisis's three types of service; prevention policy, rapid response to lower-level need, and sustained support.

84 of the 120 studies included at stage 2 were not reviewed, meaning that **35** studies were selected for analysis (see References for details). Each study was analysed using EPPI, using the review questions as a thematic framework. For the purposes of this summary and the report, overall findings are presented in detail whilst, to avoid duplication, detailed analysis for each of Crisis's definitions for ending homelessness are summarised in Appendix 2.

## Conclusions

### Types of effective services

The review suggests that **sustained services, targeted to meet specific needs across time** (because needs can change) are effective. Effective services include those which provide **Intensive Case Management** and **Critical Time Interventions**. Effective services incorporate **Permanent Supported Housing** elements, support for people into accommodation through provision of **housing vouchers and subsidies, and guidance on benefits and information about services**. The review found that, in relation to what works in:

- **Preventing immediate homelessness**, a combination of approaches showed promise with speedy access to financial support and suitable housing options being very important.
- **Rapidly responding to people with low level needs**, accessible services and the ability to make appropriate referrals in a time critical environment are key, for instance, by providing rapid rehousing, transitional housing, financial assistance, private sector housing or permanent accommodation.

- **Sustained support for people with complex needs**, requires developing services which are able to identify and engage and sustain support to people over periods of time, during which needs invariably develop and change, hence expert-involved case management services work best.

### Features of effective services

The review suggests that the following features contribute to the effectiveness of services:

- **Fidelity.** Adherence to particular aspects of models/designs of service that are found to be successful.
- **Context.** Adapting and aligning services to local settings and context.
- **Person-centred responses.** Developing and providing a range of targeted and customised services, providing the right service at the right time; this also means providing services that are attuned to and reflect the personal circumstances of people, particularly with regards to their journey out of homelessness.
- **Relationships with key workers.** One to one, strong and developed relationships between client and case/support worker.
- **Integration.** Multi-component and multi-agency (e.g. health, local authority and housing providers) services.
- **Relationships with landlords.** Strong positive relationships between clients and landlords.
- **Housing market.** A local housing market with the resources to respond flexibly to meet homelessness needs.

### Barriers

The review suggests that the following issues are barriers to delivering effective services:

- **Lack of services for people with complex needs.** People with complex needs, such as a mental health illness, are more difficult to engage with in terms of assessing and providing flexible, responsive and sustained expert-led person-centred support. People with complex needs experience less successful service outcomes.
- **Challenges in maintaining sustained multi-agency working.** Evidence suggests that initially effective combined efforts often cannot be sustained.
- **Lack of access to the local housing market.** People who are at risk of homelessness or are homeless find accessing the local housing market more challenging, and experience poor relationships with landlords.
- **Lack of monitoring data.** There is a lack of data about, and monitoring of, homeless people and those at risk of homelessness, resulting in a lack of information to inform the design and development of services which are fit for purpose.
- **Lack of access to services for people from vulnerable and harder to reach groups.** There is a lack of access to appropriate services to meet the needs of specific population groups, such as those with mental health illness, people from black and minority ethnic communities, and people with substance dependencies.

- **Lack of high-quality studies included in published reviews.** This creates a lack of clarity for service providers about the reliability of much of the evidence about what works to end homelessness.

### **Quality of evidence including on cost effectiveness**

The majority of the studies selected for analysis were considered to be high quality, however, taking a best evidence approach also led to the inclusion of a small number of studies that were of low to medium quality. This particularly applied to mixed method and cost-benefit studies and means that there were few:

- **high-quality studies** with process/qualitative evidence able to link service delivery with quantitative outcomes, limiting the ability to generalise learning beyond the local context of any particular study.
- **robust assessments of cost-effectiveness** included in the review. However, those studies reviewed reported encouraging economic assessments (e.g. Oxera, 2013; Bee and Woods, 2010; Ohio Housing Agency, 2016).

### **Approaches to evaluation and outcome measures**

Studies analysed represented a range of evaluation types, including, randomised controlled trials, comparative evaluations, mixed methods studies and qualitative evaluations. Outcome measures included:

- Those directly related to particular **service features**.
- The number/percentage of **days of homelessness**.
- The number/percentage of **days stably/continuously housed**.
- Outcomes/measures relating to the **use of shelters**.
- Outcomes/measures relating to **tenancies**.

### **Gaps in the evidence base**

The review identified a lack of evidence about what works for a number of specific population groups:

- **Black and minority ethnic (BAME) groups** rarely featured in studies and when they did, outcomes were not as positive as for other groups.
- None of the studies selected focused only on people in **transient accommodation**, that is, those who were sofa-surfing, squatting, or living in unsafe environments and moving locations constantly.
- There are also **few robust evidence-based successful family services**.

Other gaps included:

- Insufficient **experimental research**, particularly Randomised Controlled Trials across multiple sites.
- The lack of studies that **combine experimental research with qualitative research**.
- Little measurement of **fidelity of services** across service sites which can impact on interpretation of findings.
- Gaps in assessing **longer-term outcomes** of services.

- Gap in consistent and robust **economic** and **cost-benefit evidence**, especially originating in the United Kingdom.

## Opportunities

This review suggests a number of opportunities for stakeholders to improve how they work together to end homelessness by:

- Increasing the supply of **affordable housing**.
- Expanding support for and developing **specialised services** for a range of population groups.
- Conducting **further research** (e.g. on hard to reach groups, family services and to develop a suite of outcome measures, including those related to economic assessments).
- Funding and supporting **innovative and successful** services.
- Facilitating better **multi-agency needs-based working**.
- Maximising **cross-sector research** opportunities.
- There is a pressing need to develop:
  - **shared language** and **understanding** around what is needed for, and the various types of, **economic assessment** (i.e. value for money, cost benefit, opportunity costs, social return on investment).
  - **consistency** in relation to what are accepted as acceptable measures of potential benefits/opportunity costs of interventions (i.e., reduced criminal justice-related costs, such as custodial costs, reduced emergency shelter costs, reduced health costs, such as hospitalisations).
  - clarity of purpose for and how to appropriately apply economic assessment.
  - reliable and long-term **accessible cost-related data sources**.

## Implications

Finally, we suggest the following are key factors to achieving successful outcomes for services working to address homelessness. These observations are designed to be read in conjunction with those made in Peter Mackie's recent review on what works in relation to rough sleeping, published in December 2017 by Crisis<sup>5</sup>. Mackie et al. draw our five policy principles<sup>6</sup> and, while these principles are also supported by the evidence generated by this review, we think there are an additional four important aspects

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<sup>5</sup> Mackie, P et al. (2017) Ending rough sleeping: what works? An international evidence review.

<sup>6</sup> *Recognise heterogeneity* – of individual rough sleepers' housing and support needs and their different entitlements to publicly funded support. Local housing markets and rough sleeper population profiles will also vary across the UK. *Take swift action* – to prevent or quickly end street homelessness, through interventions such as No Second Night Out (NSNO), thereby reducing the number of rough sleepers who develop complex needs and potentially become entrenched. *Employ assertive outreach leading to a suitable accommodation offer* – by actively identifying and reaching out to rough sleepers and offering suitable accommodation. *Be housing-led* – offering swift access to settled housing including the use of Housing First. *Offer person-centred support and choice* – via a client-centred approach based on cross-sector collaboration and commissioning (pxx).

underpinning the drive to end homelessness; the role of people and organisations, multi-component responses (and service integration), coproduction and monitoring and evaluation.

### **The role of people and organisations**

Employing both analysis of current organisations and based on feedback from Crisis and the AG the review suggests the following in relation to the role of people and organisations in contributing to ending homelessness.

- **People with lived experience of homelessness** should be involved in co-designing evaluation and services and be at the centre of all provision. They could take a peer-led role as mediators and advocates, identifying, engaging and involving others who are 'hidden' from providers and services, e.g., entrenched rough sleepers and those in transient accommodation.
- **The charitable homelessness sector and other local community and voluntary organisations** could do more to work together, and with public services towards ending homelessness; providing services, contributing to the evidence base on what works and to continue to innovate, trial and test services to end homelessness.
- **Government organisations at national and local levels** have a vital role in ending homelessness through providing cross-departmental integrated strategic direction and developing policy related to preventing and addressing homelessness, employing a coproductive approach. Key elements are developing ways of working that fit better with the services required to address homelessness, supporting improvements to the housing market and supporting longer-term innovation and development in services with sustained and stable funding for delivery and evaluation.
- **Institutions and statutory services** (health, social care, criminal justice and education) could do more to contribute to ending homelessness through improved multi-agency working across services and in partnership with voluntary and community organisations. Public services gather a wealth of data, and improving access to and better sharing of data would enhance the potential to monitor and evaluate homelessness-related services.
- **General public/wider community.** To end homelessness, it is important to harness the support of the public in building a consensus that homelessness in the UK is completely unacceptable. This means working with communities and members of the public to inform, involve and engage communities in working to end homelessness. Promoting engagement and involvement would help develop both understanding and trust, as well as identifying ways in which people who are homeless or at risk of homelessness could contribute to addressing key local challenges; for instance, helping meet lower level care needs through services, such as Homeshare and Social Prescribing (helping also to reduce demands on local public services).

### **Multi-component responses and integration**

Many people who require support have **complex needs**, which change over time and often **require responses at multiple points**; hence the importance of **sustained integrated responses** and a range of time-critical services of all kinds (universal,



indicated and selective). The review suggests that **suites of services** should be brought together in **holistic, multi-disciplinary, sustained integrated service offers**. In this way, people with varied, complex and/or changing needs are more likely to be provided with services that meet their needs at the times when people most need them. Housing policy and practice and **housing related services** are important aspects of integrated efforts to end homelessness. While tested 'models' for services are useful, the review also shows that local context is important, and that plans need to be **person-centred and realistic**.

## Coproduction

Involving and engaging people with lived experience of homelessness, and the wider community in service design would enable services to:

- **better access and engage** harder to reach groups
- **map, understand and keep abreast of developments** in the multiple access points and opportunities to intervene that present across services and communities
- **mobilise opinion and debate** to coproduce solutions in the widest community-centred way possible
- emphasise and reflect the **importance of one to one relationships** in providing successful person-centred services.

## Monitoring, evaluation and sharing learning

Building on the wealth of reviews and current evidence, we think **an ongoing systematic review** of what is working (and what is not) to end homelessness is needed; the evidence generated would contribute to the development of the knowledge base for the New Centre for Homelessness Impact being set up by Crisis and Glasgow Homelessness Network,<sup>7</sup>.

As a sector, we need to think carefully about what we consider to represent the **gold standard in evaluation** – and about how we grade evidence, share learning and design research. Key challenges for researchers and those who rely on the evidence which research and evaluation provides are how to:

- **define and redefine 'quality'** in evaluation and review the purposes for evaluation
- decide in a transformative social care environment, which **evaluation designs and methods are appropriate**, offer **best value** and are able to provide **actionable and timely evidence**
- help stakeholders **engage with the evidence**
- **coproduce research** in the widest sense with all participants, particularly those with lived experience of homelessness
- best support 'local' **evidence agendas**, whilst at the same time creating transferable learning
- explore **what works for different groups of people** (i.e. BAME, people experiencing transient homelessness, people with complex needs)

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<sup>7</sup> For further information see <https://www.homelessnessimpact.org/>.

- develop a **suite of homelessness-related outcome measures** and study designs that could be adopted to create a more coherent and reliable body of developing evidence
- develop robust and realistic economic and **cost-benefit models**
- work together to design and conduct **longer-term studies** (utilising enhanced data sharing and data mining).

## Final thoughts

In his recent report for Crisis<sup>8</sup>, Professor Glen Bramley surmises that the most acute forms of homelessness are likely to keep rising, and that a 60 per cent increase in the provision of new housing could reduce levels of homelessness by 19 per cent by 2036, while increased prevention work could reduce levels by 34 per cent in the same period.

This review shows that there is potentially a wealth of evidence about what works in services to end homelessness, but the evidence base is as varied in terms of quality as it is vast in scope. The challenge is to coordinate and develop a more coherent approach to generating reliable evidence about what works in preventing homelessness and to making that evidence more accessible to those who need it and Crisis and Glasgow Homelessness Network's Centre for Homelessness Impact<sup>9</sup> will be well-placed to take the lead in this respect.

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<sup>8</sup> Homelessness projections: Core homelessness in Great Britain (August, 2017), Crisis.

<sup>9</sup> See <https://www.homelessnessimpact.org/> for more information.

# 1. Introduction

## 1.1 Context for the review

According to Heriot-Watt University<sup>10</sup>, nearly 160,000 households, estimated to represent just under a quarter of a million people, are experiencing the worst forms of homelessness across Britain and, assuming a status quo, rough sleeping is forecast to rise by 32 per cent by 2026. The same report estimates that at any one time in 2016 across Britain 9,100 people were sleeping rough, compared to previous estimates placing rough sleeping at 4,134 households for England, 68,300 households\* were sofa surfing, 19,300 households were living in unsuitable temporary accommodation, 37,200 households were living in hostels and that 26,000 households were living in other circumstances (including, 8,900 households sleeping in tents, cars or on public transport, 12,100 households living in squats and 5,000 households in women's refuges or winter night shelters).

As part of its 50<sup>th</sup> year, Crisis is embarking on a project to research and evidence long term solutions for ending homelessness. At the end of 2018 Crisis will publish a strategy to end homelessness. As part of this strategy Crisis need to understand the currently available evidence on homelessness services, their effectiveness and how much they cost to implement.

Consecutive UK governments have provided funding for a number of homelessness services. These include the Supporting People programme introduced across the UK from 2003 which was designed to fund housing related support for homeless people<sup>11</sup>. Specific capital funding was targeted at hostels (through Places of Change), and a series of initiatives have addressed rough sleeping – e.g. the Rough Sleepers Initiative (RSI), No Second Night Out and the Homelessness Transition Fund.

More localised projects also exist, funded through statutory and voluntary sources. These are often aimed at a specific group, for example homeless people who have complex needs or address a particular issue such as progressing homeless people into training and employment. In many cases services are not funded on a long term basis and there are many examples of pilots that have been tested either in a particular locality or with a specific population group.

Services to reduce or end homelessness are not only targeted at those in the most acute need and already experiencing homelessness. Homelessness prevention approaches are also in place and are often targeted at those most at risk. However, the extent to which programmes, funding and services are evidenced or evaluated is variable and the extent to which these models can be scaled up or translated to other contexts is often unknown.

In this context Crisis has commissioned the Social Care Institute for Excellence (SCIE) to conduct a rapid evidence assessment (REA) to review

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<sup>10</sup> Homelessness projections: Core homelessness in Great Britain (August, 2017), Crisis.

<sup>11</sup> <http://researchbriefings.files.parliament.uk/documents/RP12-40/RP12-40.pdf>.

the evidence on current and past services targeted at addressing and reducing homelessness across England, Scotland and Wales.

## 1.2 Aims and objectives

The overall aim of this review was to understand what services work to address and end homelessness, and the quality of evidence that exists in published studies. The REA has been framed around Crisis's five definitions of ending homelessness:

1. No one sleeping rough.
2. No one forced to live in transient or dangerous accommodation such as tents, squats and non-residential buildings.
3. No one living in emergency accommodation such as shelters and hostels without a plan for rapid rehousing into affordable, secure and decent accommodation.
4. No one homeless as a result of leaving a state institution such as prison or the care system.
5. Everyone at immediate risk of homelessness gets the help they need that prevents it happening.

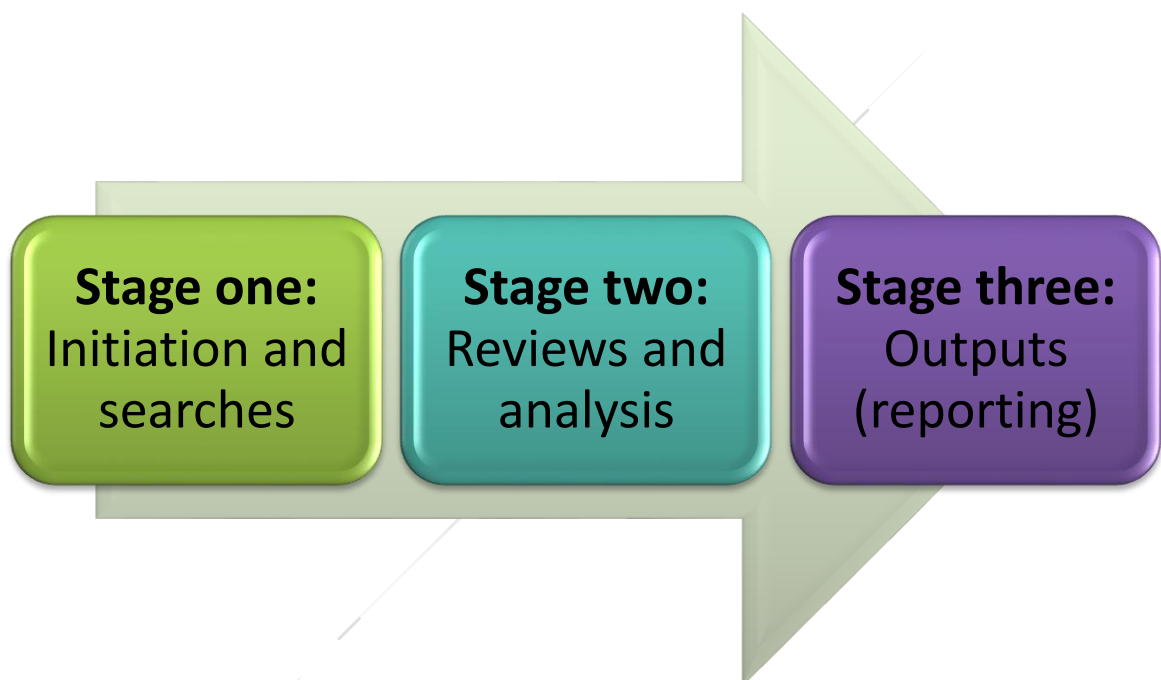
Specifically, the review sought to provide reliable evidence to answer the following questions:

- What **services are effective** in addressing, reducing or preventing people from becoming homeless?
- What are the **features of effective** services that address reduce or prevent people from becoming homeless?
- What are the **barriers** to addressing, reducing or preventing people from becoming homeless?
- What is the **quality of evidence** about the effectiveness (including cost effectiveness) of what works in addressing, reducing or preventing people from becoming homeless?
- What **approaches to evaluation** have been used to evidence the success of services aimed at preventing people from becoming homeless?
- What works in **preventing homelessness, rapidly responding to people with low level needs** and in **sustained support** for people with complex needs?
- What works for specific groups of people?

## 1.3 Methodology

For this review, SCIE adopted a Rapid Evidence Assessment approach (REA). While REA review methods vary widely in terms of the language and methods used to describe them<sup>12</sup>, our approach was informed by our extensive experience in undertaking reviews of this type. Working in collaboration with Crisis and an expert Advisory Group (AG), our review has benefitted from input and insight. Our approach had three stages, see figure 1.

**Figure 1: Overall process diagram**



### 1.3.1 Protocol development

REAs are limited by their resources and timescale but they provide a quick and clear examination of the evidence informed by a review protocol. Crisis and SCIE worked in partnership along with the support of the AG, to formulate the protocol and subsequent review (see Appendix 1). We agreed review goals and questions, sources and our inclusion and exclusion criteria. The protocol also describes the data extraction and quality standards used for study assessment. The approach we have employed is based on SCIE's

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<sup>12</sup> Agency for Healthcare Research and Quality. (2012). EPC Methods: An exploration of methods and context for the production of Rapid review. Rockville. U.S. Department of Health and Human Services. Pp.49. Available at: [https://www.ncbi.nlm.nih.gov/books/NBK274092/pdf/Bookshelf\\_NBK274092.pdf](https://www.ncbi.nlm.nih.gov/books/NBK274092/pdf/Bookshelf_NBK274092.pdf) [Accessed 26 July. 2017].

review methods and are adapted from the Government social research services **rapid review toolkit** for use within social care.

SCIE undertook pre-scoping searches prior to the development of the protocol to gather a cross-section of data and to test our search approaches. These confirmed that evidence on homelessness is both vast and far-reaching across international sources. Working with Crisis and the AG, we agreed an approach that sought to narrow the focus of our work and concentrated on identifying which services that work in preventing, reducing or addressing homelessness using peer-reviewed journal sources and independent evaluations.

### 1.3.2 Searching and screening

SCIE's information specialists carried out searches for articles and published grey literature in October 2017 using a variety of sources such as databases, search engines and websites (see Appendix 1.1 for further details). This included a prescribed set of relevant organisations which were identified in development of the review protocol. A core search approach was defined and translated across a variety of platforms and the results were managed in a reference library (EPPI reviewer 4) where we removed duplicate studies, undertook screening, committed inclusion criteria and conducted coding along with final data extraction. A full description of the search approach, sources and search terms is included in the review protocol (Appendix 1.1).

Screening was based upon the set of inclusion and exclusion criteria described in our protocol. The review protocol describes the types of study examined and the key factors looked for in terms of relevance. References were screened using the criteria described in our protocol in two stages, Stage 1 based on the title and abstract and a second stage based on screening the full text of the included studies from Stage 1. This resulted in 120 included studies making it through to the third and final stage of selection, researcher review, where a best evidence approach was applied to make the final selection of studies for inclusion. After an initial scan for quality on title and abstract, only the studies that included a methods section, were clear how data was collected and included sufficient data for the results to be useful were considered for final inclusion. All studies that met this inclusion criteria were sorted within themes, and a hierarchy of evidence approach was employed to ensure that a range of study types were included in our final selection. A best evidence approach to final study selection was used, and included:

- **The five definitions of ending homelessness as defined by Crisis.** 120 studies have been coded against five themes (see Table 1 below). The themes reflect the outcome measures Crisis have selected to determine the effectiveness of their forthcoming strategy to end homelessness (and they are summarised in the tables that follow and also described in our protocol).

- **A selection of study approaches.** Studies were selected against each theme to include a range of study designs (Systematic Reviews, Randomised Controlled Trials, QE, mixed methods and case studies).
- **Quality of study.** Where, in each theme we had more than one type of study to select from, we applied the quality tests described in our protocol. Taking a best evidence approach and with the input of Crisis and the AG a number of studies were selected, including those involving cost-benefit content from the UK.
- **Housing First.** There were a large number of high quality studies of housing which made it through Stage 2 screening (n=25.) In order to include a range of types of service, we agreed with Crisis to select up to four of these studies on the basis of the most comprehensive, recent and high quality.
- **Referrals from Crisis and the advisory group.** We have included 11 studies that were recommended by the advisory group and Crisis.
- **A mix of service/prevention types.** We selected studies to align where possible to Crisis's three types of services; prevention policy, rapid response to lower-level need and sustained support.

In total 35 studies were included in our review based on selection using the best evidence approach. A full list of studies is included in the references. Tables 1 to 4 below summarise our screening and thematic approach to selecting studies and ensuring we have a mix of types of study and provide information for the 120 studies selected at stage 2. Detailed descriptive statistics for the 35 studies included in the review are provided in Chapter 5, Tables 5.1 – 5.3 and in Appendix 1.1, Tables A6 to A12.

**Table 1 Number of studies at stage 3 by theme and initial quality assessment**

Theme	High	Medium	Low
Rough sleeping	34	5	4
Transient accommodation	19	2	0
Emergency accommodation	29	5	2
People leaving state institutions	14	5	0
People at risk of homelessness	29	2	1
Homelessness (type not specified)	26	9	3

*Note: studies may have been coded to more than one theme.*

**Table 2 Number of studies by study design**

Study design	Count
Systematic Review (SR)	8
Randomised Controlled Trial (RCT)	17
Quasi-Experimental (QE)	22
Mixed methods (MM)	46
Case study – effectiveness (CSE)	20
Qualitative (Qual)	7
<b>Total</b>	<b>120</b>

*Note: design labelling is based on the hierarchy of evidence initially used to categorise all studies at stage 3 for our best evidence approach.*

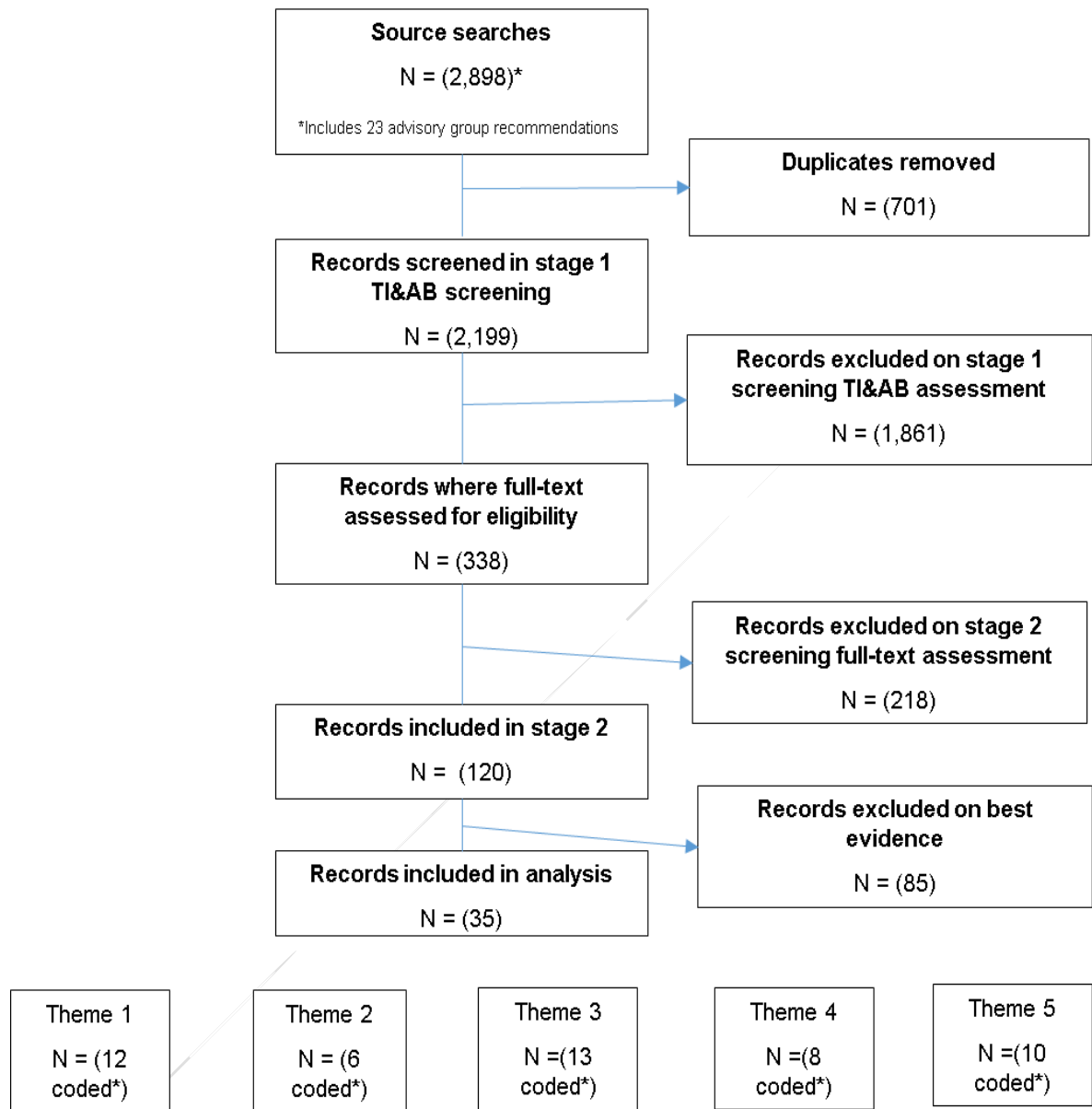
**Table 3 Number studies by theme and study design**

Theme	SR	RCT	QE	MM	CSE	Qual
Rough sleeping	0	6	4	16	12	3
Transient accommodation	0	4	3	9	4	0
Emergency accommodation	2	6	7	11	7	2
People leaving state institutions	1	2	6	4	5	0
People at risk of homelessness	5	1	3	16	6	0

*Note: studies have been coded to more than one theme.*



**Table 4 Screening inclusion and exclusion**



\*Numbers contained multiple coded records

Table 4 summarises our search, screening and selection of studies.

## 1.4 Structure of the report

Following this introductory chapter, the report is divided into a further nine Chapters, two appendices and a references section as follows<sup>13</sup>:

- Chapter 2: types of effective service.
- Chapter 3: core features of effective services.
- Chapter 4: barriers to providing effective services.
- Chapter 5: an assessment of evidence.
- Chapter 6: approaches to and measures used for evaluation.
- Chapter 7: what works in services that prevent homelessness, rapidly respond to people with low level needs and provide sustained support for people with complex needs.
- Chapter 8: services for families, people leaving institutions and people with complex needs.
- Chapter 9: conclusions.
- Chapter 10: implications.
- Appendix 1: review protocol and descriptive statistics.
- Appendix 2: summaries of analysis for each of Crisis's five definitions for ending homelessness.
- Appendix 3: further explanation of services referred to in the review.
- References: including:
  - studies included in analysis
  - studies selected at stage 2, but not included in analysis
  - additional references used in report content.

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• <sup>13</sup> Chapters 2 – 8 present analysis at the general level, each chapter uses summary boxes to draw attention to findings which relate to Crisis's five definitions of ending homelessness and each chapter concludes with a chapter summary.

## 2. Types of effective service

In this chapter we present analysis about what types of services are effective. Analysis suggests that the following types of services are effective at addressing, reducing or preventing homelessness:

- Sustained support (see Appendix A3.1 for further details on all services referred to in this report).
- Intensive Case Management / Critical Time Intervention (see Appendix A3.2 for further details on all services referred to in this report)..
- Housing vouchers and subsidies (see Appendix A3.3 for further details on all services referred to in this report).
- Person-centred, integrated multi-component approaches (see Appendix A3.4 for further details on all services referred to in this report)..

### 2.1 Sustained support

The review included four sustained support studies, which explored the impact of Housing First on different populations. The Housing First studies included:

- A review of the impact of the At Home-Chez Soi Canadian Housing First demonstration project (Aubry et al., 2015) for people with severe mental illness and chronic homelessness.
- An evaluation of the impact of Housing First combined with Intensive Case Management on an ethnically diverse sample with mental health problems (Stergiopoulos et al., 2015).
- A study exploring the impact on housing retention in a Housing First study on chronically homeless individuals with severe alcohol problems (Collins et al., 2013).
- The Housing First study in Europe (Busch-Geertsema Volker, 2014) funded by the European commission and implemented in five sites: Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon. The majority of people across sites were chronically homeless, and many had substance abuse and mental health illnesses.

Housing First studies all reported a positive impact on their treatment groups. Participants with severe mental health illness in the At Home-Chez Soi Housing First programme, experienced positive outcomes, with the intervention group spending 73% of their time in stable housing compared with 32% for the control group (Aubry et al., 2015).

An ethnically diverse group with mental illness (Stergiopoulos et al., 2015) spent a significantly higher percentage of time in stable residences compared to those in the comparison group (75.2% vs 39.5%).

Approximately half of chronically homeless individuals demonstrated housing retention in the Housing First study, (Collins et al., 2013) thereby challenging the view that homeless people do not want housing. Participants stayed a median of 675 days and 46% stayed the entire two-year period. Additionally, only 23% of participants had returned to homelessness at the end of the two-year period. The findings indicated that age, alcohol use, interpersonal

sensitivity, and hostility predicted housing retention in this Housing First project.

A five-site European study (Busch-Geertsema Volker, 2014) reported high housing retention rates in four of the five projects - 90% in Amsterdam, Copenhagen and Glasgow, and 80% in Lisbon. The fifth site experienced difficulties maintaining fidelity to the Housing First model, which had an impact on outcomes. Additionally, three of the sites had high proportions of substance abusers and the results add to the evidence of positive housing retention outcomes of the Housing First approach for people with severe addiction, and even for those with active use of heroin and other hard drugs.

The findings summarised above, are in line with the broader and extensive literature connected to Housing First, which taken as a whole suggests Housing First's common principles around sustained person-centred support result in supporting people to achieve stability in their housing-related outcomes. Our analysis also suggests that Housing First has been successful as a targeted service to support particular population groups (such as ethnically diverse groups and those with mental health illness), and that its success has been sustained when transferred beyond the United States of America.

## 2.2 Case management

Of the studies reporting the effectiveness of particular case management models, two compared the success of a number of models of case management including Standard Case Management (SCM), Intensive Case Management, Assertive Community Treatment (ACT) and Critical Time Intervention. Some combined with Permanent Supportive Housing and housing subsidies. Among the participants there was a significant percentage that were recruited from shelters. Most participants suffered from mental illness and/or substance abuse problems (Clark et al. 2016; de Veet et al., 2013).

These studies found that the more intensive the case management model, the more successful it was. For example, Clark et al. (2016) reports that Critical Time Intervention and Assertive Community Treatment, particularly when combined with Permanent Supportive Housing demonstrated improvements in homelessness after six months. However, there was no longer-term follow up of housing outcomes. Both services operated within a Housing First model and had access to housing vouchers. A significant number of participants were recruited from emergency accommodation.

Two in-depth studies of Critical Time Intervention (see Appendix 3 for further explanation), Herman et al. (2011) and Kaspro and Rosenbeck (2007), have relevance for Crisis's fourth theme; people leaving state institutions.

### **People leaving state institutions**

Both services reported significant reductions in the number of nights spent homeless. Herman et al. (2011) report that mentally ill patients being discharged from hospitals over the course of the Critical Time Intervention service were associated with a five-fold reduction in the odds of spending nights homeless compared to the comparison group. Similarly, Kaspro and Rosenbeck (2007) report that, for a ninety-day period, their treatment group leaving psychiatric institutions receiving Critical Time Intervention had 19% more days housed than did those in their comparison group and that the treatment group also had significantly more days housed at the six, nine, and 12 month follow-up intervals.

These findings suggest that Critical Time Intervention can be an effective rapid response service for people experiencing critical transitions in their lives, and has evidenced being effective with a range of target groups - including those with substance abuse issues, who have a mental illness, or who are military veterans. The findings also indicate that Critical Time Intervention services may work better when combined with Permanent Supportive Housing or Housing First as this provides a sense of longer-term security (see Appendix A3.1 for further details).

## **2.3 Housing vouchers and financial assistance**

When considering implications for services in the United Kingdom, caution should be exercised when reviewing the reported impact and added effectiveness of housing vouchers, as the studies referred to below took place in the United States of America, where there is no national state intervention to support housing cost unlike the United Kingdom. What these studies show is that vouchers to meet their housing costs and/or financial assistance helped homeless people get back on their feet. This included preventative, rapid response and sustained response provision to a range of population groups.

For example, the preventative Homebase Community Prevention programme (Abt, 2013) consisted of a network of neighbourhood centres where families, were provided with housing vouchers (as part of a wider range of support) to pay rental or utility arrears, moving costs and security costs, to help stabilise them. Abt reports a significant difference in shelter use between intervention and control groups, with the intervention group families spending an average of 22.6 fewer nights in shelter than the control group. Findings also indicate that the Homebase Community Prevention project reduced the percentage of intervention families who spent at least one night homeless over a 27-month follow up period from 14.5% & to 8.5%.

A preventative service (Evans et al., 2016) examined the effectiveness of temporary financial assistance for people at risk of homelessness by using data from the Homelessness Prevention Call Centre in Chicago, which

processes a large number of calls annually for financial assistance with rent, security deposits or utility bills. The authors compared families who called when funds were available with those who call when they were not. The reported sample consisted of 4,448 calls – 3,574 need help with rent and 874 for security deposits, just over half (58%) of callers called when funds were available. Evans et al. found that for families that called when there was fund availability, there was a 76% decline in the likelihood of homelessness after six months and, for the same group, time spent in shelter over the six months following their call, fell by 2.6 days, which was noted as a very modest change. Evans also found that families with lower than average median income in the sample were most likely to reduce the likelihood of entering a shelter within six months. Evans’s study is an example of temporary financial assistance reducing the likelihood of homelessness preventing some individuals from having to enter a shelter and that their evidence also points towards such schemes being more effective, when potentially targeted groups that could benefit more from the assistance, such as very low-income individuals and families

A rapid response service, Daybreak (Ohio Housing Agency, 2016), provided a range of support for young people between the ages of 18-21, about half of whom had lived on the streets. Amongst the support provided was a rental subsidy service, which was reported to have had positive results for young people who took part in the service. Nearly all (97%) exited from housing into safe destinations - moving in with family or friends, renting their own apartment or accessing a housing subsidy.

The Veterans Housing Prevention Demonstration project (Cunningham et al., 2015), included short- to medium-term housing assistance in the form of vouchers (for up to 18 months), including security deposits, rent, moving cost assistance, and utilities. The authors reported that by the end of the programme, 85% of veteran households were stably housed, and that at six and 12 months follow-ups the majority, 76%, lived in their own homes, while 18% were staying with family and friends. Additionally, when asked what was most helpful about the service, the most common response from veterans was the help paying rent (current or arrears) and utilities. One veteran who was struggling to pay household bills, whilst waiting for her veteran’s disability claim to be processed, described how Veterans Homelessness Prevention Demonstration project had given them time to get out of debt:

*“I think the helpful part, of course, is the financial stability; that’s what you’re coming here [to the Veterans Homelessness Prevention Demonstration project] for, so that was a major burden that let off and then—then once I finally did have my VA checks come in, I could catch up on the stuff they [the Veterans Homelessness Prevention Demonstration project] weren’t paying for.”*

(Cunningham et al., 2015: p.67)

A three-year sustained support service Family Options (U S Department of Housing and Urban Development, 2016) included priority access to housing subsidies and is relevant to Crisis’s Emergency accommodation theme.

### **Transient accommodation, emergency accommodation, people at risk of homelessness**

The Family Options programme focused on families living in shelters. It compared a number of different types of service, including priority access to long term housing subsidies, access to short-term subsidy in the form of rapid rehousing or project-based transitional housing.

The findings indicated that only priority access to long-term subsidies resulted in significant results. The authors reported on a number of outcome measures:

*“At both the 20- and 37-month follow-up points, assignment to the SUB intervention reduced by more than one-half the proportion of families who reported having spent at least 1 night in shelter or in places not meant for human habitation, or doubled up, in the past 6 months; increased the proportion of families living in their own place by 15 percentage points; The study team also measured use of emergency shelters during two 12-month periods: months 7 to 18 after random assignment and months 21 to 32 after random assignment. Relative to usual care, assignment to the SUB intervention reduced the proportion of families with a stay in shelter by almost one-half during the earlier period and by more than three-fourths during the later period.”*

(U S Department of Housing and Urban Development, 2016: p. 4)

Family Options reported the impact of long-term housing subsidies, claiming that ‘for most families, homelessness is a housing affordability problem that can be remedied with long-term housing subsidies without specialized services’ (p: 12). See Appendix A3.2 for further details.

Our review indicates that the provision of housing vouchers to meet their housing costs or subsidies, either with or without other support can result in positive outcomes for a range of subgroups. It seems that subsidies provide valuable forms of financial assistance, which can provide people with peace of mind and the space to focus on the other challenging aspects of securing stable housing.

## **2.4 Person-centred multi-component services**

A number of services were specifically designed to meet the needs of their target groups, via tailored multi-component services. They employed a combination of services, taking a whole-systems, person-centred approach to help people secure stable or permanent housing, and were successful in being able to do so. The combination of services tended to include support workers, mentors, transitional or supportive housing, individualised service plans, training and skills development and advice and access to services, e.g. employment or benefits services.

One example employing this approach was The Home to Stay (Levitt et al., 2013) rapid response service which focused on families living in emergency accommodation. The aim of the service was to use housing subsidies and

case workers to help families access services with the goal of transitioning into permanent housing. The families in the Home to Stay intervention group were found to exit a shelter without housing subsidies (73%) more quickly than those in the control group (56%). Findings also indicated that the intervention group spent fewer days in shelter than the control group - 376 days versus 449 days respectively.

Another example of person-centred support was the New York based Frequent Users Service Enhancement initiative; a 2 year service which had consisted of providing Permanent Supportive Housing operated by not for profit providers, which included housing subsidies as well as provision of intensive case management for people with mental health issues, and clinical supervision and any other support needed to offenders coming out of the criminal justice system (Aidala et al., 2014). At 12 months and 24 months respectively, 91% and 86% of participants were reported to have maintained permanent supportive housing compared to only 42% of the comparison group at 24 months. Similarly, shelter use was also significantly lower - 146.7 days lower than the comparison group.

A multi-component service which operated on a Permanent Supportive Housing model, the Brisbane Common Ground programme, (Parsell et al., 2015). The service was centred on a location, which included 146 units in a 14-storey building. The service was targeted at those with low to moderate income and those who had suffered from chronic homelessness. The service provided on-site concierge support, communal areas where people were able to access informal support, and access to more mainstream services such as drug and alcohol counselling, personal counselling, vocational assistance, domestic assistance and personal care. With regards to housing outcomes, the Brisbane programme reported that it had removed access-related barriers for people experiencing chronic homelessness with complex needs to housing, and nurtured the conditions for tenants to sustain stable housing. Additionally, tenants reported high satisfaction levels with many aspects of their housing, including: meeting their needs; privacy; affordability of rent; size and condition of their unit; building design; and access to communal areas.

Our review included two person-centred services aimed at young people. As previously outlined, the rapid response service, Daybreak (Ohio Housing Agency, 2016), provided a number of services to young people between the ages of 18-21, about half of whom had lived on the streets. The services included different models of transitional housing services, including case management, a rental subsidy programme and a range of support services such as employment training and advice about and how to access services. The authors reported positive results for young people who took part in the programme. Nearly all, (97%), exited from transitional housing into safe destinations - moving in with family or friends, renting their own apartment or accessing a housing subsidy. Those who had a General Education Development certificate or had completed high school were more likely to complete the programme. Additionally, ethnicity was also reported as significant factor related to outcomes; white participants were more likely to complete Daybreak's housing program than their counterparts and Hispanic participants were least likely of all to complete the programme. Importantly, the authors noted that the longer a participant was engaged in the



programme, the more likely they were complete the programme, suggesting that intervening over a longer period of time had been important to housing programme completion.

Nightsafe's (2017) Safelinks person-centered multi-component preventative service aimed at young people, was reported as being successful and is relevant to Crisis's theme around transient accommodation.

### **Transient accommodation, emergency accommodation, people at risk of homelessness**

The Nightsafe Safelinks (Nightsafe, 2017) project included a combination of practical day centre support - known as Platform 5 - and a mentoring scheme. The day centre provided support for young people including basic facilities such as laundry, showers, storage facilities and lunch and delivered a range of life skills and health workshops. The mentoring scheme was for young people with chaotic lives and worked to enhance the services of other agencies by supporting and ensuring that young people stayed positively engaged. The aim of the preventative service was to help young people who are precariously-housed, or at risk of homelessness overcome barriers to living a safe, settled and productive life.

The project reported on a number of outcomes which highlighted the success of the project. The intended outcome of '*young people gaining long term accommodation with support from mentor*' met its target three times over - 223 young people had secured long term accommodation by the end of Quarter nine compared to an original target of 60. One young person remarked:

*'My family kicked me out and said it would make me grow up faster. I was 16 years old. I felt scared and nervous and friends told me about Nightsafe. I think I will be dead, seriously ill or in jail if I wasn't in this place.'*

(Nightsafe, 2017: p.19)

The project also aimed to reduce repeat stays in emergency shelter from 37 to 20; authors reporting that this was actually reduced down to 10. Finally, 118 young people were reported as having gained a recognised qualification in budgeting and home management compared to a project set target of goal of 75, therefore the authors concluded, helping participants sustain tenancies (see Appendix A3.4 for further details).

## 2.5 Chapter summary

The review suggests that **sustained services, targeted to meet specific needs across time** (because needs can change) are effective. Services include those which provide **Intensive Case Management** and **Critical Time Interventions**. Effective services incorporate **Permanent Supported Housing** elements, support for people into accommodation through provision of **housing vouchers and subsidies, and guidance on benefits and information about services**.

### 3. Features of effective services

In this chapter we report on core features associated with successful services. The studies reviewed provided evidence about the enablers and core features of effective services. Analysis of studies suggests that the following types of core features and services are effective at addressing, reducing or preventing homelessness:

- Fidelity to service models whilst allowing for flexibility.
- One to one support.
- Multi-agency working and coproduction.
- Relationships with landlords and access to the housing market.
- The right service at the right time.

For further details about all of the services referred to below, see Appendix 3.

#### 3.1 Fidelity to service models whilst allowing for flexibility

A key theme reported in studies was fidelity to service models whilst allowing for adaptability to different groups and contexts was a core feature of success. The Housing First studies reinforced other literature that has demonstrated the service's fidelity to design is significantly related to improving housing outcomes.

Fidelity is important in terms of transferability. Stergiopoulos et al. (2015), Aubry et al. (2015) and Busch-Geertsema Volker, (2014) demonstrate that the Housing First model can be successful outside the US context (the first two Housing First services were implemented in Canada with the third being implemented across Europe).

Aubry et al. (2015) and Busch-Geertsema Volker (2014) demonstrate that fidelity to the model of Housing First is very important to outcomes. In the latter study, the one site (Budapest) that diverged significantly from the model experienced the poorest outcomes. The same studies also found that implementation can also be adaptable based on different target group needs and context. In the At Home-Chez Soi project context the service was adapted to operate in different ethnicity-related contexts, using community-specific types of services.

Collins et al.(2013) study on housing retention of chronically homeless people highlighted Housing First's open door policy, which enabled participants to leave the service, for example as a result of episodes of violence and jail time, and then return with no judgement or consequences. This was echoed by Busch-Geertsema Volker (2014) in their review of Housing First across five sites in Europe where participants appreciated that they were treated with empathy and dignity and could talk openly about their addiction problems

Fidelity also appears to be important in relation to Critical Time Intervention. Clark et al.(2016) relied on the prescribed model of Critical Time Intervention itself being a successful service for people during a high-risk transitional period. Fidelity to this model was identified as being key to its success. Clark

et al. reported that their study comprised of a mix of structure and flexibility; for example, while the model limited treatment goals to three, it was also responsive to participants needs and therefore did not overly pre-define the types of services. The emphasis rather being on the timing and structure of services to get participants through the service. Some participants reported that given the time-limited nature of the service, it forces participants to move towards independence more quickly.

## 3.2 One to one support

Across the projects, when service participants were consulted, they often referred to the indispensable role of their one to one support provided by both peer and support worker/case manager/case officers, which they believe often positively affected outcomes.

### Peer support

The Nightsafe Safelink's project (2017) reported that the role of volunteer mentors was crucial to the success of the project. Volunteers had been trained and were confident in providing young people with the support they needed. This included advocacy support when attending external meetings, supporting access to health, education and employment services, academic support and participation in more structured activities to alleviate feelings of loneliness and bring about change in to what the young people said were the chaotic lives they were used to. As one young person was reported to have said:

*"...they helped me with shopping and worked to support me to look after myself better, washing clothes and budgeting my money better. (Name of mentor) helped me to be allowed back into Mall, which really boosted my confidence. I felt like I could do things again and didn't feel as anxious all the time."*

(Nightsafe, 2017: p.17)

Similarly, the Veterans Homelessness Prevention Demonstration project (Cunningham et al, 2015) reported participants' positive views regarding their case managers, particularly regarding those who were veterans as well. The 'peer' workers were identified as playing a key role in supporting participants and providing them with someone trusted with whom they could air their grievances and discuss their experiences. Comments from participants reported included these two reflections:

*"It's nice when you have somebody that knows you, knows your experiences, and can be there."*

*"Just airing my grievances, having someone to talk to because we all have certain issues, certain vices that we need to just speak to someone about."*

(Cunningham et al, 2015: p.67)

### **Support workers/case managers/case officers**

Parsell et al. (2015) report that the support provided by tenancy managers in the Brisbane Common Ground project was key to the success of the service, particularly important were the processes and approach taken by these managers when engaging with tenants. Additionally, participants reported that having this support available onsite was felt to be particularly beneficial and practical.

Cameron et al.'s (2009) qualitative case study of a sustained support housing support outreach and referral pilot for at risk or homeless people with HIV also reported that a key enabler for the success of the project was the flexible support worker role, which helped people access a range of statutory and non-statutory services, helping participants to navigate their way around social care, health, housing and employment.

The Department for Communities and Local Government's<sup>14</sup> (2017) sustained support London Social Impact Bond service aimed at rough sleepers was also designed around a navigator role, whereby key workers adopted a personalised and flexible approach, supporting the participants to access existing provision and achieve sustained long-term outcomes.

Sanctuary Schemes (Jones et al, 2010) reported that participants often referred to having access to information, advice and advocacy from Sanctuary Scheme officers or housing officers as invaluable.

### **3.3 Multi-agency working and coproduction**

A number of projects reported that multi-agency working and coproduction, in various forms, were enablers for the success of services.

Some coproduction has included both collaboration between, and funding from national government departments. For example, the Frequent Users Service Enhancement initiative (Aidala et al, 2014) for offenders leaving the criminal justice system was a collaboration between New York City Department of Correction (DOC), the NYC Department of Homelessness Services (DHS), the NYC Housing Authority and the Corporation for Supportive Housing (CSH) and this was key to the design and success of the programme. They provided a one-off benefit of \$6,500 to housing providers, and also went on to provide training and technical assistance and oversee implementation of the programme. The authors claim that collaboration between public services and local housing providers was key to the success of the programme.

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<sup>14</sup> The Department for Communities and Local Government is now the Ministry for Housing, Communities and Local Government which, supported by 12 agencies and public bodies, aims to create great places to live and work, and to give more power to local people to shape what happens in their area.

Another example of successful multi-agency working was the Veterans Homelessness Prevention Demonstration project (Cunningham, et al. 2015) which also is relevant to Crisis's theme of People at risk of homelessness.

#### **Theme 5: People at risk of homelessness**

The Veterans Homelessness Prevention Demonstration project, a three-year collaboration between the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Veterans Affairs (VA), and the U.S. Department of Labor (DOL) designed to include rapid rehousing, a combination of short- to medium-term housing assistance in the form of vouchers (up to 18 months), including security deposits, rent, moving cost assistance, and utilities, case management and access to health and employment services.

The Veterans Homelessness Prevention Demonstration project involved working with housing providers, local agencies and veteran medical centres, amongst others. The national government organisations also led on local-level coordination, which was a feature of the national collaboration that took place from the beginning of planning through the implementation of the programme. As one Veterans Homelessness Prevention Demonstration project provider explained, "*It takes a community to serve a Veteran (p. v)*," Strong partnerships and solid relationships between local agencies were reported as important factors in the success of the programme. Of the programme, one veteran said:

*"I just want to say I was really down. I didn't know what to do, and they gave me help. Basically, they saved me. They helped me with my rent, with my bills. They gave me information. Like [my veterans' employment representative], he taught me how to get jobs."*

(Cunningham et al, 2015: p.

xv). See Appendix A3 for further details.

The Rough Sleepers Initiative (Fitzpatrick et al, 2005) was implemented through a strategic planning framework including the local authority, health board and the Supporting People team in each area. Fitzpatrick et al, report that the service's success was reported to be as a result of '*improvements in coordination and joint working it had encouraged, the improvements in standards and performance it had facilitated and the culture and attitudinal change it brought about at both national and local level*' (Fitzpatrick et al, 2005; p. 51). One local authority representative commented:

*"RSI was probably the first time different agencies had sat round the table."*

(Fitzpatrick et al, 2005: p. 54)

Cameron et al.'s (2009) qualitative case study of a housing support outreach and referral pilot for at risk or homeless people with HIV, was reported as being largely successful due to coproduction and multi-agency working at the local level. Authors reported that there was a shared recognition of the needs of homeless people with HIV across local authorities and primary care trusts, and the need for a dedicated service to help them sustain their tenancies. The

pilot was therefore focused on bridging organisational boundaries and collaboration to meet peoples' need. Another key partner in the delivery of this project was the national charity commissioned to deliver the project. Although the charity had no experience in providing tenancy support, they were well established in providing people with HIV with a range of services and had access to a range of networks. Cameron et al. note that the reputation of the agency and the trust it engendered in the participants was an important factor in success. Support workers were therefore able to draw on the organisation's services and networks to refer participants to services like community transport services and the delivery of specially prepared meals. These services added value in that they enabled participants to live independently. A primary care representative commented that:

*“Although the focus is around housing, it links people in holistically to a range of services and deals with people as a whole; as a result of this approach, the service was able to deal with people with very challenging needs that other services can't meet.”*

(Cameron et al, 2009: p. 5)

Parsell et al. (2015) also report that multi-agency working, an integrated approach and a shared vision was key to the effectiveness of the Brisbane Common Ground supportive housing project. Parsell et al. report that developing clear roles and responsibilities for the three providers - tenant support, tenancy management and security were important in ensuring that all staff had an explicit understanding of the complex needs of the tenants and understanding how best to support the tenant group. Other key facilitators of multi-agency working were reported as good communication within and between the three providers, having highly professional staff who maintain confidentiality and drawing on external specialist services to meet tenants' needs.

Other projects such as Nightsafe's Safelinks (2017) and the Individual Budgets project (Brown, 2013) also reported partnership working between agencies at the local level as important to positive outcomes, such as increased footfall into services and referrals, minimising bureaucratic procedures, and meaningful communication and links across agencies.

### 3.4 Relationship with landlords and the housing market

Studies show that relationships with landlords and access to the housing market were key aspects of the success of services.

The Individual Budgets pilot (Brown, 2013) involved key worker support and an Individual Budget to be used flexibly to secure housing. Although the pilot faced a number of barriers, one of its main strengths was reported as providing access to funds to address housing costs. This meant that landlords had been more amenable to taking on clients when they came with the back-up of funds and a support worker. Brown reported that support workers would often frame the pilot as a 'special programme' to create confidence in landlords that high-risk people would get extra support, thereby providing

participants with access to a greater range of accommodation options than would otherwise have been the case.

The Sharing Solutions programme (Batty et al, 2015) was designed for single people at risk of homelessness and included sharing arrangements between tenants, primarily in the private rented sector. A number of different models were used. For example, intensive training before moving into independent shared accommodation, accessing former student housing, peer mentored schemes where more experienced tenants provide support and advice to new tenants and lodgings where participants are housed in homes with spare rooms. Batty et al. reported that the programme had been partially successful in setting up tenancies. Batty et al. reported that key enablers were the state of the local housing market and relationships with landlords. Successes reported included the supply and access to affordable suitable accommodation, successfully managing and negotiating shared accommodation schemes both from and landlord and tenant perspectives. Landlord engagement was reported as a key contributor to success, and those schemes that had existing relationships with landlords tended to do better. Additionally, incentivising landlords by vetting, matching supporting tenants or paying Housing Benefit directly to the landlord were also aspects that were reported to have worked well. Of the models evaluated, the lead tenant /peer mentor schemes were highlighted as the most successful, primarily because they had facilitated better communication and relationships between tenants and landlords. Some landlords reported, they were attracted to schemes largely by non-financial incentives *'because schemes acted as a trusted mediator who could 'micro-manage' any issues'* (Batty et al, 2015: p. 11).

Considering the results reported in the Batty et al. study, it may be the case that landlords are more open to what they consider high-risk tenancies if they can find a way to limit their liability and often find this confidence in an established scheme or programme with or without funding.

### 3.5 The right service at the right time

Studies reported that it was important for people to be ready to benefit from particular services, and that services needed to be attuned to a person's personal circumstances, for example previous experience, of homelessness, personal health-related circumstances (including those related to addictions and mental health), previous engagement with services and interventions and outcomes achieved, drug and alcohol addiction and attitudes towards homelessness. Evidence indicates that such person-centred approaches and delivery result in a greater likelihood of positive outcomes. Zierler et al.'s (2013) study which evaluated a programme that aimed to accommodate homeless families in apartments in the private rented sector in Vienna, found that at the individual level, the *'will to change'* was a key element of change. Regardless of obstacles and setbacks, evidence shows:

*"Users who are motivated to change their behaviour, have the capacity to understand the realities of their situation, and take responsibility for their own life seem to derive the most benefit from the opportunity."*

(Zierler et al, 2013; p.13)

The participants were initially in temporary accommodation with the goal to move into permanent housing within eight months. Within this period, the support offered to the families covered securing income, household budget planning and assistance, and coaching in house-hunting in the private rented housing sector.

Similar findings were echoed in the Individual Budgets pilot (Brown, 2013) where personal circumstances were identified as crucial for individuals in achieving maximum benefit from Individual Budgets. Individuals who were at a point in their life where they were able to co-develop solutions to their homelessness were more successful in doing so. As one participant commented:

*“It works for some people that actually want to better themselves or get themselves out of the rut they are in at the time. The staff can see there is a change in me before I was even offered the Individual Budgets. I wanted to do something instead of just drinking myself stupid and being on the streets...”*

(Brown, 2013: p. 41)

These findings indicate that individuals are often at very different points in their journey through homelessness and their recovery from substance abuse which can impact on their engagement with interventions. Person centred delivery that focuses on providing the right services at the right time can therefore be crucial to achieving successful outcomes. Hence, rather than a person’s readiness to change being a key factor, it is a service’s readiness to meet the needs of homeless people with the right approach at the right time.

### 3.6 Chapter summary

The review suggests that the following features contribute to the effectiveness of services:

- **Fidelity.** A key success feature is fidelity – which means adherence to particular aspects of models/designs of service that are found to be successful.
- **Context.** Adapting and aligning services to local settings and context.
- **Person-centred responses.** Developing and providing a range of targeted and customised services, providing the right service at the right time; this also means providing services that are attuned to and reflect the personal circumstances of people, particularly with regards to their journey through homelessness.
- **Relationships with key workers.** Strong and developed relationships between client and peer and/or case/support worker.
- **Integration.** Multi-component and multi-agency (e.g. health, local authority and housing providers) services.
- **Landlords.** Strong positive relationships between clients and landlords.
- **Housing market.** A local housing market with the resources to respond flexibly to meet homelessness needs.



## 4. Barriers to providing effective services

The studies reviewed provided evidence about the barriers faced when attempting to provide homelessness-related services. Analysis of studies revealed the following as key themes:

- Vulnerable groups with complex needs.
- Relationships with landlords and access to the housing market.
- Multi-agency working.
- Length of time, sustainability and consistency of support offered.
- Lack of data and monitoring and longer-term tracking.

### 4.1 Vulnerable groups with complex needs

One of the most common barriers to addressing homelessness relates to securing positive outcomes for vulnerable groups and those with complex needs and a lack of sustained services able or intended to meet these needs. This barrier tends to be experienced by chronically homeless people, people with substance abuse problems, precariously-housed groups and those with severe mental health problems. Three Housing First studies reported difficulty in achieving results with vulnerable groups.

Aubry et al. (2015) reported that there was a significant minority for whom Housing First failed to achieve longer-term housing stability. This group was characterised by people with longer histories of homelessness, and a strong sense of belonging to their street networks. Such chronic histories of homelessness therefore may not be best suited to the Housing First model and need may need more customised services. The same studies also reported that the Housing First services were less successful with those with severe psychiatric issues and those with serious drug abuse problems, indicating the need for more specialised support (Collins et al, 2013). Adapting the Housing First model for different target groups therefore seems to need some further consideration.

The Rough Sleepers Initiative (Fitzpatrick et al, 2005) also identified specific groups who were found to be difficult to engage. This included people with complex needs such as mental health and/or substance abuse problems. Another group identified as hard to engage were people who were precariously housed, at risk of sleeping rough, and staying with friends, relatives or sofa surfing. There was also evidence that Housing First was less successful with people described as being in perpetual crisis. As one Housing First manager was reported to have said:

*“We work with a group, I would say, of about 20-25 who are hard core rough sleepers, on average, but then if we kind of extend our definition of rough sleeping, there’s a lot of people who stay in places that are unsafe, so they’re not out on the street...women staying with punters, staying somewhere that is unsafe, just to have somewhere to say. People with complex needs who let’s say go through a continuous cycle of crisis.”*

(Fitzpatrick et al, 2005: p. 71)

Similarly, a barrier associated with the Daybreak (Ohio Housing Agency, 2016) programme was identified because outcomes demonstrated that Daybreak was better suited for young people with lower level needs than compared to those with more complex needs. Participants with a history of placements in the foster care system, sexual abuse or criminal activity were less likely to complete the programme. The same was reported as being true for BAME participants, whose needs authors surmised, may have required provision which better reflected the needs of BAME participants.

## 4.2 Relationships with landlords and the housing market

As well as being an enabler, poor relationships with landlords and a lack of access to the housing market were often reported as a key barriers stopping people settling into sustained housing. The housing market suffers both from a lack of affordability and from a lack of quality in both the private and public sector. Landlords are often unwilling to take on tenants whom they consider to be high-risk clients or generally difficult to negotiate with.

For example, although the Sharing Solutions (Batty et al, 2015) programme did demonstrate some success with landlords and housing markets it also experienced challenges. Negotiating and working with landlords was reported to be time consuming and difficult, for example, in convincing landlords to rethink their letting strategies. In addition, social housing organisations were reported as often unwilling to get involved due primarily to the negotiation of the Spare Room Subsidy by Discretionary Housing Payment. Lodging schemes in particular proved problematic to establish as lease arrangements with landlords were difficult. There was also the view reported that the 'culture of sharing' varied across local housing market contexts - where such a culture was accepted, it was easier for schemes to develop. However, in general, authors felt there was a need for an attitudinal shift in the housing sector when it comes what they referred to as a 'culture of sharing.'

Zierler et al.'s (2013) study, which evaluated a programme that aimed to accommodate homeless families in private rented sector apartments, reported that the primary challenge to the success of the programme had been that families often faced discrimination from landlords who had been reluctant to give them tenancies out of fear of conflicts in the neighbourhood. Rising rents and a lack of experience with the real estate market had also made it harder for families to secure accommodation and social housing was therefore seen as a safer option.

Another project that faced significant issues with the housing market was No Second Night Out (Hough and Jones, 2011) and its findings are relevant to Crisis's rough sleeping theme.

### **Theme 1: Rough sleeping**

The No Second Night Out (Hough and Jones, 2011) pilot was implemented in ten London boroughs and consisted of a 24-hour hub staffed by assessment and reconnection workers. It provided a place where individuals' needs could be assessed at any time and a single service offer was provided which meant that no one has to spend a second night out. One of the key challenges that faced the pilot was access to appropriate accommodation including the private rented sector:

For example, people who were identified as suitable for the private housing sector often had to wait a very long time - six weeks or longer, particularly when they were waiting for benefits decisions and on waiting lists. This put increased pressure on the project in relation to where people were housed during this period, and participants often ended up spending a lot of time in bed and breakfast or hostel accommodation.

There was also a challenge with temporary accommodation reported. A shortage of accommodation combined with the 72-hour response target for the programme meant that people often received inappropriate accommodation. There were reports of accommodation being dirty, without electricity, or shared with drug users, which threatened the stability and security of people who were looking to avoid such environments:

*"The place [hostel] they housed me is full to the brim with addicts. [Previously] I went to [drug] treatment, I stopped using, I found myself a job – and now [...] there is no help to keep me on that road." (former participant)*

*"It was a complete state, there was food in the fridge but the fridge had been switched off for ages so it stank and there were maggots and everything...the walls were filthy...there was no gas and no electric and it was flea ridden – I had to sleep here for one night with no gas and no electric and fleas biting me...the place was a state but the next day a cleaner came – and did a very poor job, then they came and put the gas and electric on but I have had to battle to get pest control to come round." (former participant)*

(Hough and Jones, 2011: p. 17, 22)

See Appendix A3 for further details.

The Rough Sleepers Initiative (Fitzpatrick et al, 2005) also faced challenges with the local housing supply. For example, there was a shortage reported of affordable housing located outside areas with high crime rates. There were also difficulties reported in accessing temporary accommodation, a lack of suitable move-on accommodation and difficulties in securing permanent accommodation.

### 4.3 Multi-agency working

Multi-agency working is core feature of effective services, however, in some studies challenges in partnership working were also identified as barriers to successful outcomes.

The Individual Budgets (Brown, 2013) study reported that, at one site, partnership challenges had been so difficult that ultimately the pilot had stalled. Although there had been initially good relationships between the local authority, homelessness agencies and other organisations, once the pilot started this partnership had worked less well. Authors reported the causes as a lack of capacity to deliver the programme across the organisations, slow decision-making on the hiring of an Individual Budgets coordinator and difficulties in services' reconfiguring their time and resources needing to be more flexible, than had been the case before Individual Budgets. Partner agencies also faced bureaucratic challenges in that they had to use their own money for the pilot and faced issues and delays in getting reimbursement from the local authorities. The authorisation for expenditure had also been an issue across most areas and when these difficulties arose, staff reported that it had risked unsettling the relationships that had been built between support workers and participants. As one support worker reportedly commented:

*“The flexibility and speed it gives you for addressing individual needs. A pair of socks might not be much but it gives you a chance to talk while you are walking about the shops rather than sat in a hostel.”*

(Brown, 2013; p. 33)

No Second Night Out (Hough and Jones, 2011) had also faced challenges in interagency collaboration. This had largely been because the service had worked towards a deadline of 72 hours to provide participants with a single service offer and move them on into accommodation. However, partner agencies that the service had depended on, for example Housing Options and outreach teams, and benefits agencies tended to work to longer timescales. For instance, it had taken up to three weeks to get a decision from a benefit application, and five days to get an appointment with the Housing Options teams. For the pilot to have been more successful, the authors conclude that it would have required other agencies to change their practices including offering more rapid response times.

Sanctuary Schemes (Jones et al, 2010) reported difficulties in inter-agency working. There was evidence of a lack of communication between agencies and concerns that participants were not receiving support or being made aware of the services available to them. Domestic violence teams in particular were reported as being under a great deal of pressure with long waiting lists, which had made access to support difficult and this was also true of other agencies such as Women's Aid, counselling services and police domestic violence teams.

The Veterans Homelessness Prevention Demonstration project (Cunningham et al, 2015) reported that the staff and programme managers found it difficult to engage with some stakeholders, for example the DoL, perhaps the authors surmised because it did not receive any funding. It was also noted as difficult

for the participants to engage with career and employment centres, because the centres were accustomed to dealing with people who were more 'job ready'.

#### 4.4 Duration of service, sustainability and consistency of support offered

Studies reported that the short length of time of support offered, the lack of sustainability of that support and variable consistency of the support provided negatively affected outcomes.

For example, there was a great deal of variation in the types of installations and security measures implemented in households in the Sanctuary Schemes study (Jones et al, 2010). There had also been variability in the support offered to households. Although many participants reported that they had been offered some level of support, there was also evidence reported of unmet need. For instance, some people had needed longer and more sustainable support such as child contact resolution, legal remedies, managing money and help with setting up a new home, while others had required more specialist help than had been available related to addressing substance abuse and mental health problems.

Additionally, the families in the Home to Stay (Levitt et al, 2013) intervention group were found to have exited shelter accommodation without housing subsidies (73%) quicker than those in the control group (56%). Findings also indicated that the intervention group spent fewer days in shelter than the control group - 376 days versus 449 days respectively. All the findings were more pronounced for recent shelter entry families than older shelter entry families, indicating the authors thought that homeless people entrenched in the shelter system needed longer and more sustainable services to secure housing stability.

The Rapid Response-Housing Demonstration (Finkle et al, 2016) also reported inconsistency in the support that had been offered across the project sites. There had been differences in case management intensity, duration of assistance provided, length of rental subsidy and depth of rental subsidy. The sites had also implemented changes to these services through the course of their delivery and this had made it more difficult for the study to draw conclusions about the outcomes achieved.

A rapid response pilot programme (Slesnick and Erdem, 2013) exploring the impact of an integrative approach targeted at substance abusing mothers living in shelters also found that longer-term and more sustained support was needed for this vulnerable group; their findings are relevant to Crisis theme covering emergency accommodation.

#### **Theme 3: Emergency accommodation**

The ecologically-based pilot programme (Slesnick and Erdem, 2013) employed a combination of approaches including supportive housing, case workers, housing vouchers and subsidies and substance-abuse counselling to stabilise substance-abusing mothers housing situations. The service was

found to have been partially successful. Whereas substance-abusing mothers in the treatment group had demonstrated a faster improvement in independent living than had those in the control group at the three and six month follow up, this difference declined significantly at nine months for the intervention group, whereas the control group remained the same at both time points. The decline was found to coincide with the cessation of support services indicating the need for longer-term support given the severity of needs faced by this vulnerable group so as to sustain improvements (see Appendix A3 for further details).

## 4.5 Lack of monitoring and long-term outcome measures

Some projects reported that a lack of monitoring data had made it difficult to measure outcomes. For example, there was limited monitoring data collected as part of the Sanctuary Schemes project (Jones et al, 2010) and therefore Jones et al. had been unable to explore impacts beyond immediate outcomes. In retrospect the authors listed data that would have been useful in evaluating programme impact, for example:

- the number of referrals to the service
- any reasons why Sanctuaries were decided to be inappropriate
- the number of Sanctuaries installed
- the types of Sanctuary measures installed and the cost
- the types of households using Sanctuary
- the number of households that were able to remain in their home
- any attempted breaches of sanctuaries
- any repeat incidents of domestic violence.

The Rough Sleepers Initiative (Fitzpatrick et al, 2005) also reported that the project monitoring system had not been able to track the number of rough sleepers and that method used for data capture had resulted in a lot of missing cases. Additionally, the authors report that it had been difficult to collect sufficient information from enough organisations and, as a result, data on service activity and outcomes had been limited, which had meant evidence on service effectiveness was equally limited. The authors concluded that both the range of data collected and response rates/numbers were of poor quality.

Finally, there is limited longer-term data available, often because of challenges in tracking participants beyond the end of an service and, therefore, little evidence about sustainability of outcomes. For instance, in the No Second Night Out (Hough and Jones, 2011), three months after many of the reconnections made by the programme hub, three-quarters of former participants could not be contacted.

## 4.6 Chapter summary

The review suggests that the following issues are barriers to delivering effective services:

- **A lack of services for people with complex needs.** People with complex needs, such as a mental health illness, are more difficult to engage with in terms of assessing and providing flexible, responsive and sustained person-centred support. People with complex needs experience less successful service outcomes.
- **Challenges in maintaining sustained multi-agency working.** Evidence suggests that initially effective combined efforts cannot be sustained.
- **Lack of access to the local housing market.** People who are at risk of homelessness or are homeless find accessing the local housing market more challenging, and experience poor relationships with landlords.
- **Lack of monitoring data.** There is a lack of data about, and monitoring of, homeless people and those at risk of homelessness, resulting in a lack of information to inform the design and development of services and services which are fit for purpose.
- **Lack of access to services for people from vulnerable and harder to reach groups.** There is a lack of access to appropriate services to meet the needs of specific population groups, such as those with mental health illness, people from black and minority ethnic communities, and people with substance dependencies.
- **Lack of high-quality studies included in published reviews.** This creates a lack of clarity for service providers about the reliability of much of the evidence about what works to end homelessness.

## 5. Assessment of evidence

In this section we present our assessment of the evidence reviewed, analysis is presented using the following themes:

- Quality.
- Limitations.
- Cost-effectiveness.

### 5.1 Quality

After selection, 21 studies were assessed as being of high quality, 10 were considered to be of medium quality and 4 of low quality. An overview of the quality of studies are presented Table 5.1 – 5.3 below.

**Table 5.1 Number of studies by quality**

Study type	Count	High Quality	Medium Quality	Low Quality
Systematic Review	4	4	0	0
Randomised Controlled Trial	5	4	1	0
Non Randomised controlled trial	1	1	0	0
Comparison evaluation	5	3	2	0
Literature review (not systematic)	1	1	0	0
Studies with quantitative outcomes	1	0	1	0
Cost-effectiveness/ economic	2	0	0	2
Evaluation	16	8	6	2
<b>Total</b>	<b>35</b>	<b>21</b>	<b>10</b>	<b>4</b>

*Note: quality assessment is explained in Appendix A1.*



**Table 5.2 Number of studies by type of service and quality of studies reviewed**

Type of Intervention	Count	High Quality	Medium Quality	Low Quality
Assertive Community Treatment	2	2	0	0
Critical Time Intervention	5	4	1	0
Housing First	5	4	1	0
Housing vouchers and subsidies	5	2	3	0
Individual Budgets	1	1	0	0
Intensive Case Management	5	4	1	0
Permanent Supportive Housing	4	3	1	0
Person-centred multi-component approaches	5	2	3	0
Social Impact Bond	1	1	0	0
<b>Totals</b>	<b>33</b>	<b>23</b>	<b>10</b>	<b>0</b>

*Note: some studies have been coded to more than one theme*

**Table 5.3 Number of studies by Crisis defined themes and quality of studies reviewed**

Crisis defined themes	Count	High Quality	Medium Quality	Low Quality
Prevention	4	2	2	0
Rapid response for people with low level needs	15	8	6	1
Sustained response for people with low level needs	18	12	3	3
<b>Total</b>	<b>37</b>	<b>22</b>	<b>11</b>	<b>4</b>

*Note: two studies have been coded to more than one theme*

Assessment of quality showed that high quality studies were not only limited to Randomised Controlled Trials and Systematic Reviews. There were evaluations, some using mixed methods and some using only qualitative methods that were also assessed of being as high quality.

### 5.1.1 High quality studies<sup>15</sup>

Examples of Systematic Reviews of high quality include de Veet et al.'s (2013) review and comparison of case management models and Bassuk et al.'s (2014) review on the effectiveness of housing services for families. The high quality is attributable to a robust approach to design, clear inclusion/exclusion criteria, comprehensive literature searches, detailed characteristics of included studies and the appropriate reporting of findings and conclusions.

Examples of Randomised Controlled Trials of high quality were Levitt et al.'s (2013) evaluation of the 'Home to Stay' pilot and Slesnick and Erdem's (2013) evaluation of ecologically-based treatment for substance-abusing mothers. The high quality was attributable to an appropriate study design, robust and detailed sampling procedures, clearly outlined and appropriate data collection and outcome measures, and the validity and usefulness of the results presented.

Examples of evaluations and comparison evaluations of high quality were the Sharing Solutions programme (Batty et al, 2015), the Individual Budgets pilot (Brown, 2013), the Frequent Users Service Enhancement initiative (Aidala et al, 2014) and Critical Time Intervention with people with mental illness at hospital discharge (Herman et al, 2011). These included a mix of quantitative and qualitative approaches to evaluation. The assessment of high quality was a result of clearly justified research design, clear sampling and recruitment procedures along with detailed profiles of sample achieved, clear data collection procedures including topic guides, researchers, date and location and finally in-depth reporting.

### 5.1.2 Medium quality studies

The assessment of quality shows the medium quality studies tended to consist of evaluations. Quantitative examples of medium quality studies include Kaspro and Rosenbeck's (2007) evaluation of Critical Time Intervention with homeless veterans after psychiatric hospitalisation, the evaluation of the Daybreak (Ohio Housing Agency, 2016) service and the evaluation of the Rapid Re-Housing Demonstration project (Finkle et al, 2016) with homeless families. These studies tended to receive a 'medium' assessment of quality because of a lack of confidence in the consistency of their approach. There was missing data and problems relating to sampling procedures and data collection, and it was unclear that the outcomes were definitely a result of the programme.

A qualitative example of a medium quality study was Nightsafe's Safelinks (Nightsafe, 2017). The report received a 'medium' assessment because of a lack of justification of research design, little information on sampling,

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<sup>15</sup> Where, in each theme we had more than one type of study to select from, we applied the quality tests described in the protocol. Taking a best evidence approach and with the input of Crisis and the Advisory Group a number of studies, while not considered as high quality, were selected, for example, those involving cost-benefit content from the United Kingdom. Hence, this review included studies not graded as high quality, which highlights the need to improve standards of evidence.

recruitment and included sample and no discussions of the limitations of the evaluation.

A medium quality mixed methods evaluation was Zierler et al.'s (2013) supported housing project in Vienna for families. This received at medium grading because of weaknesses included potential sampling and selection bias, and a failure to measure or report on the consistency of the approach. Qualitative weaknesses primarily included a lack of data on sampling, recruitment and data collection procedures.

### **5.1.3 Low quality studies**

The two cost-benefit studies included in the review were both graded as of low quality and therefore there are no high quality assessments of cost-benefit included in this review.

## **5.2 Limitations**

### **5.2.1 Generalisability of findings**

Many studies, even high quality ones, outlined a number of caveats to their findings. The most common caveat included the warning against generalising findings. For example, the four studies evaluating the impact of the Housing First model identified lack of generalisability due to unique context, sample, and services as caveats to their findings. One study looked specifically at an ethnically diverse sample, another at chronically homeless people and another was located in Europe.

The Home to Stay programme (Levitt et al, 2013) also mentioned the limitations of generalisability - reporting that findings related to episodic and recidivist families may not generalise to other homeless families. Similarly the New York City Shelter context may not generalise to other contexts. This was echoed by Slesnick and Erdem (2013) in the ecological treatment for substance-abusing mothers, where the sample was small (30) and where African American women were over-represented.

### **5.2.2 Longer-term outcomes**

A number of studies also highlighted the need for tracking longer-term outcomes. The Individual Budgets pilot (Brown, 2013) reported that the participants should be followed up for 12 months after the pilot's completion to get a better idea of longer-term outcomes. Similarly, there was limited data available on the sustainability of outcomes in the No Second Night Out project (Hough and Jones, 2011); three months after the many reconnections made by the hub, 75% of former participants could not be contacted.

The evaluations of the Housing First models as well as the evaluation of a Critical Time Intervention service (Herman et al, 2011) also questioned whether the length of time of follow-up is long enough to ascertain long term impact of the services. More specifically, they were concerned that some outcomes may need a longer time period to demonstrate improvement.

### 5.2.3 Methods and design

A number of studies reported specific methodological issues. With regards to the Daybreak programme, (Ohio Housing Agency, 2016) selection bias was a limitation, whereby it was noted that young people who are suspicious of authority figures or less likely to seek help were excluded from the sample, and this therefore was also likely to have had an impact on the generalisability of findings. The use of self-reporting by participants, particularly with respect to substance abuse or psychiatric symptoms was also reported as problematic as it could result in reporting bias (Kaspro and Rosenbeck, 2007) and can distort treatment outcomes (de Veet et al, 2016).

Additionally, the Department for Communities and Local Government<sup>16</sup> (2017) reported that in the Social Impact Bond programme, the accuracy of improvements in rough sleeping was dependent upon an individual being seen on the street by an outreach worker and being recorded as bedded down in the Combined Homelessness and Information Network database. Similarly, accommodation outcomes are routinely recorded on Combined Homelessness and Information Network when they are known, however, the level of recording quality and/or staff knowledge of someone's arrival into accommodation was thought to differ according to the type of accommodation being accessed. The Rapid Re-Housing Demonstration project (Finkle et al, 2013) reported difficulties in recruiting participants, the primary challenge had been that of timing, with participants at some sites already been enrolled before the start of the evaluation, while at others they had been included in the outcome measures upon completion of the Rapid Re-Housing Demonstration project.

Finally, some projects reported that an absence of a control or a comparison group meant that although the authors are confident in their findings they cannot draw firm conclusions about their programmes (Cunningham et al, 2015; Parsell et al, 2015).

Jones et al. (2010), referred to the lack of monitoring and data collected during their study. Examples of missing data, included the number of referrals to the service; the number of Sanctuaries installed; the types of Sanctuary measures installed and the cost; and the types of households using Sanctuary. Additionally, Jones et al. also recommended that services should gather data on medium- to longer-term outcomes for households including the number of service users who were able to remain in their homes; any attempted breaches; and, any repeat incidents of domestic violence.

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<sup>16</sup> The Department for Communities and Local Government is now the Ministry for Housing, Communities and Local Government which, supported by 12 agencies and public bodies, aims to create great places to live and work, and to give more power to local people to shape what happens in their area.

## 5.3 Cost-effectiveness

Studies that included some form of economic assessment of outcomes, usually reported varying degrees of positive outcomes. However, analysis showed there was a wide variance in modelling and methods employed and, hence, consistency and robustness of the approaches and outcomes reported.

### 5.3.1 Cost benefit and opportunity costs

Centrepont's (Oxera, 2013) study was specifically focused on cost-benefit analysis of the services provided to young people. The main data sources used in the analysis include: the University of Sheffield's FOR-HOME study on recently resettled homeless people, the National Audit Office's report on the costs of youth crime on the criminal justice system, Office for National Statistics data on wages by age and occupation, and the Department for Education's research into costs of treating families with multiple problems. The overall approach to calculating the benefits of the programme were the avoided costs to society as well as avoided costs of later services if Centrepont had not intervened. The report considers the benefits delivered by Centrepont in the following five ways: increased taxes and wages due to increased employment; reduced benefit claims due to higher wages; reduced crime; reduced substance abuse; and reduced treatment costs of mental health problems. These calculations included:

- Before and after employment rates of Centrepont's clients and information about their wages from a tracker survey. Oxera then estimates the extra welfare benefits that would have been drawn without Centrepont's s and uses these sources of data to estimate tax benefit. The benefit from additional tax revenue was estimated at around £12,332.35.
- The cost of crime estimated by using information on the incidence of crime among Centrepont's clients, the likely rate of crime had Centrepont not intervened, and the public costs associated with different types of crime. Reduction in crime rates is based on the probability of re-offending by youth offenders in general and measures the avoidance of costs to the criminal justice system that would otherwise have been incurred. The authors estimate this to be £2,639 per client.
- Combing the estimated treatment costs for substance abuse and alcohol problems with the reduction in the probability of substance abuse to estimate that reduction in expected treatment costs. Oxera claims treatment saving can be as much as around £950 per client.
- The reduction in the probability of clients suffering from mental health and the cost avoided due to the early intervention by Centrepont. This benefit was estimated to be £46 per client.

The total benefits of Centrepont service were estimated to equal £22,174 per client. Additionally, the costs of service by Centrepont were estimated at £14,240 per client. This Oxera concludes was equivalent to an overall benefit to cost ratio of 2.40:1. That meant, for every £1 spent by Centrepont, £2.40 was saved in public costs.

Bee and Woods (2010) used the Cap Gemini model created for the Department of Communities and Local Government in 2009 as a starting point, and created a regional spreadsheet and another for each of the thirteen participating local authorities. Bee and Woods used local data on the Supporting People programme provision and local social care costs. Their model used averaged values in an attempt to evaluate the costs that were avoided through Supporting People programme funded services. It does this by comparing the total annual cost to public finances for a Supporting People programme client to an assumed 'counterfactual scenario of alternative provision' if Supporting People programme services were not available. The model compared the average costs of an average client over the course of one year. The costs which were modelled include adult social care; criminal justice system costs; health costs; housing costs; and welfare benefit costs. However, it was unclear how the cost assumptions had been estimated, and the data sources used and the Cap Gemini model referred to were not described in any detail. Bee and Woods presented results for a range of groups:

- Socially excluded clients - regional spend= £17.3m; regional expenditure avoided = £13.2m; expenditure avoided as % of Supporting People programme spend= 72%.
- Young people regional spend = £1.2m; regional expenditure avoided = -£0.2m; expenditure avoided as % of Supporting People programme spend = -16%.
- Homeless families in settled accommodation - regional spend = £0.5m; regional expenditure avoided = -£0.10m; expenditure avoided as % of Supporting People programme spend = -19%.
- Homeless families in temporary accommodation - regional spend = £1.3m; regional expenditure avoided = £0.7m; expenditure avoided as % of Supporting People programme spend = 52%.
- Women fleeing domestic violence - regional spend = £3.2m; regional expenditure avoided = £7.6m; expenditure avoided as % of Supporting People programme spend = 237%.

Bee and Woods also noted that there had been no saving for young people and homeless families in settled accommodation.

A common approach to demonstrating value for money was offsetting service budgets or funding against estimated costs from various sources of what could have been potentially incurred shelter use, jail time and hospitalisation – opportunity costs. For example, Ohio Housing Agency (2016), reported a budget of \$1.32 million for the operation of the project in the previous fiscal year and computed that this came to \$67 per client per day. The authors compared this figure to the cost of potential of a range of other cost-related outcomes/scenarios such as:

- \$68 for county jail across Ohio as estimated by the Ohio Department of Rehabilitation and Corrections.
- \$106 for emergency shelter at the Lighthouse Youth Services shelter which included the cost of supportive services.

- \$585 for state psychiatric facility according to data from the Ohio Department of Mental Health and Addiction Services.
- \$2,490 for an inpatient hospital stay if a young person develops an acute condition.

The Ohio Housing Agency concluded that Daybreak housing was less costly for taxpayers than most of the other places homeless youth could find themselves and that it had provided services designed to prevent future jail time or hospitalisation.

Evans et al. (2016) in their analysis of the effectiveness of the provision of financial assistance to prevent families from becoming homeless, calculated that the cost per homeless spell avoided is about \$10,300, which included the operating costs of the call centre and delegate agencies as well as the cost of financial assistance. The authors then used estimates provided from other studies to estimate public costs (healthcare, jail time, food stamps) of \$5,148. Similarly they relied on other studies to estimate the cost of providing shelter for individuals who become homeless for the first time to be \$2,400. Finally, they also considered private benefits, more specifically the mortality-reducing benefit which they estimated at \$13,000, although Evans et al. caveated this by clarifying that none of the estimates of the impact of homelessness on mortality were causal. Nevertheless they went on to estimate total benefits of \$20,548 which was almost twice the \$10,300 cost of reducing homelessness through financial assistance.

There are also studies that, while assessing costs, provide little information about their sources of costs and expenditure and the nature of these costs. The Family Options Study (US Department of Housing and Urban Development, 2016) reported that the cost to families in longer term housing subsidies group (the only successful model) was \$3,800 (9%) higher than the total cost of programmes used by those assigned to the usual care group. Initially, the cost of long-term subsidies was offset by the expensive use of shelter by the usual care group but over time, as costs for the usual care group declined, the monthly difference increased. At twenty months this differential was reported to be only \$20 higher for the intervention group but by month 37 this differential had reached \$136.

Jones et al's (2010) cost-effectiveness model estimated that for an average cost of around £47,064, Sanctuary Schemes can reduce costs of offences of domestic violence by about £53,228 and an additional £36,000 from the reduction of homelessness. Costs were estimated based on number of households where sanctuaries were installed and an estimate of households that were at risk of domestic violence. Benefits were primarily based on reduction in domestic violence incidents (although this was not specific to the sanctuary schemes) and the alternative of rehousing families. However, the authors concluded that in the absence of better monitoring data it was not possible to confirm that this is a reliable estimate of cost-effectiveness.

The Sharing Solutions (Batty et al, 2015) programme used the Crisis 'Making it Count' tool, which indicated a total gross saving of £625,000 against a total cost of £120,000. That is £1 of grant funding generated £5.21 of savings.

However, there was no detail about how the 'Making it Count' tool operated and the estimated costs and benefits.

Parsell et al. (2015) reported that with regards to the value for money calculation of the Brisbane Common Ground project that key documents were not provided to the research team and thus the analysis of the costing of the model was limited. But the authors concluded, despite this caveat:

*“Compared to the costs to the Queensland Government of a person being chronically homeless for twelve months, a twelve month tenancy at Brisbane Common Ground achieves a tenant reducing their annual use of Queensland Government services – including the cost of providing Brisbane Common Ground – by \$13,100. Using government administrative data that rigorously measures service usage, the analysis has identified Brisbane Common Ground achieves a cost offset of \$13,100 per tenant per year.”* (Parsell et al: p. 4)

Another study caveated in relation to cost-effectiveness was the one conducted by the Frequent Users Service Enhancement initiative (Aidala et al, 2014), which is also relevant to Crisis's people at risk of homelessness theme.

#### **Theme 4: People at risk**

- Aidala et al. calculated costs by determining the number of people served, the resources used, estimating the cost per unit by resource type and calculating total and per client cost of the service. Amongst other support, this included the one-time \$6,500 affordable housing voucher, program services and operation fees, funding received, and participant costs including rent subsidies, rent contribution and furniture allowance. The cost was estimated at \$23,290.
- Benefits were calculated by estimating (from a range of sources) jail costs, shelter stay, and the use of physical, mental health and alcohol services; costs were thus estimated for the intervention and control group. This resulted in estimated savings of \$15,680, offsetting the total cost by 67%.
- Aidala et al, heavily caveated their findings, for example reporting the lack of inclusion of prison or nursing home stays and the fact that medical and service use is based on self-report only. However, despite these caveats the authors concluded:

*“Findings from this cost evaluation suggest that removing policy and system barriers limiting access to housing assistance for persons with criminal convictions, incorporating housing into re-entry services, expanding existing housing resources available for homeless persons with health and behavioral health challenges, and giving housing providers an additional one-time \$6,500 enhancement per client for more intensive supportive services immediately post release would result in cost savings to corrections, homelessness and health care systems for persons who would otherwise continue their cycling between jail and crisis care institutions.”* (Aidala et al, 2014: p. 51)



### 5.3.2 Value for money/unit costs

Brown (2013) reported that the Individual Budgets pilot had demonstrated value for money. While an original budget of £80,000 had been allotted, actual spend had been less than half of this, at £34,317.96, which had enabled a greater number of people to be supported, 79 instead of the 50 originally anticipated. Average expenditure per participant was £434.40, which the project staff felt demonstrated significant savings to the public as a result of reduced criminality and reactive health care. However, the authors concluded that funding for the sustainability of the programme is crucial and to this end a more robust cost-benefit analysis should be undertaken.

The Homebase Community Prevention project (Abt, 2013) reported that 22.6 nights less were spent in shelter, at a cost of \$105.81 per night of shelter, this was thought to represent an average savings per treatment group member of \$2,375. The operating costs of the programme were estimated at an average of \$1,896 per treatment group member and there had been an average use of \$339 financial assistance provided over the two years, which meant that the average costs of Homebase Community Prevention services for each participant had been estimated as \$2,235. The authors conclude that saving from reduced nights in shelter offsets the costs of the programme per family served by \$140. However, the authors caveated their findings by identifying the statistical uncertainty of using estimates, which is had been particularly pronounced given the limited sample size.

## 5.4 Chapter summary

The majority of the studies selected for analysis were considered to be high quality, however, taking a best evidence approach also led to the inclusion of a small number of studies that were of low to medium quality. This particularly applied to mixed method and cost-benefit studies and means that there were few:

- **high-quality studies** with qualitative evidence able to link programme delivery with quantitative outcomes, limiting the ability to generalise learning beyond the local context of any particular study.
- **robust assessments of cost-effectiveness** included in the review. However, those studies reviewed reported encouraging economic assessments (e.g. Oxera, 2013; Bee and Woods, 2010; Ohio Housing Agency, 2016).

There is a pressing need to develop:

- **shared language and understanding** around what is needed and the various types of economic assessment (i.e. value for money, cost benefit, opportunity costs).
- **consistency** in relation to what are accepted as acceptable measures of potential benefits/opportunity costs of interventions (i.e., reduced jail time, reduced shelter costs, reduced hospitalizations etc).
- clarity of purpose and how to appropriately apply economic assessment.
- reliable and long-term **accessible data sources**.

## 6. Approaches to evaluation

In this section we present analysis about how studies had approached their evaluations and outcome measures employed. Analysis showed that a number of key types of evaluation methods and outcome measures had been used to evaluate services:

- Experimental approaches with established models and government-funded projects.
- Qualitative and mixed method evaluation approaches of pilots and sub-group specific evaluations.
- Diversity of measures.

### 6.1 Experimental

Approximately half of the studies reviewed were a mixture of experimental and quasi-experimental evaluation. These included Randomised Controlled Trials, Non-Randomised CTs, and comparison group evaluations. For example, the Randomised Controlled Trials included Levitt et al's (2013) randomised trial of the 'Home to Stay' programme for families and Stergiopoulos et al's (2015) Randomised Controlled Trial of a Housing First intervention with an ethnically- diverse sample. The comparison group evaluations included the Fuse initiative for offenders (Aidala et al, 2014), the impact of different case management models (Clark et al, 2016), and the Family Options Study (US Department of Housing and Urban Development, 2016).

Given that these were generally quantitative experimental studies their approaches to evaluation were quite similar. For the Randomised Controlled Trials methods included random assignment to control and treatment groups, strict eligibility and thus sampling criteria, face to face interviews often relying on self-report at baseline and at regular follow up intervals. Written and informed consent was obtained from participants who generally received compensation for interviews. Independent researchers tended to carry out the interviews. Some studies also used standardised tools to measure the fidelity of different models of services. Data analysis consisted of statistical testing, primarily using different versions of logistic regression to test effects between groups, including mixed regression models, chi square tests, and paired sample t-tests.

Reviewed studies also included comparison evaluations, for instance the Family Options Study (US Department Housing and Urban Development, 2016) and the comparison of the impact of different case management models (Clark et al, 2016). These were quasi-experimental studies and therefore mirrored many Randomised Controlled Trial features. These studies usually included a comparison of outcomes between intervention groups and/or comparison and control groups. Purposive sampling tended to be used, particularly because the evaluations were looking at specific sub-groups. The evaluations also all had strict eligibility criteria for inclusion in the

study. They also tended to include qualitative data from staff and management.

## 6.2 Qualitative and mixed method

Most qualitative evaluation approaches included interviews or telephone surveys with stakeholders sometimes including both national and local level organisations, such as government departments, funding bodies, service providers, agencies. The interviews focused on strategy and rationale as well as the implementation, enablers and barriers of the project and finally views on outcomes for participants.

Interviews or focus groups with participants happened at different intervals during the project. In some cases participants were provided with small financial compensation for their participation. Interviews with participants tended to be face-to-face, semi-structured and focused on the views and experiences of the programmes in-depth.

Qualitative data was transcribed verbatim and often a data analysis package such as Nvivo had been used. Some qualitative approaches included a review of the relevant literature usually conducted at the start of the evaluation, to help define the research questions and the approach towards the rest of the evaluation.

Cameron et al's (2009) evaluation of a housing outreach and support service for homeless people with HIV included interviews with partner agencies who were asked their views on whether or not the pilot was achieving its aims and objectives, and to describe the factors that supported or hindered efforts to work across housing, health and social care boundaries. In addition, all participants were asked to participate in the research by their support worker, and interviews with 13 were completed. As the period of individual support ranged between six months and nine months, it had not been possible to follow the same people throughout as was originally intended, which reflected the difficulty of engaging vulnerable groups in the research process. The independence of the research team was emphasised, and all respondents (professionals and service-users) were assured that data would be reported anonymously. Interviews were transcribed and analysed thematically using a coding frame developed from a review of the joint-working literature.

The evaluation of the Individual Budget pilots (Brown, 2013) was primarily a qualitative evaluation. It included interviews with service providers over three different time periods and interviews with participants at the outset and at the end of the pilot.

Qualitative case study approaches were also employed where implementation of the programme was across multiple sites. They employed similar methods as described above although analysis tended to happen at and across site level. For example, the evaluation of the Sharing Solutions programme (Batty et al, 2015) was carried out in three stages using a largely qualitative case study approach. This included a literature review, interviews with three Crisis officers, and five members of the Advisory Group. Interviews explored the funding process, the operation of the Advisory Group and the nature of support provided by Crisis. The evaluation at site level included interviews

with project workers, tenants, landlords and supporting local authorities. There was also some analysis of local monitoring data that was available by the scheme.

The qualitative evaluation of the Sanctuary Schemes programme (Jones et al, 2010), included five elements, telephone interviews with national stakeholders and interviews with 32 key stakeholders from 12 national level statutory and voluntary level organisations. Eight case study areas were selected from a sample of 48 Sanctuary Schemes which had responded to a request for information from CLG in 2008. In total, across all eight case study areas, 63 agency and service provider representatives were interviewed and 49 interviews were conducted with participants. The research team only managed to interview two children, as most families did not want their children to take part.

Mixed method approaches tended to include the qualitative approaches described above as well as an analysis of data usually collected from different databases and/or the use of a survey. For example, the evaluation of the Daybreak programme (Ohio Housing Agency, 2016) included a mix of methods - an evaluation logic model was constructed through surveys, interviews and focus groups with Daybreak staff, youth and other stakeholders. The study also included a literature review to look at best practice in services for homeless youth. Finally, data was collected from the programme's internal client management system for analysis and to report on outcomes.

The evaluation of the VPHD (Cunningham et al, 2015) also used a mixed methods approach, with two waves of site visits taking place. Interviews were conducted with key stakeholders involved in programme design and delivery. Participants were selected based on the following eligibility criteria: recent veterans who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND); female veterans; and veterans with children. Information about participants was collected from programme administrative data at the start and end of the study. Study participants also responded to a baseline and follow up survey and took part in focus groups.

### 6.3 Outcome measures

There was great diversity of outcomes measured across the studies, which reflected the different target groups and specific aims of services. However, common typologies emerged and are listed in the table on the next page.

<p><b>Loosely defined outcome measures:</b></p> <p>Pilot programmes or specifically designed programmes for young people.</p>	<p><b>Number/percentage of days of homelessness:</b></p> <p>Housing First and Critical Time Intervention evaluations</p>	<p><b>No/% of days stably/continuously housed:</b></p> <p>Housing First evaluations and studies relating to people at risk of homelessness.</p>	<p><b>Measures relating to the use of shelters:</b></p> <p>Families who had been recruited from emergency accommodation such as shelters.</p>	<p><b>Outcomes /measures relating to tenancies</b></p>
<p><i>Individual Budgets pilot (Brown, 2013):</i> The number of clients who can be shown to be accommodated in some form of stable accommodation at the conclusion of the pilot</p> <p><i>No Second Night Out (Hough and Jones, 2011):</i> The percentage of participants that had a positive departure, that is a move into some form of accommodation or reconnection to another area</p> <p><i>The Safelinks project (Nightsafe, 2017):</i> Young people sustaining their accommodation, living a settled life style and moving into education, training and employment</p> <p><i>Daybreak (Ohio Housing Agency, 2016):</i> The completion of the programme, which meant that participants had received the full range of available services, as appropriate to his or her case, before transitioning to another housing situation.</p>	<p><i>(Clark et al, 2016):</i> Comparison of days homeless with days housed, with homeless consisting of anyone who answered shelter, street/out- doors, or institution to the question 'In the past 30 days, where have you been living most of the time? "</p> <p><i>Herman et al, 2011:</i> Percentage of participants in experimental and control groups with any homelessness during each follow-up interval.</p> <p><i>Kasprow and Rosenbeck, 2007:</i> Housing status measured by including items concerning the number of days in the past 90 that clients were homeless (living in shelters or on the streets), living in an institution (hospital, residential treatment facility, or jail), or housed (living in their own home or with others)</p>	<p><i>Aubry et al's (2015) review of the At Home-Chez Soi project Housing First project:</i> Time spent in stable housing.</p> <p><i>Veterans Homelessness Prevention Demonstration project (Cunningham et al, 2015):</i> Percentage of veterans in stable housing as compared to those in unstable housing, literally homeless or at imminent risk after exiting the programme and at follow-up.</p> <p><i>Collins et al. (2013) evaluation of housing retention in an Housing First:</i> Number of days continuously-housed after participants moved into the programme.</p> <p><i>Stergiopoulos et al, (2015)</i> Housing stability assessed using the Residential Time Line Follow-back (RTLFB) inventory to calculate number of days spent continuously housed</p> <p><i>Aidala et al. (2014):</i> The percentage of days spent continuously housed.</p>	<p><i>Levitt et al. (2013):</i> <i>The time taken for families to exit shelter without subsidies.</i></p> <p><i>The Homebase Community Prevention project (Abt, 2013):</i> The average number of nights spent in shelter, the percentage of participants who spent at least one night in shelter and the percentage of families that submitted an application for shelter over the 27 month period follow up.</p> <p><i>The Family Options Study (US Department Housing and Urban Development, 2016):</i> Housing stability as proportion of families spending at least 1 night in shelter at specific follow up times, and the proportion of families with emergency shelter stays over two 12 month periods</p>	<p><i>The Sharing Solutions programme (Batty et al, 2015):</i> The number of participants that had been provided with accommodation /tenancies at the end of the programme</p> <p><i>Cameron et al. (2009):</i> The number of clients for whom they had arranged a tenancy, and the number of tenancies that were sustained at three monthly intervals</p> <p><i>Zierler et al's (2013) study with families:</i> The percentage of participants housed in private rented apartments.</p> <p><i>Parsell et al. (2015) Brisbane Common Ground project</i> The number of people who sustain their tenancies over 32 months</p>

## 6.4 Chapter summary

Studies analysed represented a range of evaluation types, including, randomised controlled trials, comparative evaluations, mixed methods studies and qualitative evaluations. Outcome measures included:

- Those directly related to particular **service features**.
- The number/percentage of **days of homelessness**.
- The number/percentage of **days stably/continuously housed**.
- Outcomes/measures relating to the **use of shelters**.
- Outcomes/measures relating to **tenancies**.

## 7. Crisis-defined types of service

Crisis as part of its plan to end homelessness has typologised types of interventions and policy solutions into three areas; prevention, rapid response for people with low level needs and sustained support for people with complex needs. In this section we present analysis of studies that provided specific learning that could be categorised to these themes. All of the studies referred to have already been referenced and described previously, therefore, to avoid duplication service details are only described as they specifically relate to each theme.

### 7.1 Prevention

Prevention for the purpose of this review and Crisis plan to end homelessness focuses on services which prevent homelessness at the point of risk, rather than further upstream. Immediate risk refers to an assessment that homelessness is likely to occur in the next 56 days which reflects the current statutory framework in Wales and England where local authorities have a duty to take reasonable steps to prevent homelessness up to 56 days before it happens.

#### 7.1.1 Overview of studies

Four studies were reviewed which explored the impact of services aiming to prevent homelessness and they focused on projects using a combination of approaches and one financial assistance project.

#### 7.1.2 Effective prevention policy services

##### **Multi-component services**

A number of studies used a combination of approaches to address person centred needs. The Homebase Community Prevention project (Abt, 2013) for families offered neighbourhood centres which provide case management, information on welfare rights and consumer advice, developed service plans and provided financial assistance for the intervention group.

##### **Multi-agency services**

The Rough Sleepers Initiative (Fitzpatrick et al, 2005) funded services within a strategic planning framework including the local authority, health board and the Supporting People programme team in each area. The funds were used in a variety of ways, the most common being rent deposit schemes, and outreach and support workers. Amongst other things, funds were also often used to provide access to emergency accommodation, street worker teams, and day centres. It has largely been a successful programme with statistical evidence gathered from George Street Research showing that levels of rough sleeping fell since the programme began.

## **Financial assistance**

One study that looked specifically financial assistance; Evans et al. (2016) used data from Homelessness Prevention Call Centre in Chicago, which processes a large number of calls annually for financial assistance with rent, security deposits or utility bills. The authors compared families who call when funds are available and those who call when they are not available. The project demonstrated modest success.

### **7.1.3 Enablers and barriers**

Person-centred approaches, with multiple components and the support of a case manager or support worker were seen to be enablers and key to the success of programmes. Multi-agency partnership working was also identified as a key enabler (Abt, 2013; Nightsafe, 2017; Fitzpatrick et al, 2005).

Barriers to success included engaging people with complex needs or those who were precariously housed (Fitzpatrick et al, 2005). Additionally finding affordable housing, temporary accommodation and securing permanent accommodation also proved to be a challenge when attempting to help prevent homelessness.

## **7.2 Rapid response for people with low-level needs**

### **7.2.1 Overview of studies**

Studies were reviewed that that explored the impact of rapid response services for people with low level needs. Analysis revealed that rapid response services focused on a number of types of service:

- Access to a range of housing.
- Critical Time Interventions.
- Pilot projects and target group specific projects.

### **7.2.2 Effective rapid response services**

#### **Rapid response multi-component services**

Many of the rapid response studies were aimed at providing people with multi-component services, with access to a range of housing with other support, including case management, financial assistance, securing income, apartment search. The types of housing people were trying to secure accommodation in included:

- rapid rehousing
- transitional housing
- supportive Housing
- private sector housing
- permanent accommodating.

For instance, the Veterans Homelessness Prevention Demonstration project (Cunningham et al, 2015), which included rapid rehousing of veterans along with other support such as financial assistance and case management. The programme reported considerable success.



The Daybreak programme (Ohio Housing Agency, 2016), provided young people with different models of transitional housing, along with other support including advice, financial assistance and a support worker.

The Rapid Re-Housing Demonstration project (Finkel et al, 2016), offered families rapid rehousing and a package of temporary assistance.

Zierler et al, 2013 reported on a service which aimed to move homeless families from temporary accommodation into apartments in the private rented sector in Vienna. The support offered to the families covered securing income, household budget planning and assistance, and coaching in house-hunting in the private rented housing sector.

### **Targeted services**

There were also pilot projects and target group specific projects which demonstrated some success. For instance, the Sanctuary Schemes (Jones et al, 2010) programme was designed to enable households at risk of domestic violence to remain in their own permanent accommodation. This included a combination of risk assessment and the instalment of security measures (such as lock changes, home link alarms, CCTV cameras) based on the level of risk experienced by the households. However, there was little data collection and monitoring, which made it difficult draw firm conclusions about success of the programme.

### **7.2.3 Enablers and barriers**

#### **Enablers**

Key enablers were:

- Financial assistance, case manager support and a willingness to change on the part of participants (Cunningham et al, 2015; Zierler et al, 2013; Ohio Housing Agency, 2016).
- Fidelity to the Critical Time Intervention model, which was comprised of a mix of structure and flexibility.
- Case officers and a readiness for change were reported as key enablers (Brown, 2013; Jones et al, 2010).

#### **Barriers**

Barriers included:

- Difficulty in multi-agency working and in achieving positive outcomes for those with more complex needs such ethnic minority groups, and young people with a history of placements in the foster care system, sexual abuse or criminal activity (Cunningham et al, 2015; Ohio Housing Agency, 2016).
- Discrimination towards families from private sector landlords which made it difficult for families to navigate the real estate market, and created a preference for social housing (Zierler et al, 2013).

- Affordability and income, Finkel et al. (2016) reported issues of affordability. Families surveyed frequently cited not being able to pay the rent (57%) and not being employed as (75%) big problems with respect to housing stability.
- Fewer contacts with case workers meant they failed to establish a connection with participants, and therefore the service reported weaker housing stability in these cases (Herman et al, 2011).
- Remote, rather than face to face may reportedly contributed to more mixed results (Kasprow and Rosenbeck, 2007).
- Poor multi-agency working, that is, a lack of timely access to services from benefits teams, housing agencies and outreach teams (Brown, 2013; Hough and Jones, 2011).
- A lack of access to appropriate accommodation including in the private rented sector (Hough and Jones, 2011).
- The inadequate length and type of support offered to some participants (Jones et al, 2010).

## 7.3 Sustained response for people with complex needs

### 7.3.1 Overview of studies

Analysis showed that sustained support response services focused on a number of types of service:

- Housing First.
- Case management models.
- Longer-term population-group specific services.

### 7.3.2 Effective sustained support services

#### Sustained support services

The sustained support studies reviewed included a number of Housing First studies, and also included projects with different target groups, including ethnically diverse samples, those suffering from mental illness, those with severe alcohol problems or drug abuse, and the chronically homeless. Some of these studies were based outside the United States of America, in Canada and in Europe. All reported a positive impact on their treatment groups, in terms of improved outcomes in housing stability (Aubry et al, 2015; Stergiopoulos et al, 2015; Collins et al, 2013; Busch-Geertsema Volker, 2014).

#### Case management

There were also a number of studies comparing or evaluating case management models (Clark et al, 2016; de Veet et al, 2013). Studies generally reported that the more intensive the case management model, the more successful it was (Clark et al, 2016; de Veet et al, 2013). For example,

Clark et al. (2016) reported that Critical Time Intervention and Assertive Community Treatment, particularly when combined with Permanent Supportive Housing demonstrated remarkable improvements in homelessness after 6 months. Unfortunately there was no longer term follow-up of housing outcomes. Both services operated under a Housing First model and had access to housing vouchers. Amongst the participants there were a significant percentage that were recruited from shelters. Most participants suffered from mental illness and/or substance abuse problems.

### **Sustained population group specific services**

The three years Family Options Study (U S Department of Housing and Urban Development; 2016) found that only priority access to long-term subsidies resulted in significant positive results. The authors reported on a number of outcome measures thus:

*“At both the 20 and 37-month follow-up points, assignment to the SUB intervention reduced by more than one-half the proportion of families who reported having spent at least 1 night in shelter or in places not meant for human habitation, or doubled up, in the past 6 months; increased the proportion of families living in their own place by 15 percentage points.*

(U S Department of Housing and Urban Development, 2016: p. 5)

A housing support outreach and referral pilot (Cameron et al, 2009) for at risk or homeless people with HIV, under the Supporting People programme programme included flexible working with support workers to assist individuals to set up a housing tenancy and provide on-going support to ensure that the tenancy was maintained.

A four-year programme commissioned by the Greater London Assembly, and funded by the Department of Communities and Local Government (2017) was designed to encourage new and innovative means of financing services, to provide personalised support to an entrenched group of rough sleepers in London. Services were designed around a Navigator approach, whereby key workers adopted a personalised and flexible approach, supporting the participants to access existing provision and achieve sustained long-term outcomes.

The Brisbane Common Ground Permanent Supportive Housing project (Parsell et al, 2015) targeted people with low to moderate income, and those who had suffered from chronic homelessness. The programme provided on-site concierge support, communal areas where people were able to access informal support, and connection with mainstream services such as drug and alcohol counselling, personal counselling, vocational assistance, domestic assistance and personal care.

### 7.3.3 Enablers and barriers

#### Enablers

Key enablers were:

- Fidelity to the sustained support models' processes and principles were reported to be very important as was adaptability for sub-groups and context, which in turn resulted in a greater likelihood of replicable success when services were rolled out (Aubry et al, 2015; Stergiopoulos et al, 2015; Collins et al, 2013; Busch-Geertsema Volker, 2014).
- Intensive case management; studies comparing or evaluating case management models reported that key enabler was that the more intensive the case management models, the more successful it was (Clark et al, 2016).
- Longer-term financial assistance and subsidies (U S Department of Housing and Urban Development; 2016).
- Coproduction and multi-agency working at the local level (Cameron et al, 2009).
- Intensive/daily support and case management (Parsell et al, 2015).
- Multi-agency working (Aidala et al, 2014).

#### Barriers

Barriers included:

- Challenges meeting the needs of people with more complex needs (Aubry et al, 2015; Stergiopoulos et al, 2015; Collins et al, 2013; Busch-Geertsema Volker, 2014).
- Challenges in being able to effect change in ingrained risky behaviour. Clark et al. (2016).
- Challenges in negotiating with stakeholder, such as landlords (Batty et al, 2015).
- Challenges in developing and maintaining inter-agency relationships (Batty et al, 2015).
- Challenges in securing culture changes, for instance in relation to housing and sharing (Batty et al, 2015).

## 7.4 Chapter summary

The review found that, in relation to what works in:

- **Preventing immediate homelessness**, a combination of approaches showed promise with speedy access to financial support and suitable housing options being very important.
- **Rapidly responding to people with low level needs**, accessible services and the ability to make appropriate referrals in a time critical environment are key, for instance, by providing rapid rehousing, transitional housing, supportive housing, private sector housing or permanent accommodation.
- **Sustained support for people with complex needs**, requires developing services which are able to identify and engage and sustain support to people over periods of time, during which needs invariably develop and change, hence case management models work best.

## 8. Services for specific population groups

The studies reviewed included a focus on a number of population groups. Where sufficient evidence exists for population groups, the effectiveness of these services and the enablers and barriers they faced are discussed. All of the studies referred to have already been referenced and described previously, therefore, to avoid duplication service details are only described as they specifically relate to each population group. The groups for whom analysis was possible were:

- Families.
- People leaving institutions: prison leavers, hospital discharges, and recent military veterans.
- Vulnerable groups: people experiencing mental illness, chronic illness and substance abuse.

### 8.1 Families

#### 8.1.1 Effective services for families

The services providing effective services included multiple components, offered both rapid and sustained support and were delivered within multi-agency frameworks.

The Home to Stay (Levitt et al, 2013) rapid response programme used housing subsidies, case workers and support for families to access services to assist their transition from shelters into permanent housing.

The preventative Homebase Community Prevention project (Abt, 2013) consisted of a network of neighbourhood centres where families were assigned case workers who developed individualised family service plans which include both referrals to, and information about, a range of services providing welfare and consumer advice. Homebase Community Prevention project also provides vouchers to pay rental or utility arrears, moving costs and security costs, to help stabilise families.

The Rapid Re-Housing Demonstration project (Finkel et al, 2016) offered families rapid rehousing and a package of temporary assistance. There was quite a lot of variability in services provided across sites, for example the length of Rapid Re-Housing Demonstration project assistance provided, the depth of rental subsidy provided and the frequency of case management required for programme participants. The project reported a mix of outcomes, which were described previously.

A rapid response programme (Zierler et al, 2013) aimed to move homeless families from temporary accommodation into apartments in the private rented sector in Vienna. The support offered to the families included help to secure an income, household budget planning and assistance, and coaching in house-hunting in the private rented housing sector and the service was partially successful.

The Family Options Study (U S Department of Housing and Urban Development, 2016) implemented and compared a number of different types of service, including priority access to long term housing subsidies, access to short-term subsidy in the form of rapid rehousing or project based transitional housing. The study found that only priority access to long-term subsidies resulted in significant results.

A systematic review by Bassuk et al. (2014) looked at rapid response and sustained support services for families at risk of homelessness. Services were categorised as (i) transitional or permanent supportive housing with Intensive Case Management; (ii) usual care in emergency shelter, transitional housing, and permanent supportive housing with the types of services not specified; and (iii) a systems approach featuring collaboration between housing or homeless agencies and child welfare or development agencies (multi-agency working).

### **8.1.2 Enablers and barriers for services aimed at families**

#### **Enablers**

Enablers included:

- Motivation/will to change, Zierler et al. (2013) reported that at the individual level, the 'will to change' was the key element of change.
- Long-term housing subsidies, The Family Options Study (U S Department of Housing and Urban Development; 2016) highlighted the impact of long term housing subsidies and argued that '*for most families, homelessness is a housing affordability problem that can be remedied with long-term housing subsidies without specialized services*' (p. 12).'

#### **Barriers**

Barriers included:

- Challenges in effecting change in people with longer experiences of homelessness (Levitt et al, 2013).
- Challenges in rehousing families in the private sector (Zierler et al, 2013).
- The poor quality of family intervention studies coming from the grey literature, with poorly defined interventions, failure to measure fidelity of interventions and on the whole weak methodological rigour (Bassuk et al, 2014). This findings features across this review.

## **8.2 People leaving institutions**

Studies were reviewed that focused on people leaving institutions, such as hospital discharges, prison leavers, offenders leaving the criminal justice system, and recent military veterans. Many of these groups also had complex needs, for instance, suffering from mental illness or substance abuse problems.

## **8.2.1 Effective services for people in transition**

### **Case management**

The majority of studies compared and evaluated the impact of different case management models, such as Intensive Case Management, Assertive Community Treatment and Critical Time Intervention. For instance:

- Clark et al. (2016) compared Assertive Community Treatment and Critical Time Intervention in two different settings of Permanent Supportive Housing. Both programmes operated under an Housing First model and reported that both Critical Time Intervention and Assertive Community Treatment, particularly when combined with Permanent Supportive Housing demonstrated marked improvements in homelessness after 6 months.
- de Veet et al. (2013) conducted a systematic review of the effectiveness of a range of models and reported that Assertive Community Treatment and Critical Time Intervention were the only models that had a positive impact on housing, amongst other outcomes.
- Herman et al. (2011) reported that mentally ill patients being discharged from hospitals over the course of the Critical Time Intervention service were associated with a five-fold reduction in the number of homeless nights compared to the comparison group.
- Kaspro and Rosenbeck (2007) reported that veterans leaving psychiatric institutions receiving Critical Time Intervention had 19% more days housed than the comparison group in the previous 90 days, and also had significantly more days housed at the six, nine, and 12 month follow up intervals.

These findings indicate that Assertive Community Treatment and Critical Time Intervention can be effective services for people experiencing critical transitions in their lives, and demonstrate evidence of working with a larger range of target groups including those with more complex needs such as people with substance abuse issues, who have a mental illness, or who are veterans. The findings also indicate that Critical Time Intervention services may work better when combined with Permanent Supportive Housing or Housing First as this provides a sense of longer term security.

### **Multi-component services**

There were two services which reported positive outcomes using multi-component approaches:

- The Frequent Users Service Enhancement two year service initiative in New York used housing subsidies provided as well as provision of Intensive Case Management to mental health, clinical supervision and any other support needed to offenders coming out of the criminal justice system (Aidala et al, 2014).

- the Veterans Homelessness Prevention Demonstration project (Cunningham et al, 2015) included rapid rehousing, a combination of short- to medium-term housing assistance in the form of vouchers (up to 18 months), including security deposits, rent, moving cost assistance, and utilities. It also provided case management and support with welfare rights and consumer advice, more specifically access to health and employment services.

## **8.2.2 Enablers and barriers associated for services for people in transition**

### **Enablers**

Enablers included fidelity to the Critical Time Intervention model, multi-component multi-agency working (Aidala et al, 2014) and financial assistance (Cunningham et al, 2015).

### **Barriers**

Key barriers for Critical Time Intervention services, included:

- Participants who had relatively few contacts with their Critical Time Intervention workers did less well (Herman et al, 2011).
- A lack of face to face contact with key workers was associated with poorer outcomes (Kasprow and Rosenbeck's, 2007).
- The lack of expert input to support people with complex needs, such as mental health illnesses (Aidala et al, 2014).
- Challenges for project leads in engaging other organisations and stakeholders (Cunningham et al, 2015).

## **8.3 People with complex needs**

Studies that focused on services for people with complex needs, included those suffering from mental illness, alcohol problems, chronic illness and substance abuse problems.

### **8.3.1 Effective services people with complex needs**

Many services focused on groups with a variety of vulnerabilities and complex needs, the most common vulnerabilities were mental health illness and severe alcohol problems, followed by drug abuse and chronic homelessness.

#### **Housing First**

Housing First sustained services focussing on the needs of vulnerable groups reported positive outcomes, and included:

- A review of the impact of the At Home-Chez Soi project Canadian Housing First demonstration project for people with severe mental illness and chronic homelessness (Aubry et al, 2015).



- An evaluation of the impact of Housing First combined with Intensive Case Management on an ethnically diverse sample of people with mental health problems (Stergiopoulos et al, 2015).
- A study exploring the impact on housing retention in an Housing First study on chronically homeless individuals with severe alcohol problems (Collins et al, 2013).
- A multi-site Housing First study in Europe (Busch-Geertsema Volker, 2014).

### **Case management**

Other types of services that focused on these complex needs included case management models - Assertive Community Treatment and Critical Time Intervention specifically. These were discussed in the previous section on people in transition. Two studies focused on vulnerable women. The rapid response service Sanctuary Schemes (Jones et al, 2010) - was designed to enable women in households at risk of domestic violence to remain in their own accommodation. This included a combination of risk assessment (for example, the whereabouts of the perpetrator, the level of violence and nature of incidents) and the instalment of security measures (such as lock changes, home link alarms, CCTV cameras) based on the level of risk experienced by the households.

### **Rapid response**

A rapid response ecologically-based pilot programme (Slesnick and Erdem, 2013) explored the impact of an integrative approach targeted at substance-abusing mothers living in shelters by using a combination of approaches including supportive housing, case workers, housing vouchers and subsidies and substance abuse counselling to stabilise their housing situations. The service was reported as has previously been explained as only partially successful. See Appendix 3 for further explanation about this service.

### **Outreach**

One study focused specifically on people suffering from chronic illness. Cameron et al. (2009) conducted a qualitative case study of a housing support outreach and referral pilot for at risk or homeless people with HIV, under the Supporting People programme. The pilot included working with support workers to assist individuals to set up a housing tenancy and provide ongoing support to ensure that the tenancy was maintained. The support workers also registered participants with relevant health services and made sure they knew how to access these services.

## **8.3.2 Enablers and barriers associated with complex needs**

### **Enablers**

Key enablers included:

- Fidelity to the Housing First model whilst allowing for flexibility (Aubry et al, 2015; Busch-Geertsema Volker, 2014; Collins et al, 2013).
- Open door/non-judgmental approaches (Collins et al, 2013; Busch-Geertsema Volker, 2014).
- Choice in accommodation (Jones et al, 2010).
- Coproduction and multi-agency working (Cameron et al, 2009).

## Barriers

Barriers included:

- Challenges with affecting change in people with chronic histories of homelessness where participants demonstrate a strong sense of belonging to their street networks (Collins et al).
- A lack of specialist support for people with severe psychiatric issues or severe drug abuse problems (Collins et al, 2013; Aubry et al, 2015).
- 'Structural' constraints, challenges in securing rapid access to housing as well as long waiting lists for scattered (across different sites) social housing (Busch-Geertsema Volker 2014).
- A lack of individualised support plans (Jones et al, 2010).
- A lack of effective inter-agency working (Jones et al, 2010).
- Absence of monitoring data (Jones et al, 2010).
- A lack of longer-term sustained support (Slesnick and Erdem, 2013).

## 8.4 Chapter summary

The review found that, in relation to what works for:

- **Families**, were multiple component services, offered both as rapid and sustained support and delivered within multi-agency frameworks.
- **People in transition from state institutions**, were case management and multi-component services.
- **Vulnerable groups**, were sustained services focussing on the needs of vulnerable groups reported positive outcomes, as did Case management, rapid response and outreach services.

## 9. Conclusions

### 9.1 Types of effective services

The review suggests that **sustained support services** that are targeted to **meet the changing needs** of different populations are most effective. This included **established models such as Housing First** which have been tried and tested across the US, and are now being tested internationally as well. Housing First services can work with people with complex needs, especially when they are combined with case management and supportive housing.

Other services that are effective are a few types of **case management**, for example, Intensive Case Management is a **sustained support** service which supports individuals through **one-on-one case management**, to develop plans, enhance life skills, address health and mental health needs, engage in meaningful activities and build social and community relations. Another type of case management is the established model of Critical Time Intervention, a **rapid response** service, which has been particularly successful with people who are in transition - leaving prisons and hospitals. These case management models also tend to work well when **combined with Housing First or Permanent Supportive Housing** elements.

Services that support people to access accommodation through the provision of **housing vouchers** have also demonstrated effectiveness. The provision of **financial assistance** seems to help lift some of the immediate burden that people may face in securing their housing, for example those facing evictions. Finally, services that take a **person centred approach**. Including outreach and therefore provide a **tailored set of services** and multi-component services for the population targeted have also been effective. Multi-component services tend to include support workers, mentors, transitional or supportive housing, individualised service plans, training and skills development and advice and access to services, e.g. employment or benefits services.

### 9.2 Core features of effective services

The review suggests a number of features that contribute to the effectiveness of services and services.

For example, **fidelity** to established models - their principles, aims, processes and implementation is a key feature for services like Housing First and Critical Time Intervention. However, being able to **adapt** and align delivery models to fit different settings and contexts with different service set ups, and different population groups, for example, ethnic minority groups, is also important.

Another key core feature of effectiveness was the presence and role of a **key support worker/ case manager** to provide support and advice to clients. The role of this person could be broad or very specific. For some participants, the key worker was someone they could talk to, trust, and confide in therefore increasing their support structure. Other participants felt that this role was key in being able to navigate services, benefits and referrals. Providing advocacy

and attending meetings with participants also helped them feel more confident about their interactions with services.

**Multi-agency services and coproduction**, both at the national and local level, was also a core feature that facilitated the effectiveness of services. A **shared vision, common goals, clear roles and responsibilities and flexibility** in providing support were key to different services working together efficiently and in a timely manner. Additionally, funding, buy-in, support and training, and oversight from national level organisations also worked well in motivating local agencies to work together.

Strong positive relationships between **clients and landlords** were also key to success. **Landlords were more amenable** to take on homeless people who they considered as 'high risk' clients, when they were part of fund-backed programme, were incentivised to do so, and where vetting and **support was provided** to clients via a support worker. These conditions helped landlords limit their liability on taking on clients with a history of homelessness. Similarly, a **local housing market with the resources** to respond to homelessness needs and ensure access to affordable suitable accommodation was also important.

### 9.3 Barriers

The review suggests a number of barriers to providing services. One of the most common barriers to addressing homelessness relates to securing sustained outcomes for **vulnerable groups** and those with complex needs. This tends to include chronically homeless people, people with substance abuse problems, precariously housed groups and those with severe mental health problems. This is because they tend to be more difficult to engage with in terms of assessing providing person and need-specific support. In the absence of this they tend to experience less successful service outcomes.

Additionally, the review also suggests that people who are at risk of homelessness or are homeless find **accessing the local housing market** more challenging. They often face discrimination from landlords who are reluctant to give them tenancies out of fear of conflicts in the neighbourhood. Rising rents and a lack of experience with the real estate market also made it harder for them to access the market. There is also the issue of unsuitable or inappropriate accommodation, for example a shortage of affordable housing located outside of areas with high crime rates, or temporary accommodation, which was reported as dirty, without electricity, or shared with drug users, which threatened the stability and security of people who were looking to avoid such environments

There was also a reported **lack of data about and monitoring** of homeless people and those at risk of homelessness and therefore a lack of information that could be used to design and develop fit for purpose services. It also meant that outcomes could not be measured, especially the sustainability of outcomes, and therefore the effectiveness of services could not be established.

**Multi-agency working** was also experienced as a challenge for many services. This tended to include bureaucracy, slow decision making, delays in referrals and lack of communication between local agencies.

**Access to support and services** over an appropriate length of time was also identifying as limiting the effectiveness of services. This particularly included access to mental health services and alcohol and drug abuse treatment. For people with complex needs this often stunted their longer-term outcomes.

## 9.4 Assessment of evidence

The majority of the studies selected for analysis were considered to be high quality, however, taking a best evidence approach also led to the inclusion of a small number of studies that were of low to medium quality. This particularly applied to mixed method and cost-benefit studies and means that there were few:

- **high-quality studies with qualitative evidence** able to link programme delivery with quantitative outcomes, limiting the ability to generalise learning beyond the local context of any particular study
- **robust assessments of cost-effectiveness** included in the review. However, those studies reviewed reported encouraging economic assessments (e.g. Oxera, 2013; Bee and Woods, 2010; Ohio Housing Agency, 2016).

A further limitation referred to by authors was the lack of tracking longer-term outcome measures to ascertain the long-term impact of services. In addition studies reported specific methodological issues - selection bias, the absence of a comparison or control group or self-reporting bias as having a potential impact on confidence in the findings.

## 9.5 Approaches to evaluation and outcome measures

Using a hierarchy of evidence and taking a best evidence approach across the five themes, we selected a range of evaluation approaches.

Approximately half of the studies reviewed were a mixture of experimental and quasi-experimental evaluation, which included Randomised Controlled Trials, Non-Randomised CT, and comparison group evaluations and tended to be evaluations of established models or government funded services.

There were also a number of qualitative or mixed method evaluations approaches of pilots and population- group specific evaluations. Most qualitative evaluation approaches included interviews or telephone surveys with different stakeholders sometimes including both national and local level organisations and interviews or focus groups with participants happened at different intervals during the project. Mixed method approaches tended to include the qualitative approaches described as well an analysis of data usually collected from different databases and/or the use of a survey.

There was great diversity of housing outcomes measured across the studies, given the different target groups and specific aims of services. However, a few common themes emerged:

- **Loosely defined outcome measures**, for example the number of clients who can be shown to be accommodated in some form of stable accommodation at the conclusion of the pilot. The percentage of participants that had a positive departure, which is a move into some form of accommodation or reconnection to another area.
- **Number/percentage of days of homelessness**, for example: Comparison of days homeless with days housed, with homeless consisting of anyone who answered shelter, street/out- doors, or institution to the question '*In the past 30 days, where have you been living most of the time?*'
- **Number and/or percentage of days stably/continuously housed**, for example housing stability assessed using the Residential Time Line Follow-back (RTLFB) inventory to calculate number of days spent continuously housed.
- **Measures relating to the use of shelters**, for example, housing stability as proportion of families spending at least 1 night in shelter at specific follow up times, and the proportion of families with emergency shelter stays over two 12 month periods.
- **Outcomes /measures relating to tenancies**, for example, the number of clients for whom they had arranged a tenancy, and the number of tenancies that were sustained at three monthly intervals.

## 9.6 Gaps

The review identified a lack of evidence about what works for a number of specific population groups. For example, **Black and minority ethnic (BAME) groups** rarely featured in studies and when they did, outcomes were not as positive as for other groups. This suggests that there is room to improve BAME engagement and involvement, for person centred services to be designed. People from BAME may have specific cultural needs that need to be built into services.

Additionally, none of the studies selected focused only on people in **transient accommodation**, that is, those who were sofa surfing, squatting, or living in unsafe environments and moving locations constantly. This group was considered a 'hidden' subgroup from homelessness services and hard to reach as well as low priority. It is therefore not surprising that little research has been published about what works for this group. This reflects a **serious gap** in the evidence and further research into this sub-group is urgently needed in order to identify what works in terms of interventions.

There are also **few robust evidence-based successful family services**, other than the Family Options Study, which found that only the access to long-term housing subsidy was effective. A systematic review by Bassuk (2014) looked at rapid response and sustained support services for families at risk of homelessness. The authors highlighted the **poor quality of family service studies** reviewed. The evaluations tended to suffer from limitations such as weak study design dropouts and weakness of data collection methods. The

description and reporting of the service, its duration, and frequency was also considered weak. The studies also did not provide insight into issues such as fidelity of the service, the level of qualifications/expertise required of staff or about smaller sub-groups of family populations.

The review also identified other gaps relating to methodological issues and evaluation approach gaps. For example, there was felt to be insufficient **experimental research**, particularly Randomised Controlled Trials **across multiple sites**. This was mentioned regarding case management models, Housing First with different target populations across single and scattered site housing, and the impact of Critical Time Intervention impact on different target groups and in different contexts. Another important gap is the lack of studies that **combine experimental research with qualitative research** which can be used to inform organisational factors that enable or facilitate success of programmes and which helps identify and describe generalisable findings in depth and detail, focusing on the voice and lived experience of participants.

Methodologically, there was little measurement of **fidelity of services** across intervention sites, which can have an impact on interpretation of findings and attributing success to services. Similarly there were gaps in assessing **longer-term outcomes** of services, which meant that long-term impact or sustainability of impact of services was not clear. Finally, there was a clear gap in consistent and robust **cost benefit analysis** to help inform the decisions commissioners make.

## 9.7 Opportunities

This review suggests a number of opportunities for stakeholders to improve how they work together to end homelessness by.

- Working with landlords and housing agencies to **increase the supply of affordable housing**, both in the public and private sector. People exiting programmes may often find themselves at risk of homelessness again if they cannot find accommodation.
- **Expanding support and developing specialised programmes** for a range of population groups; for instance, for people with complex needs: the chronically homeless, young people with a history of violence or criminality, those with severe psychiatric conditions and drug abuse problems.
- Conducting **further research** into other hard to reach sub-groups, for example those who often remain 'hidden' such as people in transient accommodation that may need targeted support.
- Conducting further research to explore what works for **family services**.
- Funding and supporting **innovative and successful** services and services, for example the Rough Sleeping Initiative, Sharing Solutions, No Second Night Out.
- Facilitating better **multi-agency working**, particularly at the local level to develop responses and services for homeless people and those at risk of becoming homeless in a timely fashion.

- Conducting research focusing on designing a rigorous and robust suite of **outcome measures** for measuring the impacts and outcomes of services that have a connection/contribution to ending homelessness.
- There is a pressing need to develop:
  - **shared language and understanding** around what is needed for, and the various types of, economic assessment (i.e. value for money, cost benefit, opportunity costs, social return on investment)
  - **consistency** in relation to what are accepted as **proxy opportunity costs measures**
  - clarity of purpose for and how to appropriately apply economic assessment
  - reliable and long-term **accessible cost-related data sources**.
- Recognising that there are multiple risk and protective factors associated with homelessness, therefore, it would be useful to work to **integrate a set of key homelessness measures into all related evaluation and research**.



## 10. Implications

Finally, we suggest the following are key factors to achieving successful outcomes for services working to address homelessness. These observations are designed to be read in conjunction with those made in Peter Mackie's recent review on what works in relation to rough sleeping, published in December 2017 by Crisis<sup>17</sup>. Mackie et al. draw our five policy principles<sup>18</sup> and, while these principles are also supported by the evidence generated by this review, we think there are an additional four important aspects underpinning the drive to end homelessness; the role of people and organisations, multi-component responses (and service integration), coproduction and monitoring and evaluation.

### 10.1 The role of organisations

#### 10.1.1 People with lived experience of homelessness

People with lived experience of homelessness should be involved in co-designing evaluation, services and be at the centre of all provision, for instance:

- **co-designing and helping conduct evaluation** of services
- helping to **identify, engage and involve people** who are **'hidden'** from providers and services, e.g., entrenched rough sleepers and those in transient accommodation
- be **involved and engaged** in the **identification of needs** to inform design services and support provided
- acting as **mentors, mediators and advocates** for individuals and between user groups and other agencies and organisations.

#### 10.1.2 Charitable homelessness sector and other local community and voluntary organisations

Our review shows that there continues to be much the sector could do to improve working together towards ending homelessness, by.

- **Providing homeless people with services** that help them overcome the challenges they face in securing housing, this includes:
  - Negotiating with landlords.
  - Providing advocacy and support during meetings with other agencies.
  - Arranging access to appropriate **emergency accommodation**.

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<sup>17</sup> Mackie P., et al. (2017) Ending rough sleeping: what works? An international evidence review.

<sup>18</sup> *Recognise heterogeneity* –of individual rough sleepers' housing and support needs and their different entitlements to publicly funded support. Local housing markets and rough sleeper population profiles will also vary across the UK. *Take swift action* – to prevent or quickly end street homelessness, through interventions such as No Second Night Out (NSNO), thereby reducing the number of rough sleepers who develop complex needs and potentially become entrenched. *Employ assertive outreach leading to a suitable accommodation offer* – by actively identifying and reaching out to rough sleepers and offering suitable accommodation. *Be housing-led* – offering swift access to settled housing including the use of Housing First. *Offer person-centred support and choice* – via a client-centred approach based on cross-sector collaboration and commissioning (pxx).

- Providing **one-to-one support**.
- Providing **advice and information** about eligibility for benefits and help with accessing mental health, and housing options services.
- Providing **financial assistance** in the form of housing subsidies and vouchers.
- **Contributing to the evidence base** on what works in preventing and addressing homelessness and addressing the gaps in evidence by:
  - Supporting **research on transient communities**, including outreach to identify this hidden population.
  - Supporting research on **family services** and on ethnic minority groups.
  - Continuing to **test Housing First and Critical Time Intervention models** and identify what additional services are needed to address the needs of people with severe psychiatric and substance abuse problems.
  - Supporting further research into the **duration and typologies of support** that are needed for people experiencing different types of homelessness.
  - Commissioning and/or conducting **systematic evaluations and cost-benefit analyses** of services.
- **Contributing to the design, delivery and implementation of specific services:**
  - Provide **expert advice on person-centred** needs including for specific population groups.
  - Provide other agencies and institutions involved with **access to their networks and expertise** on the potential availability of other support services.
  - Facilitating **access to and collection of data** to ensure outcomes reported are reliable and helping to facilitate longer-term evaluation.
  - Continuing to **campaign for change**, particularly in relation to rapid access to affordable and appropriate accommodation in the private and public sectors.

### 10.1.3 Government organisations

Government organisations at national and local levels have a vital role in ending homelessness, by:

- **Providing strategic direction** and developing policy related to preventing and addressing homelessness, employing a coproductive approach, involving people with lived experience, and agencies and organisations with expertise in this field.
- **Supporting and bringing about changes** that make the property market, including the private sector, more affordable and landlords more amenable to housing solutions.
- **Providing funding for evidence-based programmes**, evaluation of these programmes and to **test new and innovative** pilot projects.
- **Providing infrastructure**, oversight and local coordination over the implementation and delivery of services by statutory providers.
- **Government departments working in partnership** thereby providing other agencies with shared funding, cross sector buy-in, access to data and monitoring and wider expertise.
- Contributing to the development and implementation of **fidelity requirements** and produce **guidance and toolkits**.

- Bringing about **new ways of working and culture change** thereby improving multi-agency working (for instance, developing ‘fast-track’ options for financial assistance and other time-sensitive service-related components).

#### 10.1.4 Institutions/statutory services

**Institutions and statutory services** (health, social care, criminal justice and education) could do more to contribute to ending homelessness through:

- **Improved multi-agency working** including coproduction, shared ownership and accountability services.
- **Minimising bureaucracy**, providing adaptable and flexible help to each other, as far as is possible within capacity and timescale constraints.
- **Embracing new ways of working**, for example by providing reactive support outside of usual service governance and structures.
- **Sharing tracked outcomes** and data to ensure better longer-term measurement of the effectiveness of services and outcomes for people.
- **Improving monitoring and data collection** and producing useful analyses of this collected data.
- Providing **clear and accessible points of contact** for homelessness related efforts, fostering strong communication and relationships.
- Consider establishing **link workers who operate across services** as part of homelessness services.
- Providing **guidance, referrals and access** to wider networks.
- **Raising institutional and staff awareness** and knowledge about the cross-cutting issues related to homelessness and complex needs (i.e. mental health and substance abuse).

#### 10.1.5 General public/wider community

To end homelessness, it is important to harness the support of the public in building a consensus that homelessness in the UK is completely unacceptable. This means working with communities and members of the public to:

- **Harness the support of the public** in building a consensus that homelessness in the UK is unacceptable.
- Continue to involve and **develop services with the general public**, for instance versions of Homeshare.
- As a result of engaging with homeless people, use the resulting trust established with service users to help statutory organisations deliver services.
- Raise **awareness and knowledge** about homelessness with an emphasis on the ways the general public could contribute to ending homelessness.
- Explore with the general public how people who are **homeless or at risk of homelessness could contribute to addressing key local challenges**; for instance, helping meet lower level care needs via Homeshare and Social Prescriptions (helping also to reduce burdens on local public services).

## 10.2 Multi-component services and integration

Many people who require support have **complex needs**, which change over time and are often **require responses at multiple points**; hence the importance of **sustained integrated responses** incorporating a range of flexible time-critical services of all kinds (universal, indicated and selective):

- **Universal services** are those available to everyone; these would include information, guidance and advice for all of the participants in the sector, not just people in need of support.
- **Indicated services** are those targeted at particular groups, for instance those in transient accommodation.
- **Selective services** are those targeted at individuals, for instance person-centred sustained services using case workers.

The review suggests that suites of services should be brought together in **holistic multi-disciplinary integrated service offers**. In this way, people with complex and changing needs are more likely to be provided with services that they need at the time they need them. While evidence suggests that there are core features associated with successful services, the review also shows that **local context is important**, and that plans need the room to be **person-centred and realistic**.

## 10.3 Coproduction

Involving and engaging people with lived experience of homelessness and the wider community in intervention and service design would enable the services to:

- **Involve and engage people with lived experience of homelessness** and the wider community in service design.
- Access and engage **harder to reach groups**.
- **Map and understand and keep abreast of developments** in the multiple access points and opportunities that present across services and communities to intervene to end homelessness (not just via housing and homelessness services).
- **Better mobilise opinion and lead the debate** - coproducing the answers in the widest community-centred way possible – the third pillar of Crisis's plan is to build consensus, and in consensus there lies the promise of permanent solutions.
- Emphasise and account for the **importance of personal relationships** in providing successful services. Relationships between the public and those with lived experience of homelessness, between case worker and client and between landlord/home owner and people needing housing. **Relationships are key** to delivering person-centred, asset-based responses, they are key to ensuring that the changing needs of individuals and ever changing local contexts are taken into consideration and appropriate responses put in place.

## 10.4 Monitoring, evaluation and sharing learning

Building on the wealth of reviews and existing material, we **think an ongoing systematic review** of what is working (and what is not) to end homelessness is needed. In terms of health and social care, we are in a time of **transformational change** and challenge, to reflect this context **a virtuous and ongoing cycle of learning and evidence is needed**. Such a developing evidence base would contribute to the development of the knowledge base for the New Centre for Homelessness Impact being set up by Crisis and Glasgow Homelessness Network<sup>19</sup>.

As a sector, we need to think carefully about what we consider to be the **gold standard in evaluation** – and about how design and conduct research, grade learning and share evidence. Key challenges for researchers and those who rely on the evidence research and evaluation provides are how to:

- **Provide a high quality of evidence, while at the same time being realistic in terms of resources and sector needs in terms of information.** As a sector, we need to think carefully what we consider to be the gold standard in evaluation – the Randomised Controlled Trial. When and in what circumstances do Randomised Controlled Trials provide value in testing what works to end homelessness? In what circumstances are Randomised Controlled Trials ethically acceptable and realistic? If Randomised Controlled Trials are not possible, what alternatives could we help the sector develop?
- **Better define and also redefine ‘quality’ in evaluation and for what purpose** (i.e. audience clarity, contributing to the evidence agenda)? At present, many if not all quality frameworks at a mid-point require publication in a refereed journal; this means that much of the work reported, is graded as low or poor quality and is therefore less likely to contribute to informing service development or improvement.
- **Keep pace with change and innovation.** In a transformative social care environment, addressing complex and often fast-paced challenges such as homelessness, requires evaluation designs and methods that are equally responsive, and often attuned to specific local contexts and key questions.
- **Identify and meet the needs of harder to reach groups.** A key gap for the evidence agenda is being able to explore granularity of needs and what works for various groups of people (i.e. BAME, people experiencing transient homelessness).
- **Develop a suite of homelessness-related outcome measures and study designs.** Developing and securing stakeholder buy in for such a resource would make it possible for the sector to develop more coherent and reliable body of evidence.
- **Work together to design and conduct longer-term studies.** A key aspect of longer-term impact evaluations is access to robust and consistent monitoring data. The sector needs to work together to better facilitate access to data and tracking of outcomes for individuals.
- **Develop robust and realistic economic and cost-benefit models.** Linked to developing a suite of outcome measures and access to data is the challenge of

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<sup>19</sup> For further information see <https://www.homelessnessimpact.org/>.

creating robust and accessible economic modelling. Models are needed for the varied forms of homelessness and types of services. There is a pressing need to develop:

- **shared language and understanding** around what is needed and the various types of economic assessment (i.e. value for money, cost benefit, opportunity costs).
- **consistency** in relation to what are accepted as acceptable measures of potential benefits/opportunity costs of interventions (i.e., reduced criminal justice-related costs, such as custodial costs, reduced emergency shelter costs, reduced health costs, such as hospitalisations). Clarity of purpose and how to appropriately apply economic assessment.
- reliable and long-term **accessible data sources**.
- **Better share learning and turn and translate evidence into policy, practice and action.** How researchers and the sector share and communicate learning is a key challenge. This challenge could be in part addressed by:
  - **Supporting the development of 'local' evidence agendas.** This could be achieved by supporting local services to conduct and be able to sustain their own monitoring and evaluation.
  - **Coproducing every aspect of learning with all participants.** This would help to test assumptions, respond to local specifics and ensure research objectives/questions fit with what people locally really need to know to meet need, develop services and drive improvement.
  - **Taking a theory of change approach.** Qualitative formative and process research is vital to making and explaining links between service provision, impacts and outcomes. Hence, when evaluating a service, mixed method evaluations are desirable in almost every circumstance.
  - **Differentiating between what is generalisable and what is specific to a local context.** Whether conducting a national or local evaluation, being able to differentiate transferable learning from that which is context specific is important. It is often the case that qualitative formative and process research that helps such differentiation. We also need to question the general importance placed on transferability and wider 'roll-out' of services and models; local research, focused on supporting local development and improvement is a valid approach and, given resources and local evidence needs, may often be the most appropriate and realistic approach.

## 10.5 Final thoughts

In his recent report for Crisis<sup>20</sup>, Professor Glen Bramley surmises that the most acute forms of homelessness are likely to keep rising, and that a 60 per cent increase in the provision of new housing could reduce levels of homelessness by 19 per cent by 2036, while increased prevention work could reduce levels by 34 per cent in the same period.

This review shows that there is potentially a wealth of evidence about what works in services to end homelessness, but the evidence base is as varied in terms of quality as

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<sup>20</sup> Homelessness projections: Core homelessness in Great Britain (August, 2017), Crisis.

it is vast in scope. The challenge is to coordinate and develop a more coherent approach to generating reliable evidence about what works in preventing homelessness and to making that evidence more accessible to those who need it. Crisis and Glasgow Homelessness Network's Centre for Homelessness Impact<sup>21</sup> will be well-placed to take the lead in this respect.

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<sup>21</sup> See <https://www.homelessnessimpact.org/> for more information

# Appendix 1. Review protocol and descriptive statistics

## A1.1 Review protocol

This is the final version of the second output of the Rapid Evidence Assessment (REA) and presents the Stage 1 review protocol. The review protocol is the backbone of Stage 2: Review and Analysis and our protocol incorporates feedback received from the REA Advisory Group (AG). The protocol includes the following sections covering:

- Review themes and questions.
- Search criteria.
- Screening criteria.

## Review themes and questions

We have formulated our review themes and questions to reflect AG feedback and to more closely fit with the five **Crisis definitions** for ending homelessness.

### **Theme 1: People rough sleeping**

- Which services are effective at addressing, reducing or preventing people from sleeping rough?
- What is the quality of evidence about the effectiveness (including cost effectiveness) of what works in addressing, reducing or preventing rough sleeping?
- What are the core features of effective approaches to addressing, reducing or preventing rough sleeping?
- What are the key barriers to addressing, reducing or preventing rough sleeping?
- What approaches to evaluation have been used to evidence the success of services which address, reduce or prevent rough sleeping?

### **Theme 2: People living in transient or dangerous accommodation**

- Which services are effective at addressing, reducing or preventing people from being forced to live in transient or dangerous accommodation?
- What is the quality of evidence about the effectiveness (including cost effectiveness) of what works in addressing, reducing or preventing people from being forced to live in transient or dangerous accommodation?
- What are the core features of effective approaches to addressing, reducing or preventing people from being forced to live in transient or dangerous accommodation?
- What are the key barriers to addressing, reducing or preventing people from being forced to live in transient or dangerous accommodation?
- What approaches to evaluation have been used to evidence the success of services which address people being forced to live in transient or dangerous accommodation?



### **Theme 3: People living in emergency accommodation**

- Which services are effective at addressing, reducing or preventing people having to live in emergency accommodation?
- What is the quality of evidence about the effectiveness (including cost effectiveness) of what works in addressing, reducing or preventing people having to live in emergency accommodation?
- What are the core features of effective approaches to addressing, reducing or preventing people having to live in emergency accommodation?
- Similarly, what are the key barriers to addressing, reducing or preventing people having to live in emergency accommodation?
- What approaches to evaluation have been used to evidence the success of services aimed at preventing people from having to live in emergency accommodation?

### **Theme 4: People leaving state institutions such as a prison or the care system**

- Which services are effective at addressing, reducing or preventing people from becoming homeless after leaving state institutions?
- What is the quality of evidence about the effectiveness (including cost effectiveness) of what works in addressing, reducing or preventing from becoming homeless after leaving state institutions?
- What are the core features of effective approaches to addressing, reducing or preventing people from becoming homeless after leaving state institutions?
- Similarly, what are the key barriers to addressing, reducing or preventing people from becoming homeless after leaving state institutions?
- What approaches to evaluation have been used to evidence the success of services aimed at preventing people from becoming homeless after leaving state institutions?

### **Theme 5: People at immediate risk of homelessness**

- Which services are effective at supporting people at immediate risk of homelessness and ensuring they get the help that they need to prevent homelessness happening?
- What is the quality of evidence about the effectiveness (including cost effectiveness) of what works supporting people at immediate risk of homelessness and ensuring they get the help that they need to prevent homelessness happening?
- What are the core features of effective approaches to supporting people at immediate risk of homelessness and ensuring they get the help that they need to prevent homelessness happening?
- Similarly, what are the key barriers to supporting people at immediate risk of homelessness and ensuring they get the help that they need to prevent homelessness happening?
- What approaches to evaluation have been used to evidence the success of services aimed at supporting people at immediate risk of homelessness?

### **Theme 6: Gaps and opportunities**

- To what extent does the current evidence base, provide learning across Themes 1 to 5?
- In relation to Themes 1 to 5, what gaps exist in evidence about what works to end homelessness?

- How might gaps in evidence be best addressed?
- What opportunities exist to build 'homelessness' measures into studies that are not necessarily focused on homelessness as a key objective and that do not currently include related measures in their frameworks?

## Search criteria

We based our search criteria on the questions above, along with comments from the advisory group, we used the following sources and search terms:

### Sources

Six databases and research organisations listed below.

#### Databases:

- ASSIA
- Social Policy and Practice (Ovid)
- Social Services Abstracts
- Sociology Abstracts(ProQuest)
- SocINDEX (EBSCO)
- **HUD USER Bibliographic Database** (USA housing & homeless database)

#### Organisations

We identified a cross section of organisations which contained research publications on homelessness and searched within these for relevance to the questions. The list is not exhaustive and was complemented by additional search engine searches:

### Sources

AHURI, Albert Kennedy Trust, APPGEH for ending homelessness, Barnardo's, Building and Social Housing Foundation, Centre for Housing Policy (University of York), Centre for Social Justice, Clore Social, Crisis, European Observatory on Homelessness (operates under FEANTSA), Evaluation Support Scotland, Firststop, Glasgow Homelessness Network, GOV.Scot, GOV.UK, GOV.Wales, Homeless Hub, Homeless Link (National Homeless Alliance), Housing First England, Housing learning and improvement network, Institute of race relations, Joseph Rowntree Foundation, LGBT Foundation, Local Government Association, MEAM, Nacro, National Coordinating Centre for Public Engagement, National Homelessness advice service, Nesta, Pathway, Project Oracle, Research in Practice, Revolving Doors, The Big Issue, Shelter (regions), Social Services Knowledge Scotland (SSKS), St Basil's, St Mungo's, Thames Reach, The foyer federation, The homeless hub (Canadian), What Works Scotland, University of York.

### Terms

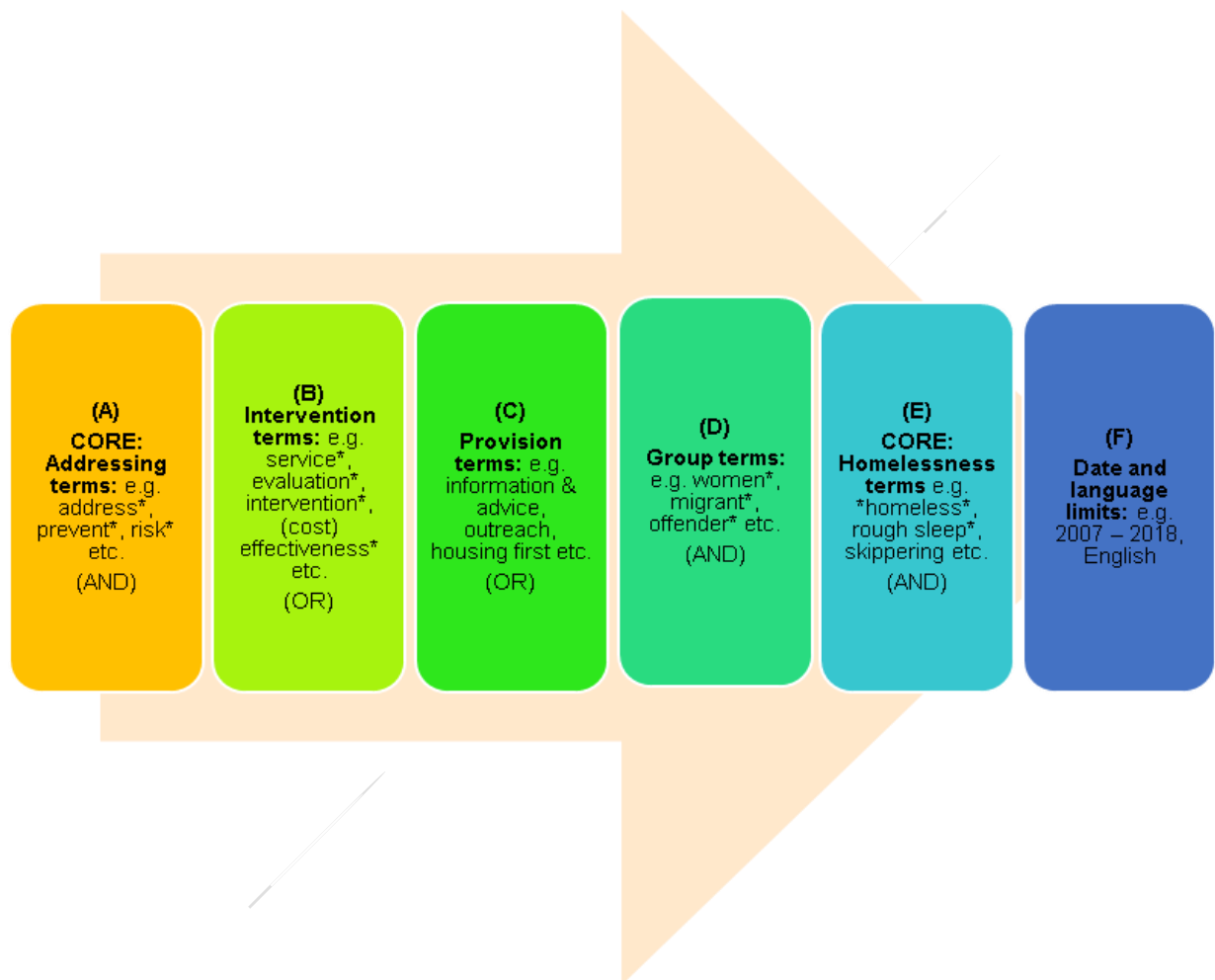
Due to the multi-faceted nature of homelessness and the services related to addressing or preventing the root causes of homelessness, we have designed a search that seeks to obtain results related to the protocol questions along with the inclusion criteria. We

incorporated the suggestions from the advisory group in relation to scope and revised the terms used.

Due to the rapid nature of the evidence review process we looked to control the number of studies included and we therefore undertook an iterative approach in the searching and the screening. Searches were formulated into groupings, see figure one.

See Figure 1 on the next page for the overall search approach.

**Figure 1: Overall search approach**



### Complementary searches

We also complemented the grouped searches above with smaller searches surrounding how homelessness is experienced and terms that do not or might not be described as 'homelessness' e.g. sofa or couch surfing. Examples are provided below:

**Single terms:** (Other terms for homelessness): "No fixed abode", Roofless\*, Sofa / couch surfing, hostel, refugee, "rapid rehousing", "trauma informed care", "floating

support”, reconnection, “staircase model”, “no second night out”, “no first night out”, “link worker model” etc.

### Proximity searches

**Example 1:** ((dangerous or emergency or temporary or insecure or overcrowded or unsuitable or unsafe or unfit or night or day or walk-in or crisis or alternative or interim or inadequate\* or substandard or intermittent\* or transient or marginal\* or problem\* or short-term or \*secure or drop-in or foyer or YMCA) adj1 (accommodation or hous\* or homeless\* or \*shelter\* or refuge\* or hostel\* or lodging\* or centre\*)).

**Example 2:** ((structural or systemic or upstream) adj (prevent\*) adj homeless\*) etc. A bespoke search was created for each database platform considering the design of each system using a variety of terms in a number of groupings. We searched within each database within the title and abstracts of studies according to the source. We also searched within Google and Google Scholar using the terms above to make sure that we identify relevant research and evaluations that are not likely to be indexed in the other research databases.

### Screening criteria

The following criteria was used to screen all records, within two stages:

- **Stage one:** based on screening the title and abstract of each record.
- **Stage two:** based on the full-text of each record.

We used EPPI reviewer 4, our reference management system, to manage the references obtained from searching. In both screening stages we worked sequentially through the following inclusion and exclusion criteria to ensure the most relevant study types with the required outcomes are selected for final inclusion. Those that are excluded at each stage will be marked for recording in a process diagram and will be identifiable if later revision is necessary.

**Table A1 Inclusion and exclusion criteria**

Inclusion & exclusion code	Reason & limits
Exclude Date	<p><b>Exclude:</b> Pre-2007</p> <p><b>Include:</b> 2007 - current</p>
Exclude Publication type	<p><b>Exclude:</b> Books, newspaper or magazine or blog or online articles, conference abstracts or proceedings, dissertation or thesis, factsheets</p> <p><b>Include:</b> All other publication types, including conference papers</p>
Exclude Scope (Homelessness)	<p><b>Exclude:</b> Studies that are not primarily about homelessness interventions, approaches or services that prevent, reduce, end, exit or tackle homelessness</p> <p><b>Include:</b> Studies about an intervention, approach or service related to preventing, reducing, ending, exiting or tackling homelessness</p>
Exclude Language	<p><b>Exclude:</b> Non-English Language</p> <p><b>Include:</b> English Language</p>
Exclude Location	<p><b>Exclude:</b> All other countries than stated in include below</p> <p><b>Include:</b> UK, EU, USA, Canada, Australia, New Zealand, Northern Ireland</p>
Exclude Outcome	<p><b>Exclude:</b> Study design does not focus on outcomes, effectiveness, impact, benefits, cost or evaluation of approach</p> <p><b>Include:</b> Studies with at least one housing focused outcome and studies that focus on outcomes, effectiveness, impact, benefits, cost or evaluation of approach</p>
Exclude age	<p><b>Exclude:</b> Children under the age of 16</p> <p><b>Include:</b> All adults over 16 years of age</p>
Include	<p><b>Include:</b> all studies not excluded by codes above for full-text retrieval or in second stage of screening include for data coding and extraction</p>

## Coding and data extraction

Once a study was included in the first screening stage we undertook a second screen based on its full-text against the same criteria. Those studies included at this full-text stage, were then coded for relevance using the criteria below in Table 2 and for quality as per Tables 3 – 5.

**Table A2 Coding of included studies on full-text Inclusion**

Full Text - Coding of Report Descriptors	
Date published	<ul style="list-style-type: none"> <li>• 2007-2010</li> <li>• 2011-2014</li> <li>• 2015-2017</li> </ul>
Publication type	<ul style="list-style-type: none"> <li>• Evaluation</li> <li>• Cost effectiveness/economic</li> <li>• Systematic review of evidence</li> <li>• Literature review</li> <li>• Randomised control trial</li> <li>• Cluster randomised control trial</li> <li>• Controlled trial</li> <li>• Survey</li> <li>• Qualitative studies</li> <li>• Studies with quantitative outcomes</li> <li>• Prevalence study</li> <li>• Review of strategy</li> <li>• Cohort study</li> <li>• Case study</li> <li>• Guidance</li> <li>• Best practice</li> <li>• Other</li> </ul>
Sector background of published document	<ul style="list-style-type: none"> <li>• Academic</li> <li>• Public body</li> <li>• Government department</li> <li>• Think Tank</li> <li>• Research Centre</li> <li>• Charity</li> <li>• Other</li> </ul>
Location	<ul style="list-style-type: none"> <li>• England</li> <li>• Wales</li> <li>• Scotland</li> <li>• Northern Ireland</li> <li>• Europe</li> <li>• USA</li> <li>• Canada</li> <li>• New Zealand</li> <li>• Australia</li> </ul>

Type of homelessness <sup>22</sup>	<ul style="list-style-type: none"> <li>• Rough sleepers</li> <li>• Transient or dangerous housing (living in cars, non- residential buildings, sofa surfing, squatting,</li> <li>• Emergency accommodation (night shelters, hostels, bed and breakfasts)</li> <li>• Acute at risk (eviction, threat of violence, prisoners due to be released, care leavers etc. time limit of within 56 days)</li> <li>• Substandard housing (unfit, insecure overcrowded)</li> <li>• Statutory homelessness</li> <li>• Not specified</li> </ul>
Type of intervention or service	<p>Prevention<sup>23</sup></p> <ul style="list-style-type: none"> <li>• Structural prevention (legislation, policy, housing supply)</li> <li>• Local authority support services</li> <li>• Welfare rights and consumer advice</li> <li>• Holistic in tenancy support</li> <li>• Targeted support and advocacy for people leaving institutions (care leavers, hospitals discharges, prison discharges etc.)</li> <li>• Critical time intervention (includes family mediation, emergency funding, risk of eviction, domestic violence risk of homelessness)</li> <li>• Other</li> </ul> <p>Intervention</p> <ul style="list-style-type: none"> <li>• Implementation of Housing First</li> <li>• Supporting people</li> <li>• Case management services</li> <li>• Multi-agency collaboration</li> <li>• Permanent /supportive housing programmes</li> <li>• Psychologically informed environments</li> <li>• Ongoing tenancy sustainment and support services</li> <li>• Rapid rehousing/Temporary accommodation</li> <li>• Trauma Informed Care</li> <li>• Floating support</li> <li>• Reconnection</li> <li>• Staircase model</li> </ul>

<sup>22</sup> Adapted from *CRISIS 5 definitions of ending homelessness*.

<sup>23</sup> Adapted from *Preventing homelessness to improve health and wellbeing: Putting the evidence into practice*. Public Health England, Homeless Link and from <http://homelesshub.ca/solutions/prevention>.

	<ul style="list-style-type: none"> <li>• No Second Night Out/ No First Night Out</li> <li>• Personal budgets</li> <li>• Link worker model</li> <li>•</li> </ul>
Groups targeted	<p>Young People</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Young Adults</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Veterans or ex-army or ex-military</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>(re) or (ex) Offenders</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Families/lone parents</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Single people</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Older people</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p><b>Women</b></p> <ul style="list-style-type: none"> <li>• Homeless</li> </ul> <p><b>At risk of homelessness</b></p> <p><b>Transition:</b></p> <p>Prison leavers</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Care Leavers</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Hospital discharges</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Asylum seekers/refugees</p>



	<ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p><b>Needs &amp; Conditions:</b></p> <p>Complex Needs/multiple needs</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Chronic illness (HIV)</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p><b>Minority Groups:</b></p> <p><b>Sexual orientation and gender status</b></p> <p>LGBT</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>LGB</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Transgender</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p><b>Ethnicity</b></p> <p>Black Caribbean/African/Other</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Chinese</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Indian/Pakistani/Bangladeshi/Other Asian</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Mixed</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Other (state)</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p><b>Resident status:</b></p>
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	<p>Asylum seeker</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Refugee</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Migrant</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p><b>Gender:</b></p> <p>Female</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Male</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p><b>Disability:</b></p> <p>Physical</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul> <p>Mental</p> <ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of homelessness</li> </ul>
<b>Full text extraction for review and analysis: Study design and aims</b>	
<p>Aims and objectives of study:</p> <p>Aims and objectives of intervention(s)/approach(es) to tackle homelessness</p>	<ul style="list-style-type: none"> <li>• Research questions/hypotheses posed</li> </ul>
<p>Methodology</p>	<ul style="list-style-type: none"> <li>• Research questions/hypotheses posed;</li> <li>• Research design;</li> <li>• Sampling strategy</li> <li>• Nature and quality of the fieldwork;</li> <li>• Process of analysis; and</li> <li>• Nature and robustness of findings</li> </ul>
<p>Participants/sample</p>	<ul style="list-style-type: none"> <li>• Groups targeted</li> <li>• Number</li> </ul>

	<ul style="list-style-type: none"> <li>• Gender</li> <li>• Age range</li> <li>• Ethnicity</li> <li>• Number of sites</li> </ul>
Type(s) of homelessness	<ul style="list-style-type: none"> <li>• Rough sleepers</li> <li>• Transient or dangerous housing (living in cars, non- residential buildings, sofa surfing, squatting,</li> <li>• Emergency accommodation (night shelters, hostels, bed and breakfasts)</li> <li>• Acute at risk (eviction, threat of violence, prisoners due to be released, care leavers etc. time limit of within 56 days)</li> <li>• Substandard housing (unfit, insecure overcrowded)</li> <li>• Statutory homelessness</li> <li>• Not specified</li> </ul>
Description of approach(es)/interventions:	<ul style="list-style-type: none"> <li>• Services provided</li> <li>• Support provided</li> <li>• Partners involved</li> <li>• Key ingredients</li> <li>• Key methods</li> <li>• Details of delivery</li> </ul>
<b>Full text extraction for review and analysis - Research questions</b>	
Effectiveness of programme/intervention	<ul style="list-style-type: none"> <li>• Evidence of effectiveness</li> <li>• Indicators and outcomes reported</li> <li>• Reliability of findings</li> <li>• Generalizability of findings</li> <li>• Limitations of findings</li> </ul>
Core features/facilitators of effectiveness of approach	<p>For examples:</p> <ul style="list-style-type: none"> <li>• Leadership,</li> <li>• Cost-effectiveness,</li> <li>• Affordable housing</li> <li>• Multi-agency working,</li> <li>• Person-centred approaches</li> <li>• Responsiveness of local authorities</li> </ul>
Barriers to effectiveness of approach	<ul style="list-style-type: none"> <li>• Navigating and accessing help</li> <li>• Affordable housing</li> <li>• Working across sectors</li> <li>• Cost effectiveness of approaches</li> <li>• Mental illness, substance abuse, domestic violence</li> </ul>

	<ul style="list-style-type: none"> <li>• Economic security</li> <li>• Political will/investment</li> </ul>
Quality assessment	<ul style="list-style-type: none"> <li>• Approach to evaluation of programme/intervention</li> <li>• Indicators and outcomes tracked (e.g. housing status, health outcomes, employment, cost effectiveness)</li> <li>• Complete the quality standards checklist for the appropriate study design (see tables 3 to 5).</li> </ul> <p>Low, medium or high quality based on standards outlined below:</p> <p>Quantitative studies quality standards contain 20 items</p> <ul style="list-style-type: none"> <li>• Mostly YES (16-20) HIGH, + at least 1 yes in each of the 6 categories)</li> <li>• Some YES (8-15) MEDIUM</li> <li>• Few YES (1-7) LOW</li> </ul> <p>Qualitative studies quality standards include 14 items</p> <ul style="list-style-type: none"> <li>• Mostly Yes: 10-14 HIGH + at least one yes in each category</li> <li>• Some Yes: 5-9 Medium</li> <li>• Few Yes 1-5 Low</li> </ul> <p>Systematic/literature reviews' quality standards include 8 items.</p> <ul style="list-style-type: none"> <li>• Mostly Yes: 6-8 HIGH + at least in each category</li> <li>• Some Yes: 4-6 Medium</li> <li>• Few Yes 1-3 Low</li> </ul>
<b>Additional information</b>	
Research gaps identified	<ul style="list-style-type: none"> <li>• Complete if any identified</li> </ul>
Key conclusions of study	

References to obtain	<ul style="list-style-type: none"> <li>Reference harvest from key studies, e.g. systematic review</li> </ul>
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**Table A3 Checklist of quality standards for quantitative studies<sup>24</sup>**

Study design	<ul style="list-style-type: none"> <li>Is the study design appropriate to answer the research question?</li> <li>How likely is it that outcomes are a result of alternative or independent variables/approaches rather than study design?</li> <li>Any bias in allocation process in experimental study? Look at randomization, control group.</li> </ul>
Sampling and selection bias	<ul style="list-style-type: none"> <li>If representative sampling was used, was the sampling frame (selection of participants) representative of the population being studied?</li> <li>Did all eligible participants have an equal chance of being recruited to the study?</li> <li>If purposive sampling was used, is the rationale for this clear?</li> <li>Were enough participants recruited to answer the study question robustly?</li> </ul>
Data collection methods	<ul style="list-style-type: none"> <li>Are variables, outcomes, indicators described clearly?</li> <li>Do the variables, outcomes, indicators measured make sense in light of research question?</li> <li>Have variables, outcomes, indicators either been previously used in research or are improvement over previous measures?</li> <li>Were data collected by persons independent of the service or intervention delivery?</li> </ul>
Withdrawals and dropouts	<ul style="list-style-type: none"> <li>Were all people recruited into the study present at the end of the study?</li> <li>Is an account given of people who discontinued participation and their reasons?</li> </ul>
Approach/intervention integrity	<ul style="list-style-type: none"> <li>Was the consistency of the approach/intervention across participants/sites measured?</li> <li>Is it likely that any participants received an unintended intervention?</li> </ul>

<sup>24</sup> Adapted from *Effective Public Health Project, SCIE Systematic Search Review: Guidelines (2<sup>nd</sup> edition)* and *Assessing Research Quality - Research Connections, Child Care and Early Education*.

Data analyses	<ul style="list-style-type: none"> <li>• Have authors reported on all variables/outcomes defined at the outset of the study?</li> <li>• Are enough data presented for results to be valid (on all variables: dependent/independent/outcomes)?</li> <li>• Are enough data presented for results to be useful (on all variables: dependent/independent/outcomes)?</li> <li>• Are the number of cases with missing data specified? Is the statistical procedure(s) for handling missing data described?</li> <li>• Are the statistical methods/tools chosen explained and appropriate?</li> </ul>
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**Table A4 Checklist of quality standards for qualitative studies<sup>25</sup>**

Study design	<ul style="list-style-type: none"> <li>• Has the researcher justified the research design in light of aims and research questions?</li> <li>• Is there a discussion of limitations of research design and the implications for the study evidence?</li> </ul>
Sampling and recruitment	<ul style="list-style-type: none"> <li>• Has the researcher has explained how the participants were recruited or what sampling method was used (random probability, stratified, purposive, convenience etc)</li> <li>• Is there a detailed profile of achieved sample?</li> <li>• Was the research explained to participants in sufficient detail and was consent to participate obtained from study participants?</li> <li>• Is there any discussion of any missing coverage in achieved samples/cases and implications for study evidence?</li> <li>• Is there documentation of reasons for non-participation among sample approached</li> </ul>
Data collection	<ul style="list-style-type: none"> <li>• Consider if it is clear how data was collected and dates of collection (focus group, survey, interview)</li> <li>• Discussion of who conducted data collection, if setting for data collection was justified</li> <li>• Discussion of procedures/documents used for collection/recording – (e.g. topic guides, interview guides, audio/video recording, notes)</li> </ul>

<sup>25</sup> Adapted from *Effective Public Health Project, SCIE Systematic Search Review: Guidelines (2<sup>nd</sup> edition)* and *Assessing Research Quality - Research Connections, Child Care and Early Education*.

	<ul style="list-style-type: none"> <li>• If methods were modified during the study, has the researcher explained how and why?</li> </ul>
Data analysis and reporting	<ul style="list-style-type: none"> <li>• Have authors reported on all variables/outcomes defined at the outset of the study?</li> <li>• Consider if there is an in-depth description of the analysis process and if thematic analysis is used, is it clear how the categories/themes were derived from the data?</li> <li>• Is there enough depth, detail, diversity of perspective to give confidence in findings?</li> <li>• Is there a discussion of generalizability of the findings to wider population and/or context?</li> </ul>

**Table A5 Checklist of quality standards for systematic reviews/rapid reviews of evidence<sup>26</sup>**

Review design	<ul style="list-style-type: none"> <li>• Did the review address a clearly focused research question?</li> <li>• Were clear inclusion/exclusion criteria established?</li> </ul>
Literature searches	<ul style="list-style-type: none"> <li>• Was a comprehensive literature search performed? Consider: <ul style="list-style-type: none"> <li>○ Key words and search strategy provided</li> <li>○ Sufficient databases searches</li> <li>○ Follow up from reference lists</li> <li>○ Consultation with experts</li> <li>○ Unpublished studies or grey literature searched</li> </ul> </li> </ul>
Studies	<ul style="list-style-type: none"> <li>• Was a list of included and excluded studies provided?</li> <li>• Were the characteristics of the included studies provided?</li> <li>• Was the quality of the included studies assessed and documented?</li> </ul>
Findings and conclusions	<ul style="list-style-type: none"> <li>• Were the results of the review combined and if so was it reasonable to do so? (homogeneity and/or heterogeneity of studies)</li> <li>• Was the quality of the included studies used appropriately in formulating conclusions?</li> </ul>

<sup>26</sup> Adapted from AMSTAR and *Systematic Review Appraisal Tool*, Critical Appraisal Skills Programme.

## A1.2 Review descriptive statistics

**Table A6 Number of studies by date**

Date period	Count
Prior 2007	1
2007-2010	5
2011-2014	13
2015-2017	16
Total	<b>35</b>

**Table A7 Number of studies by location**

Location	Count
UK	13
Europe	4
USA	15
Canada	2
Australia	1
Total	<b>35</b>

Table A6 shows the number of studies selected prior to 2007 and in three-year increments thereafter. One study was selected prior to 2007 as the result of AG advice. Table A7 shows country of publication.

**Table A8 Number of studies by theme**

Theme	Included studies
Theme 1 Rough Sleeping	12
Theme 2 Transient accommodation	6
Theme 3 Emergency accommodation	13
Theme 4 People leaving state institutions	8
Theme 5 People at risk of homelessness	11

Table A8 shows the number of studies that were coded to each of Crisis five themes for ending homelessness. Note that studies were coded to multiple themes.

**Table A9 Number of studies by type of service**

Type of service	Included studies
Preventative	4
Rapid Response	15
Sustained support for those with complex needs	18

*Note: studies two studies were coded to more than one theme*



**Table A10 Number of studies by study design and quality**

Study type	Total counts	High quality	Medium quality	Low quality
Systematic Review	4	4	0	0
Randomised Controlled Trial	5	4	1	0
Non Randomised controlled trial	1	1	0	0
Comparison evaluation	5	3	2	0
Literature review (not systematic)	1	1	0	0
Studies with quantitative outcomes	1	0	1	0
Cost effectiveness/ economic	2	0	0	2
Evaluation	16	8	6	2
<b>Totals</b>	<b>35</b>	<b>21</b>	<b>10</b>	<b>4</b>

Table A10 provides the total number of studies selected by study type and a breakdown of quality assessment of studies selected.

**Table A11 Number of studies by population groups and housing circumstances**

Target group	Homeless	At risk
Families	6	2
Young people	3	1
Young adults	3	1
Offenders	4	1
Chronic illness	4	2
Single people	3	0
Veterans	2	2
Multiple conditions or complex needs	15	1
Mental health illness	15	1
Prison leavers	3	1
Care leavers	1	2
Hospital discharges	3	1
Domestic abuse	1	2

*Note: studies may have been coded to more than one theme.*

**Table A12 Descriptive summary table by crisis themes**

<b>Descriptive labels</b>	<b>Rough Sleeping</b>	<b>Transient accommodation</b>	<b>Emergency accommodation</b>	<b>People leaving state institutions</b>	<b>People at risk of homelessness</b>
<b>Study design</b>					
Systematic Review	0	0	2	1	3
Randomised Controlled Trials	1	0	3	1	1
Non RCTs	1	1	1	0	0
Comparison evaluation	2	0	2	3	0
Literature review other	1	1	1	0	0
Quantitative outcomes	0	0	0	0	1
Cost effectiveness	2	2	2	2	0
Evaluation	5	2	2	1	6
<b>Type of service</b>					
Preventative	1	1	1	0	3
Rapid Response	4	1	4	3	4
Sustained support	7	4	8	5	6
<b>Target groups</b>					
Families	0	0	3	0	4
Young people	1	1	1	1	2
Young adults	2	1	2	1	1
Offenders	0	0	0	1	2
Chronic illness	0	1	1	0	2
Single people	1	0	0	0	2
Veterans	0	0	0	1	2
Multiple/ complex needs	5	1	4	5	3
Mental health illness	5	2	1	6	4
Prison leavers	2	0	1	3	1
Care leavers	1	0	1	1	0
Hospital discharges	1	0	1	3	0
Domestic abuse	0	0	0	0	2

*Note: studies may have been coded to more than one theme.*

## Appendix 2. Crisis's measures of homelessness summaries

Appendix 2 presents analysis for each of Crisis's five measures for ending homelessness. See Appendix 1, Tables A8 and A12 for study descriptives.

### A2.1 Rough sleeping

#### Overview of studies

The review included studies which provided findings relevant to the people sleeping rough theme.

#### Effectiveness of services

Analysis of studies that were relevant to people sleeping rough showed that the following services had been effective:

- Multi-agency working, for instance The Rough Sleepers Initiative (Fitzpatrick et al, 2005).
- Multi-component services, for instance Daybreak (Ohio Housing Agency, 2016), provided transitional housing, case management and a rental subsidy.
- Social Impact Bonds; for instance, London Homelessness Bond (Department for Communities and Local Government<sup>27</sup>, 2017)
- Person-centred services, for instance, London Homelessness Bond (Department for Communities and Local Government, 2017).
- Sustained support, for instance, Housing First models intervening with a range of subgroups (Aubry et al, 2015; Stergiopoluos et al, 2015; Collins et al, 2013).
- Intensive case management (Clark et al, 2016).
- Rapid response programmes, for instance No Second Night Out (Hough and Jones, 2011) and **Individual Budgets** (Brown, 2013).

#### Enablers and barriers to the effectiveness of services

Key enablers that facilitated the effectiveness of services included:

- Fidelity to the Housing First model whilst being adaptable to target group and context (Aubry et al, 2015; Stergiopoluos et al, 2015; Collins et al, 2013).
- Customised longer term transitional housing programmes such as the Daybreak programme (Ohio Housing Agency, 2016).
- One -on-one support from a key worker/case manager (Brown, 2013).
- Multi-agency working and partnership (Fitzpatrick et al, 2005; Brown, 2013; Hough and Jones, 2011).

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<sup>27</sup> The Department for Communities and Local Government is now the Ministry for Housing, Communities and Local Government which, supported by 12 agencies and public bodies, aims to create great places to live and work, and to give more power to local people to shape what happens in their area.

Key barriers to the effectiveness of services:

- Participants with complex needs were more difficult to engage (Aubry et al, 2015; Fitzpatrick, et al. 2005; Ohio Housing Agency, 2016).
- A lack of effective and responsive multi-agency working was a challenge (Brown, 2013; Fitzpatrick et al, 2005).
- A lack of access to affordable and appropriate housing, both temporary and permanent and in the private rented sector (Fitzpatrick et al, 2005; Hough and Jones, 2011).

### **Quality of evidence and approaches to evaluations**

The quality of the evidence reviewed was primarily high with only two studies assessed as having medium quality. The key study limitations identified were generalisability of findings to wider groups due to the services being targeted at specific groups in specific contexts, and a lack of tracking longer - term outcomes and therefore authors had not been able to assess sustainability of outcomes. Some methodological limitations were also identified relating to the accuracy of data collected and recorded in programme databases. Evaluation methods used included:

- Experimental methods such as Randomised Controlled Trials for evaluation (Aubry et al, 2015; Stergiopoulos et al, 2015).
- Mixed method evaluations (Hough and Jones, 2011; Brown, 2013; Ohio Housing Agency, 2016, and these tended to lean heavily on qualitative data.
- Evaluations included some combination of interviews and focus groups with national and/or local level stakeholders, service providers and project staff as well as either interviews or surveys with participants at regular intervals (Hough and Jones, 2011; Brown 2013).
- Secondary data (Department for Communities and Local Government<sup>28</sup>, 2017).

### **Outcome measures**

Loosely defined outcome measures:

- Completion of a programme (Ohio Housing Agency, 2016).
- Stability of accommodation (Brown, 2013).
- Accommodation outcomes (Hough and Jones, 2011).

Number/percentage of days stably/continuously housed

- Time spent in stable housing (Aubry et al, 2015).
- Number of days continuously housed after service intervention (Collins et al, 2013).
- Housing stability (Stergiopoulos et al, 2015).

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<sup>28</sup> The Department for Communities and Local Government is now the Ministry for Housing, Communities and Local Government which, supported by 12 agencies and public bodies, aims to create great places to live and work, and to give more power to local people to shape what happens in their area.

Number/percentage of days of homelessness:

- Comparison of time homeless and time housed (Clark et al, 2016).

## A2.2 Transient accommodation

### Overview of studies

The review included studies which provided findings relevant to the people in transient accommodation. All studies overlapped with other themes, particularly themes 1 and 3.

### Effectiveness of services

Analysis of studies that were relevant to people in transient accommodation showed that the following services had been effective:

- Rapid response programmes (Ohio Housing Agency, 2016).
- Transitional housing, case management and a rental subsidies (Ohio Housing Agency, 2016).
- Sustained support models (Aubry et al, 2015; Collins et al, 2013).
- Targeted multi-component services (Nightsafe, 2017).

### Enablers and barriers to the effectiveness of services

Key enablers that facilitated the effectiveness of services included:

- Fidelity to service models
- Adaptability for instance according to target group and context (Aubry et al, 2015; Collins et al, 2013).
- Sustained transitional housing programmes (Ohio Housing Agency, 2016).
- Peer-led services/ mentors (Nightsafe, 2017).

Key barriers to the success of services:

- Participants with complex needs were more difficult to engage with and also experienced worse outcomes (Aubry et al, 2015; Ohio Housing Agency, 2016).

### Quality of evidence and approaches to evaluations

The quality of the evidence reviewed was mixed with 2 being of high quality and 2 being of medium quality. The key study limitations identified were generalisability of findings to wider groups due to the services being targeted at specific groups in specific contexts, and a lack of tracking longer-term outcomes and therefore assessing the sustainability of outcomes. Some methodological limitations were also identified relating to the accuracy of data collected and recorded in programme databases. Evaluations methods used included:

- Experimental methods such as an Randomised Controlled Trial and a Non-Randomised Controlled Trial (Aubry et al, 2015; Collins et al, 2013).

- Mixed method, largely qualitative studies (Ohio Housing Agency, 2016; Nightsafe, 2017)
- Service monitoring data.

### **Outcome measures**

Loosely defined outcome measures:

- Completion of programme (Ohio Housing Agency, 2016).
- Sustained accommodation
- Proxy measures of stability (living a settled life, employment training) (The Nightsafe Safelink's project, 2017).

Number/percentage of days stably/continuously housed:

- Time spent in stable housing (Aubry et al, 2015).
- Number of days continuously housed (Collins et al, 2013).

## **A2.3 Emergency accommodation**

### **Overview of studies**

The review included studies which provided findings relevant to the people in emergency accommodation theme. Many studies overlapped with other themes, but there were a few themes specific ones as well.

### **Effectiveness of services**

Analysis of studies that were relevant to people in transient accommodation showed that the following services had been effective:

- Sustained support (Aubry et al, 2015; Stergiopoluos et al, 2015; Collins et al, 2013).
- Sustained case management including Standard Case Management (SCM), Intensive Case Management, Assertive Community Treatment and Critical Time Service (Clark et al, 2016).
- Multi-component services (de Veet, et al. 2013; Ohio Housing Agency, 2016).
- Raid response services (Bassuk et al, 2014; Levitt et al, 2013).
- Targeted services (Nightsafe, 2017; Slesnick and Erdem, 2013).
- Financial assistance and subsidies (U S Department of Housing and Urban Development; 2016).

### **Enablers and barriers to the effectiveness of services**

Key enablers that facilitated the effectiveness of services included:

- Fidelity to the service model whilst being adaptable to target group and context.
- Customised/targeted longer-term transitional housing (Ohio Housing Agency, 2016) may be more suitable for young people.

- Peer led/mentor services (Nightsafe, 2017).
- Long-term financial assistance (U S Department of Housing and Urban Development; 2016).

Key barriers to the success of services:

- Participants with complex needs are more difficult to (Aubry et al, 2015; Stergiopoluos et al, 2015; Collins et al, 2013; Ohio Housing Agency, 2016).
- A lack of time to meet needs and effect lasting outcomes (Slesnick and Erdem, 2013)
- Lack of peer reviewed programme guidance (Clark et al, 2016).
- Failure of studies to measure fidelity of programme delivery (Bassuk et al, 2014).

### **Quality of evidence and approaches to evaluations**

The quality of the evidence reviewed was primarily high, with 7 studies assessed as having high quality and 4 as medium quality. As in previous summaries, the key study limitation identified was generalisability of findings to wider groups due to the services being targeted at specific groups in specific contexts. Some methodological issues were also identified.

Evaluation methods used:

- Experimental methods such as Randomised Controlled Trials or Quasi experimental designs (Aubry et al, 2015; Stergiopoluos et al, 2015; Collins et al, 2013).
- Comparison evaluations (US Department Housing and Urban Development, 2016; Clark et al, 2016).
- Mixed methods, which leaned heavily on qualitative data (Ohio Housing Agency, 2016; Nightsafe, 2017).
- Programme monitoring data stored in the programmes databases was also analysed (Ohio Housing Agency, 2016; Nightsafe, 2017).

### **Outcome measures**

Loosely defined outcome measures:

- Completion of the programme (Ohio Housing Agency, 2016).
- Proxy measures of stability (living a settled life, employment training) (Nightsafe Safelink, 2017).

Number/percentage of days stably/continuously housed:

- Time spent in stable housing (Aubry et Al, 2015).
- Number of days continuously house (Collins et al, 2013).

Outcomes/measures relating to the use of shelters:

- Time spent in or to leave a shelter (Levitt et al, 2013; US Department Housing and Urban Development, 2016).

## A2.4 Leaving institutions

### Overview of studies

The review included studies which provided findings relevant to the people leaving state institutions theme. As in previous theme summaries, some studies overlapped with other themes, but others were theme specific.

### Effectiveness of services

Analysis of studies that were relevant to people leaving institutions showed that the following services had been effective:

- Intensive case management (Clark et al, 2016; de Veet, et al. 2013).
- Multiagency collaboration (Aidala et al, 2014).
- Targeted critical time services (Herman et al, 2011; Kaspro and Rosenbeck, 2007).

### Enablers and barriers to the effectiveness of services

Key enablers that facilitated the effectiveness of services included:

- Multi-agency working (Aidala et al, 2014).
- Flexibility and an emphasis on timing (Herman et al, 2011; Kaspro and Rosenbeck, 2007).

Key barriers to the success of services:

- Few contacts workers and a lack of relationship development (Herman et al, 2011).
- Lack of face to face contact with key workers (compared to remote forms of contact) (Kaspro and Rosenbeck's, 2007).
- Lack of peer reviewed guidance (Clark et al, 2016).

### Quality of evidence and approaches to evaluations

The quality of the evidence reviewed was primarily high, with 4 studies assessed as having high quality and 1 as medium quality. Study limitations identified by the authors related to the absence of comparison or control groups or the lack of randomisation in assignment to intervention and control groups (Kaspro et al, 2007). The use of self-reporting (de Veet et al, 2013) by participants potentially distorting outcomes, and whether the length of time of follow up (Herman et al, 2011) is long enough to ascertain long term impact of the services has also been identified.

Evaluations methods used were largely comparison evaluations using quasi experimental approaches (Aidala et al, 2014; Clark et al, 2016; Herman et al, 2011; Kaspro and Rosenbeck, 2007).



### **Outcome measures:**

Number/percentage of days of homelessness:

- Comparison of days homeless with days housed (Clark et al, 2016).
- Percentage of participants with any homelessness, using repeated measures and change over time (Herman et al, 2011).
- Number of days by various accommodation definitions (Kasprow and Rosenbeck, 2007).

Number/percentage of days stably/continuously housed:

- Proportion of time spent in continuous accommodation (Aidala et al, 2014).

Outcomes/measures relating to the use of shelters:

- Number of days of shelter use (Aidala et al, 2014).

## **A2.5 At risk of homelessness**

### **Overview of studies**

The review included studies which provided findings relevant to the people at risk of homelessness theme. Some studies overlapped with other themes, but others were theme specific.

### **Effectiveness of services**

Analysis of studies that were relevant to people at risk of homelessness showed that the following services had been effective:

- Targeted services (Abt, 2013).
- Rapid response services (Cunningham et al, 2015; Bassuk et al, 2014).
- Sanctuary/safe places services (Jones et al, 2010).
- Sustained support (Batty et al, 2015; Bassuk et al, 2014).
- Temporary financial assistance (Evans et al, 2016).
- Preventative services (Nightsafe, 2017).

### **Enablers and barriers to the effectiveness of services**

Key enablers that facilitated the effectiveness of services included:

- Person-centred services (Cunningham et al, 2015).
- Multi-component case management services (Abt, 2013).
- Positive local housing market (affordability, strong landlord relationships) (Batty et al, 2015).

Key barriers to the success of services:

- Poor financial circumstances of participants (Evans et al, 2016).
- Poor quality of studies about services for families (Bassuk et al, 2014).
- Challenges in working with governmental partners (Cunningham et al, 2015)
- Services unprepared for the specific needs/profile of participants (Batty et al, 2015).

### **Quality of evidence and approaches to evaluations**

Five of the studies were of high quality and two of medium quality. Study limitations identified by authors related to methodology, data and monitoring. There was no comparison group in the VPHD programme (Cunningham, 2015) so although the authors are confident in their findings they cannot fully attribute the results to the programme. Additionally, in the evaluation of Sanctuary Schemes (Jones, 2010), the authors referred to the lack of data and monitoring collected by the programme. A mix of evaluation methods were used:

- One Randomised Controlled Trial (Abt, 2013).
- Mixed methods approaches and qualitative approaches (Cunningham et al, 2015).
- Two evaluations used qualitative case study approaches.

### **Outcome measures**

Loosely defined outcome measures:

- Proxy measures of stability (living a settled life, employment training) (Nightsafe Safelink, 2017).

Number/percentage of days stably/continuously housed:

- Stable housing measures and comparisons with those in unstable housing (Cunningham et al, 2015).

Outcomes/measures relating to the use of shelters:

- Average number of nights spent in shelter and two secondary outcome measures (Abt, 2013)
- Percentage of participants who spent at least one night in shelter and percentage of families applying for shelter over a follow up period (Abt, 2013).

Outcomes/measures relating to tenancies:

- The number of participants that had been provided with accommodation (Batty et al, 2015).

## Appendix 3. Further explanation about services included in the review

Appendix three presents in tabular form further explanation about the services referred to throughout this report, providing an overview, detailed description and summary of outcomes for each service.

Service	Overview	Description of intervention	Outcomes
<b>A3.1 Sustained support services</b>			
<p><b>The At Home-Chez Soi Canadian Housing First demonstration project</b></p> <p>(Aubry et al, 2015)</p>	<p>This intervention included a Housing First recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing without preconditions regarding recovery from (or participation in treatment for) substance misuse or mental health problems. Person-centred support is provided on a flexible basis for as long as individuals need it.</p> <p>The At Home-Chez Soi Housing First programme was delivered in five Canadian cities: Vancouver, Winnipeg, Toronto, Montreal, and Moncton. It was aimed at people with severe mental illness and a history of homelessness.</p> <p>The study enrolled a total of 2,148 people, of whom 1,198 were assigned to receive Housing First and 950 were randomized to receive treatment as usual.</p>	<p>The interventions were implemented using the Pathways ‘ approach to Housing First. This includes the provision of consumer driven services where consumers are encouraged to select the type of housing and neighbourhood and the type, sequence, and intensity of services that best meets their needs.</p> <p>Housing and services were separated geographically, functionally, and conceptually. The housing was composed of independent apartments, owned primarily by community landlords, scattered throughout the community. The support services were provided by off-site, community-based mental health teams that were located in the community.</p> <p>There was also the facilitation of community integration, which relates to fostering a sense of belonging and participation in activities with nondisabled people in the community. The program did not rent more than 20% of the total number of units in a</p>	<p>The At Home-Chez Soi Housing First programme proved to be more effective than treatment as usual in assisting people to exit homelessness and achieve stable housing with the intervention group spending 73% of their time in stable housing compared with 32% for the treatment as usual group, over a period of two years.</p> <p>In the last 6 months of the study, 62% of intervention participants were housed all of the time, compared with 31% of treatment as usual participants; 16% of intervention participants were housed none of the time, compared to 46% of treatment as usual participants.</p> <p>In addition to these differences in housing outcomes, intervention participants also showed greater improvements, on average, in community functioning and Quality of Life than treatment as usual participants</p>

		building, in an effort to ensure that program participants lived in integrated housing with a range of diverse tenants.	
<p><b>Housing First combined with Intensive Case Management with an ethnically diverse sample with mental health problems</b></p> <p>(Stergiopoulos et al, 2015)</p>	<p>This intervention included a Housing First recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing.</p> <p>It combined this with Intensive Case Management, which is a team-based recovery oriented approach that supports individuals through one-to-one case management, the goal of which is to help clients maintain their housing and achieve an optimum quality of life.</p> <p>The intervention was delivered to ethnically diverse homeless adults in Toronto, Canada. In addition participants were older than 18 years, absolutely homeless or precariously housed, and had a serious mental disorder.</p>	<p>Participants in the intervention group were assigned to a case manager who worked with them to develop an individualized service plan based on their recovery goals, which could include supportive counselling, resource brokerage (for housing, education, employment, health, and legal issues), advocacy, skills teaching as well as crisis intervention support.</p> <p>Housing was provided in independent scattered-site housing. Housing expenses were covered by a study rent allowance of \$600 Canadian Dollars (paid directly to the landlord) and up to 30% of the participant monthly income. Participants were not required to accept or adhere to psychiatric or other treatment programs and did not have any restrictions regarding substance use.</p> <p>Individuals randomized to the treatment as usual group were able to access a variety of traditional housing programs and community services available in the city of Toronto</p>	<p>Over the 24 months of follow up participants in the Housing First/Intensive Case Management programme spent a significantly higher percentage of time in stable residences compared to those in the treatment as usual group (75.2% vs 39.5%). The participants in the intervention group also showed significant improvements in probability of hospitalization, community functioning, and a reduction in number of days experiencing problems due to and money spent on alcohol use.</p> <p>Additionally, none of the outcomes examined showed differential treatment outcomes by racialized ethnicity except physical community integration and the amount of money spent on alcohol, both of which worsened among racialized participants compared to those who were not racialized.</p>
<p><b>Housing First intervention exploring the impact on housing retention.</b></p> <p>(Collins et al, 2013).</p>	<p>This intervention included a Housing First recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing.</p>	<p>The participants were housed in single-site housing, which entails the provision of immediate, permanent, low-barrier; non-abstinence based supportive housing units within a single housing project.</p> <p>Participants in this study either received a private studio apartment, or in the</p>	<p>Participants stayed a median of 675 days and 46% stayed the entire two-year period. Additionally, only 23% of participants had returned to homelessness at the end of the two-year period.</p> <p>Findings also indicated that that older age, increased alcohol use and</p>

	<p>This particular intervention was delivered in Seattle, Washington between 2005 and 2008. There were 111 participants, all of whom were chronically homeless people with severe alcohol problems. The main aim of the intervention was to explore housing retention rates.</p>	<p>case of greater medical needs, a semi-private cubicle unit.</p> <p>On-site supportive services were tailored to the needs of individual residents and included 24-hour housing project staffing, intensive case management, nursing or medical care, access to external service providers, and assistance with basic needs. There were no requirements that milestones had to be met (e.g., clinical stability, abstinence from substances, treatment attendance, service participation) for housing attainment or maintenance.</p>	<p>interpersonal sensitivity at baseline were associated with increased retention in single-site housing. These findings suggest that this particular Housing First project retained its target population by responding to its residents needs. By contrast, those who reported using drugs at baseline were half as likely to stay over the entire 2-year period as those who did not use drugs.</p>
<p><b>Housing First interventions implemented in Europe</b></p> <p>(Busch-Geertsema Volker, 2014))</p>	<p>The Housing First project in Europe was funded by the European Commission and aimed to test the Housing First approach in five cities between, 2011 and 2013: Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon.</p> <p>Housing First is recovery-oriented approach to ending homelessness that centres on quickly moving people experiencing homelessness into independent and permanent housing without preconditions regarding recovery from (or participation in treatment for) substance misuse or mental health problems. Person-centred support is provided on a flexible basis for as long as individuals need it.</p> <p>The majority of people across sites were long-term homeless, middle aged and had no regular employment. Many had substance</p>	<p>None of the test sites was an exact replica of the pioneer project Pathways to Housing although – except for the Budapest project – they followed this example in many aspects and broadly followed most of the principles of Housing First as laid down by the ‘manual’ of this project.</p> <p>With the exception of Budapest in some of the points, the HFE test sites all worked with a client-centred approach and individual support plans, having regular home visits as a rule (and with an obligation for clients to accept them), worked with relatively high staff-client ratios (ranging between 1: 3-5 and 1: 11), and offering the availability of staff (or at least a mobile phone contact) for emergency cases 24 hours a day, seven days a week.</p> <p>The Budapest project was different from the other projects in many respects. It was trying to bring rough sleepers directly in mainstream housing</p>	<p>High housing retention rates in four of the five projects were reported - over 90% in Amsterdam, Copenhagen and Glasgow, and close to 80% in Lisbon. In Budapest it was 50%, as already discussed, this site experienced difficulties maintaining fidelity to the HF model, which had an impact on outcomes.</p> <p>This data confirmed a number of studies in the US and elsewhere that the Housing First approach facilitates high rates of housing retention, and that it is possible to house homeless persons even with the most complex support needs in independent, scattered housing.</p> <p>Finally, three of the sites had high proportions of substance abusers and the results add to the evidence of positive housing retention outcomes of the HF approach for people with severe addiction, and even for those with active use of heroin and other hard drugs.</p>

	<p>abuse and psychiatric issues, although this differed across sites.</p> <p>The number of participants included 165 in Amsterdam, 80 in Copenhagen, 16 in Glasgow, 74 in Lisbon and 90 in Budapest.</p>	<p>with support, sharing some of the basic principles of the Housing First. However, some important elements were also missing: support in</p> <p>Budapest was time limited from the beginning (to a maximum of one year), and far less intensive than in all of the other test sites (1: 24).</p>	
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## A3.2 Case management services

<p><b>Assertive Community Treatment intervention and Critical Time Intervention in Permanent Supported Housing programs.</b></p> <p>(Clark et al. 2016)</p>	<p>Assertive Community Treatment (ACT) is a practice that offers treatment, rehabilitation, and support services, using a person-centred, recovery-based approach, to individuals who have been diagnosed with a severe and persistent mental illness. Assertive Community Treatment services are provided to individuals by a mobile, multi-disciplinary team in community settings.</p> <p>Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to prevent homelessness in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in stable housing with access to needed support. Critical Time Intervention works in two main ways: by providing emotional and practical support during the critical</p>	<p>The ACT program was aimed at individuals who had long histories of homelessness and hospitalizations for serious mental illnesses. They may or may not have had co-occurring substance use disorders for which they were offered individualized substance abuse treatment by a substance abuse specialist who was part of the team, and dual diagnosis treatment groups. Housing was offered in a Housing First model - sobriety or participation in mental health treatment was not a requirement and came primarily in the form of Shelter Plus Care (permanent supportive housing) apartments.</p> <p>The CTI programme was aimed at people with a history of chronic homelessness, a history of offenses such as public inebriation, and co-occurring substance use and mental health disorders. Once enrolled in the program, the primary goal for participants was to find permanent housing. While housing for the CTI program was financed by different models most participants lived in their</p>	<p>Participants in both the ACT and CTI interventions were more likely to be housed at 6 months as compared to baseline. CTI participants also demonstrated significant improvements from baseline to 6 months in psychiatric symptoms.</p>
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	<p>time of transition and by strengthening the individual's long-term ties to services, family, and friends.</p> <p>The ACT and CTI interventions took place in the US and there were 90 participants in the former and 144 in the latter.</p>	<p>own scattered site apartments with voucher support as needed.</p>	
<p><b>Effectiveness of different case management models: Standard Case Management (SCM), Intensive Case Management (ICM), Assertive Community Treatment (ACT) and Critical Time Intervention (CTI)</b></p> <p>(de Veet et al, 2013)</p>	<p>The current study conducted a systematic review to identify different case management interventions including Standard Case Management (SCM), Intensive Case Management (ICM), Assertive Community Treatment (ACT) and Critical Time Intervention.</p> <p>A total of 33 documents were identified as relevant for this review. However several publications reanalysed previously published data, and others contained results from more than 1 research site. The final included studies included 21 unique study samples -</p> <p>5 SCM, 7 ICM, 6ACT and 2CTI.</p> <p>Of the 21 study samples, 20 were recruited in the United States and in 1 the United Kingdom. The sample sizes ranged from 80 to 722 participants; the total sample size was 5618 participants.</p> <p>Homeless subgroups included: literally homeless persons, persons at risk for homelessness, homeless veterans, homeless ex-prisoners,</p>	<p>SCM is a coordinated and integrated approach to service delivery, with the goal to provide ongoing supportive care.</p> <p>ICM is a team-based recovery oriented approach that supports individuals through one-to-one case management, the goal of which is to help clients maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. The duration of the service is determined by the needs of the client, with the goal of transitioning to mainstream services as soon as possible.</p> <p>ACT and CTI have been described earlier.</p>	<p>The findings provided some evidence that SCM is effective for this homeless subpopulation in improving housing stability, reducing substance use problems, and removing employment barriers. For the mentally ill sample, however, few of these results were replicated.</p> <p>Five out of 7 studies that assessed the effect of ICM also focused on homeless substance users. For this group, findings were non-significant.</p> <p>The 2 other ICM studies provided some evidence for a positive effect of ICM on housing outcomes for severely mentally ill homeless persons and the general homeless population.</p> <p>Results also indicated that ACT improved the housing stability of severely mentally ill as well as dually diagnosed homeless participants more than less proactive case management models.</p> <p>CTI was examined in 2 samples of severely mentally ill homeless persons, 1 group leaving a homeless shelter and the other leaving inpatient care for veterans. For both groups, CTI was significantly better than usual services</p>

	homeless substance users, homeless persons with severe mental illness, and homeless persons with co-occurring mental and substance use disorders (dual diagnoses).		in supporting housing stability and reducing psychiatric symptoms and substance use.
<b>CTI with people being discharged from hospital</b>  (Herman et al, 2011)	<p>Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to prevent homelessness in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in stable housing with access to needed support. Critical Time Intervention works in two main ways: by providing emotional and practical support during the critical time of transition and by strengthening the individual's long-term ties to services, family, and friends. Ideally, workers who have established relationships with clients during their institutional stay to deliver post-discharge assistance.</p> <p>This particular CTI took place in New York and focused on people living in transition residences following hospitalization, a history of homelessness and with a diagnosis of a psychiatric disorder. The intervention group included 77 participants and the usual care (control) group included 73 participants.</p>	<p>While living in the transitional residence, participants in both groups received basic discharge planning services and access to psychiatric treatment. After discharge, participants in both groups also received a range of "usual" community-based services depending on the individual's needs, preferences and living situation. These services usually included various types of case management and clinical treatment.</p> <p>In addition to the services noted above, participants in the intervention group received nine months of CTI following discharge from the transitional residence.</p> <p>Three workers trained by several of the model developers delivered the CTI. Two were bachelors level employees of the NYS Office of Mental Health re-assigned to this project from their regular duties. The third worker, who also performed some supervisory activities, was a more experienced worker who had previously delivered CTI in an earlier trial. Weekly supervision was carried out by clinically trained staff experienced in the model</p>	<p>Findings indicated that assignment to the CTI group was associated with a statistically significant five-fold reduction in the odds of homelessness compared to assignment to usual care only, during the final three observation intervals. The results were unchanged when adjusting for sex, ethnicity and age.</p> <p>Additionally, among those assigned to CTI there was a total of six homeless nights during the final three observation intervals, while among those assigned to the control group, there were 20 homeless nights - a statistically significant finding.</p>



<p><b>CTI with people being discharged from psychiatric institutions</b></p> <p>(Kaspro and Rosenbeck , 2007)</p>	<p>CTI as described above.</p> <p>This particular intervention was aimed at homeless Veterans with mental illness who were leaving Veteran Affairs Medical Centres (VAMC). It was implemented at 8 VAMCs: Chicago and Hines, Illinois; Houston; Lyons, New Jersey; Montrose, New York; Richmond and Salem, Virginia; and San Diego. A total of 448 participants were involved across sites.</p>	<p>The intervention was implemented over two phases. In the first phase, veterans received usual discharge planning services from inpatient unit staff and standard referral to available outpatient services. CTI case managers had minimal clinical contact with phase 1 participants. Rather, the case managers' activity was directed to the implementation of the evaluation.</p> <p>Before the second phase, case managers were trained in the CTI model by clinical staff from Columbia University, which originated CTI. The planned length of CTI services for phase 2 clients was six months. Ongoing supervision from Columbia staff was carried out through biweekly conference calls, during which current cases from each project site were reviewed.</p>	<p>On average, phase 2 clients reported 19% more days housed in the previous 90 than those in phase 1. Both groups significantly increased the number of days housed over the one-year follow-up. However, phase 2 clients had significantly more days housed at the six-, nine-, and 12-month follow-up intervals</p> <p>Additionally, phase 2 clients on average reported significantly fewer days in institutions during the previous 90 than phase 1 clients, as well as at the six-, nine-, and 12-month follow-up intervals.</p>
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### A3.3 Services including housing vouchers and subsidies

<p><b>Daybreak programme</b></p> <p>(Ohio Housing Agency, 2016)</p>	<p>Daybreak consists of a multi-purpose centre called 'Opportunity House' that serves homeless clients as between 10 and 24 years of age across a variety of interventions in Dayton, Ohio. During the evaluation period, Daybreak's housing program served runaway and homeless youth, including pregnant and parenting youth, aged 18 through 21 who were struggling to achieve independence.</p>	<p>Daybreak devised a two-step housing programme. Facilities consisted of Beachler Apartments (24 on-site units), a youth emergency shelter, and a street outreach program. An additional 30 units, called Milestones, are situated in the community. Youth from the shelter or outreach programs must be referred into Daybreak's housing program by the continuum of care's centralized intake and referral process.</p> <p>As youth progress through their individual case plans—learning life skills, attending recommended counselling sessions, obtaining</p>	<p>The programme reported positive results for young people who took part in the programme. Approximately 97% exited from housing into safe destinations - moving in with family or friends (53%), renting their own apartment (36%) or accessing a housing subsidy (19%).</p> <p>Those who had a GED or had completed high school were more likely to complete the programme. Additionally, race also played a role - white, non-Hispanic youth were more likely to complete Daybreak's housing</p>
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		<p>employment or attending school - they may “step down” to Daybreak’s scattered-site community housing. In this setting, clients can continue to receive a housing subsidy and preserve access to support services, but with the independence of an apartment separate from the Daybreak facility. Residents may transfer between the programs in accordance with their needs.</p> <p>Working with a case manager, a youth directs his or her own progression timeline and participation in supportive services depending on his or her unique needs and strengths.</p>	<p>program than non-white and/or Hispanic youth.</p> <p>Degree of vulnerability also determined the extent of success - young people with a history of sexual abuse, criminal activity, and placements in foster care were less likely to complete the program. Additionally, an important finding was that young people who participated in the Daybreak programme longer were far more likely to complete the programme, suggesting that intervention over a longer period of time is integral to housing programme completion.</p>
<p><b>Homebase Community Prevention programme</b></p> <p>(Abt, 2013)</p>	<p>The Homebase program is a network of neighbourhood-based homelessness prevention centres designed to help families avoid homelessness. These prevention centres are located in neighbourhoods of high need throughout New York City.</p> <p>More specifically, The Homebase Community Prevention (CP) programme is directed at preventing homelessness from occurring. The programme is aimed at households who are at risk of homelessness, but are not currently applying for shelter, or residing in shelter.</p> <p>Participants eligible for inclusion in analysis included 295 families with at least one child - 150 receiving</p>	<p>Participating families were assigned a case manager who helps the family preserve their housing and develop a long-term plan for housing stability. The service plan is unique to each household’s circumstances and is made in conjunction with active participation from the household itself. Service plans can offer direct services or referrals to an array of services to clients at risk of homelessness such as benefits advocacy, mediation, employment assistance, and legal referrals. Thee programme also provided limited financial assistance to pay rental or utility arrears, security deposits, or moving costs.</p>	<p>There was a significant difference in shelter use between intervention and control groups, with the intervention group families spending an average of 22.6 fewer nights in shelter than the control group.</p> <p>Findings also indicate that the Homebase Community Prevention 8.5% of intervention group families spent at least one night homeless compared to 14.5 for the control group over a 27-month follow up period.</p> <p>Finally, 9.3% of the intervention group families were likely to apply for shelter compared to 18.2% of control group families over a 27-month follow up period.</p>

	the CP programme and 145 in the control group. The programme was delivered across 11 sites and data was gathered over 27 months.		
<b>Homelessness Prevention Call Centre in Chicago</b>  (Evans et al, 2016)	<p>The study examined the effectiveness of temporary financial assistance for people at risk of homelessness by using data from the Homelessness Prevention Call Centre in Chicago (HPCC).</p> <p>The HPCC processes a large number of calls annually for access to the Emergency Rental Assistance Program which provides financial assistance to Chicago residents, directly related to the prevention of homelessness, to eligible individuals and families who are in danger of eviction in order to stabilise individuals and families in their existing rental units. The callers are screened for eligibility and then connected to local funding agencies.</p>	<p>Funding for financial assistance varies unpredictably over time. The availability of funding on any given day depends on many factors. For example, for some agencies, there are only a fixed number of appointments available each week or month, but new interview slots might become available through cancellations.</p> <p>The authors compared families who called when funds were available with those who call when they were not. The reported sample consisted of 4,448 calls – 3,574 needed help with rent and 874 for security deposits, just over half (58%) of callers called when funds were available.</p>	<p>Families that called when there was fund availability demonstrated a 76% decline in the likelihood of homelessness after six months.</p> <p>Additionally, calling when funds were available reduced the time spent in a shelter over the next 6 months by 2.6 days which was noted as a very modest change</p> <p>Additionally, families with lower than average median income in the sample were most likely to reduce the likelihood (88%) of entering a shelter within six months.</p>
<b>The Veterans Housing Prevention Demonstration project</b>  (Cunningham et al, 2015),	<p>The Veterans Homelessness Prevention Demonstration (VHPD), was a joint program of the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Veterans Affairs (VA), and the U.S. Department of Labour (DOL), It was one of the first homelessness prevention programs to exclusively serve homeless and at-risk veterans and their families.</p> <p>Five military bases were selected to participate: Camp Pendleton in</p>	<p>VHPD provided short- to medium-term housing assistance (up to 18 months), including security deposits, rent, rental arrearages (up to 6 months back rent), moving cost assistance, and utilities; case management; and referrals to community-based services and supports. Service providers could also use VHPD funds for childcare, credit repair, and transportation expenses.</p> <p>In addition to providing these supports, VHPD intended to connect veterans to health services through the VA's healthcare system and employment</p>	<p>The median length of stay in the program was 84 days, but it ranged appreciably by site, from 39 days at one site to 146 days at another. At the end of the programme 85% of veteran households were stably housed, 10% were unstably housed and only 5% were either literally homeless or at imminent risk of losing their housing.</p> <p>At six and 12 months follow-ups the majority, 76% lived in their own homes, while 18% were staying with family and</p>

	<p>San Diego, California, Fort Hood in Killeen, Texas, Fort Drum in Watertown, New York, Joint Base Lewis-McChord in Tacoma, Washington and MacDill Air Force Base in Tampa, Florida.</p> <p>The 3-year demonstration program operated from 2011 to 2014. During that time, the program served 4,824 adults and children, including 2,023 veterans, in 1,976 households.</p> <p>The program targeted specific populations: recent veterans who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND); female veterans; and veterans with children.</p>	<p>services through local workforce agencies, so the program could provide veterans with a more comprehensive set of supports and better prepare them to sustain housing on their own.</p>	<p>friends. A small percentage of 6% of veterans were homeless at follow-up.</p>
<p><b>Family Options Study</b></p> <p>(U S Department of Housing and Urban Development, 2016)</p>	<p>The U.S. Department of Housing and Urban Development (HUD) launched the Family Options Study in 2008 to learn about which housing and services interventions work best for families with children experiencing homelessness.</p> <p>The programme consisted of 12 study sites across the US, 148 programs and 2,282 families with 5,397 children. The families included in the study had all spent at least 7 days in emergency shelters.</p>	<p>The study compared a number of different types of services, including:</p> <ol style="list-style-type: none"> <li>1. Priority access to long term housing subsidies, typically a Housing Choice Voucher (SUB)</li> <li>2. Access to short-term subsidy in the form of community based rapid rehousing (CBBR)</li> <li>3. Priority access to a temporary, service-intensive stay, lasting up to 24 months, in a project-based transitional housing facility (PBTH)</li> <li>4. Access to usual care homeless and housing assistance with no priority access to any particular program (UC)</li> </ol>	<p>The findings indicated that only priority access to long-term subsidies (SUB) resulted in significant results. The authors reported on a number of outcome measures:</p> <ul style="list-style-type: none"> <li>• At both the 20- and 37-month follow-up points, assignment to the SUB intervention:</li> <li>• Reduced by more than one-half the proportion of families who reported having spent at least 1 night in shelter or in places not meant for human habitation, or doubled up, in the past 6 months;</li> <li>• Increased the proportion of families living in their own place by 15 percentage points;</li> </ul>

			The study team also measured use of emergency shelters during two 12-month periods: months 7 to 18 after random assignment and months 21 to 32 after random assignment. Relative to usual care, assignment to the SUB intervention reduced the proportion of families with a stay in shelter by almost one-half during the earlier period and by more than three-fourths during the later period.
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### A3.4 Person-centred multi-component services

<p><b>The Home to Stay Pilot</b></p> <p>(Levitt et al, 2013)</p>	<p>The Home to Stay model was designed to rapidly obtain and maintain housing for episodic and recidivist homeless families living in shelters through intensive, temporary support services coupled with a time-limited housing subsidy.</p> <p>The Home to Stay pilot was a partnership between a New York City based charitable foundation, 4 New York City based non-profit service providers, and the New York City government.</p> <p>Participants were families with at least 1 custodial child living in the New York City family shelter system. There were 138 participants in the intervention group and 192 in the control group.</p>	<p>Services provided focused on 3 strategies: moving families out of shelter rapidly using a locally funded, temporary housing subsidy; securing sufficient household income to enable families to pay market rent on expiration of the subsidy; and connecting families to community-based services that would help them to maintain housing stability after the termination of Home to Stay services.</p> <p>Each enrolled family was placed in an apartment style unit and was assigned a single case-worker who followed them from shelter into permanent housing to ensure continuity of services across that transitional period.</p> <p>Once client families were placed in housing, services focused on their obtaining a monthly household income equal to at least 200% of the family's rent obligation, obtaining a permanent housing subsidy, or both within 1 year of shelter exit. Because the availability of permanent subsidies was extremely</p>	<p>The families in the Home to Stay intervention group were found to exit a shelter without housing subsidies (73%) more quickly than those in the control group (56%). The results were even more marked for recent entry into shelter participants compared to older entry participants.</p> <p>Findings also indicated that the intervention group spent fewer days in shelter than the control group - 376 days versus 449 days respectively over an almost 3 years period.</p>
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		limited, services primarily focused on maximizing income from public benefits for all eligible household members and obtaining or increasing employment income for all adult household members.	
<b>Frequent Users Service Enhancement initiative</b>  (Aidala et al, 2014)	<p>The Frequent Users Services Enhancement (FUSE) initiative was developed in a collaboration between the Corporation for Supportive Housing; The New York City Departments of Homeless Services, Correction, Health and Mental Hygiene, and Housing Preservation and Development; The New York City Housing Authority; and ten non-profit providers of housing and services.</p> <p>FUSE provided Permanent Supportive Housing (PSH) to roughly 200 individuals who were frequently cycling in and out of jails and homeless shelters.</p> <p>PSH combines rental or housing assistance with individualised, flexible and voluntary support services for people with high needs related to physical or mental health, developmental disabilities or substance use.</p>	<p>Participants received PSH for 2 years in either scattered-site housing with services provided through mobile case management teams and other staff, or single site, mixed-tenancy buildings operated by non-profits as special needs housing with onsite services. Units were subsidized such that the tenant pays no more for rent than 30% of income or of their housing allowance from benefits.</p> <p>Housing providers were given a one-time \$6,500 payment per client to allow for flexible service funding during the critical period from recruitment and engagement to linkage with sustainable, comprehensive medical and mental health services and other support services needed to promote stability and tenant success. Use of this enhancement varied by housing program, but included spending for clinical supervision; client recruitment and engagement; intensive case management with lower client-to-case manager ratios; special FUSE II service staff to provide more intensive support during the first year of housing; and/or additional specialty services as needed.</p>	<p>At 12 months and 24 months respectively, 91% and 86% of participants were reported to have maintained permanent supportive housing compared to only 42% of the comparison group at 24 months.</p> <p>Similarly, shelter use was also significantly lower - 146.7 days lower than the comparison group. Additionally, the percentage of participants in the intervention group with any shelter episode over the study period was reduced on average by 70%</p>
<b>Brisbane Common Ground programme</b>	<p>The Brisbane Common Ground project was a model of Permanent Supportive Housing in South</p>	<p>The service was centred on a location, which included 146 units in a 14-storey building with onsite offices for both the</p>	<p>With regards to housing outcomes, the Brisbane programme reported that it had removed access-related barriers for</p>

<p>(Parsell et al, 2015)</p>	<p>Brisbane, Australia. It targeted people with low to moderate income, and those who had suffered from chronic homelessness.</p> <p>PSH combines rental or housing assistance with individualised, flexible and voluntary support services for people with high needs related to physical or mental health, developmental disabilities or substance use.</p> <p>There were 148 participants in total and 120 responded to the survey.</p>	<p>support provider and the tenancy manager. The service provided:</p> <ul style="list-style-type: none"> <li>• On-site concierge support,</li> <li>• Communal areas where people were able to access informal support,</li> <li>• The onsite provider's in-depth understanding of the challenges, opportunities for positive intervention, and lives of people who are homeless and,</li> <li>• Access to more mainstream services such as drug and alcohol counselling, personal counselling, vocational assistance, domestic assistance and personal care.</li> </ul>	<p>people experiencing chronic homelessness with complex needs to housing, and nurtured the conditions for tenants to sustain stable housing.</p> <p>Tenants reported high satisfaction levels with many aspects of their housing, including:</p> <ul style="list-style-type: none"> <li>• 88 % of respondents were satisfied with suitability of their housing to their households needs;</li> <li>• 92 % were satisfied with the affordability of their housing,</li> <li>• 82 % were satisfied with the size of their unit</li> <li>• Additionally, an overwhelming 93% though of Brisbane Common Ground as their home</li> </ul>
<p><b>Nightsafe Safelinks project</b></p> <p>(Nightsafe, 2017)</p>	<p>The Nightsafe project offers support and refuge to young people who are homeless or vulnerably housed within the Borough of Blackburn with Darwen. The Nightsafe Safelinks project in particular includes Platform 5 day-centre and a mentoring service that supports young people who arrive in crisis.</p> <p>Many of the young people accessing the Safelinks project, have become homeless or vulnerable because they have no choice, they are escaping from violence, abuse or conflict.</p> <p>The total number of visits over 9 quarters was 2,692. These visits were made by a total of 1334</p>	<p>The Nightsafe Safelinks project included a combination of practical day centre support - known as Platform 5 - and a mentoring scheme. The day centre provided support for young people including basic facilities such as laundry, showers, storage facilities and lunch and delivered a range of life skills and health workshops.</p> <p>The mentoring scheme was for young people with chaotic lives and worked to enhance the services of other agencies by supporting and ensuring that young people stayed positively engaged. It has the capacity to work 1:1 with individuals and address issues and barriers that lead to eviction and homelessness.</p> <p>The aim of the preventative service was to help young people who are</p>	<p>The project reported on a number of outcomes, which highlighted the success of the project. The intended outcome of 'young people gaining long term accommodation with support from mentor' met its target three times over - 223 young people had secured long term accommodation by the end of Quarter nine compared to an original target of 60.</p> <p>The project also aimed to reduce repeat stays in emergency shelter from 37 to 20; authors reporting that this was actually reduced down to 10. Finally, 118 young people were reported as having gained a recognised qualification in budgeting and home management compared to a project set target of goal of 75, therefore the authors concluded, helping participants sustain tenancies.</p>

	young people engaging with the project.	precariously housed, or at risk of homelessness overcome barriers to living a safe, settled and productive life.	
<b>A3.5 Other services</b>			
<b>Housing support outreach and referral pilot for people with HIV</b>  (Cameron et al, 2009)	<p>The 'Housing Support, Outreach and Referral' pilot was based in two London boroughs that are known to have some of the highest levels of homelessness in London, as well as the highest HIV prevalence rates in the country.</p> <p>The pilot provided an assertive outreach service to people living with HIV who were homeless or at risk of homelessness.</p> <p>Over the course of 15 months, 56 referrals were received of which 27 were accepted.</p>	<p>The pilot employed two workers to assist individuals to set up a housing tenancy and provide on-going support to ensure that the tenancy was maintained. The support workers also made sure that clients were registered with the full range of local primary, secondary and specialist healthcare services, and that they understood how these services should be accessed. The service was designed to be flexible, responding to the needs of the individuals themselves</p>	<p>At the end of the 15-month period 15 people had received tenancy support, of whom 12, who were previously rough sleeping or in insecure accommodation, were supported to access temporary accommodation. At the end of the 15 months, all of the tenancies, both temporary and permanent, had been maintained.</p> <p>In addition, six participants had been supported to pay off long-standing rent arrears, a further three people had negotiated payment plans for rent arrears, six Disability Living Allowance grants were awarded and 42 successful charity applications for clothes and household items were made.</p> <p>Additionally, at the point of referral, only nine of the 27 were registered with a GP. By the end of the evaluation period, all service-users were registered. Thirteen people were helped to register with an HIV clinic, and a further five service-users were supported to re-engage with HIV services.</p>
<b>London Social Impact Bond service</b>	<p>The London Homelessness Social Impact Bond was a four -year programme commissioned by the Greater London Assembly, and</p>	<p>The interventions were designed around a Navigator approach, whereby key workers adopted a personalised and flexible approach, supporting the</p>	<p>After two years the mean number of rough sleeping nights for the intervention group was 9.2 compared to 13.9 for the comparison group By</p>



<p>(The Department for Communities and Local Government, 2017)</p>	<p>funded by the Department of Communities and Local Government (DCLG).</p> <p>Social Impact Bonds are a new form of financing social programmes, which gather private investments to fund specific providers to deliver a service or programme.</p> <p>The current intervention aimed to provide personalised support to an entrenched group of rough sleepers in London. Social Investors provided the up-front investment needed for two providers to deliver interventions to 830 rough sleepers.</p> <p>Providers were paid for the results (Payment by Result) they achieved in relation to five core objectives – reducing rough sleeping, achieving long-term sustained accommodation outcomes, achieving sustained reconnections where appropriate, improving employability, and employment and health outcomes. Social investors received a return on their investment dependent on the results achieved.</p>	<p>participants to access existing provision and achieve sustained long-term outcomes.</p> <p>The intervention group consisted of 828 people and the comparison group consisted of 1199 people.</p>	<p>extrapolating from the two year results, 3,900 rough sleeping episodes have been avoided as a result of the intervention. Additionally 40% of the intervention group did not sleep rough at all in the two years after the start compared to 33% of the comparison group</p> <p>Additionally, after two years 37% of the intervention group had were long-term accommodation compared to 7% of the comparison group.</p> <p>Finally, intervention providers were proud of their achievements and investors were happy with the return on their investment.</p>
<p><b>Sanctuary Schemes</b></p> <p>(Jones et al, 2010)</p>	<p>Local authorities across the UK have been encouraged to develop interventions designed to enable households at risk of domestic violence, where appropriate and acceptable to the household, to stay in their own homes. These</p>	<p>The lead agencies responsible for the Sanctuary Scheme were housing providers or specialist domestic violence services, sometimes working in partnership. In some areas specialist domestic violence services or multi-agency domestic violence partnerships were responsible for coordinating the</p>	<p>Sanctuaries were successful in meeting their main aim of providing a safe alternative for households. Most service users said they felt much safer following the installation of Sanctuary measures although there was evidence that a few households had moved from their</p>

	<p>interventions are usually known as 'Sanctuary Schemes'.</p> <p>Sanctuary Schemes are victim centred initiatives designed to enable households at risk of domestic violence to remain in their own accommodation, where it is safe for them to do so, where it is their choice and where the perpetrator does not live in the accommodation.</p> <p>Although there are no current national figures on the number of Sanctuary Schemes in England, evidence suggests that they are widespread. A survey of homelessness prevention conducted in 2007 found that about half of England's councils (171 of 354) were operating such schemes.</p>	<p>service whilst other Sanctuary Schemes employed a full time specialist Sanctuary Scheme coordinator.</p> <p>The schemes included Risk assessment and installation of Sanctuary measures such as lock changes, home link alarms, CCTV cameras, cutting back hedges, improving lighting, erecting fences, and more sophisticated measures such as video entry systems and battery operated police alarms. The type of measures varied based on the level of risk experienced by the households.</p> <p>The programme also meant to include support for households living in a Sanctuary. However, in practice little support services were offered.</p>	<p>Sanctuary because they did not feel safe.</p> <p>However, few Sanctuary Schemes were able to provide data beyond immediate outcomes. As a result of poor data collection and monitoring, it was difficult to draw firm conclusions about success of the programme.</p>
<p><b>The Rough Sleepers Initiative</b></p> <p>(Fitzpatrick et al, 2005)</p>	<p>The Rough Sleepers Initiative was established in Scotland in 1997 with an initial budget of £16 million over the first three years with a further increase by the Scottish Executive to £63 million by 2003/4. These funds were allocated to local authorities that submitted successful bids, in partnership with other statutory, voluntary and private sector bodies, to address the needs of rough sleepers in their area.</p>	<p>The initiative funded services within a strategic planning framework including the local authority, health board and the Supporting People programme team in each area.</p> <p>The funds were used in a variety of ways, the most common being rent deposit schemes, and outreach and support workers. Amongst other things, funds were also often used to provide access to emergency accommodation, street worker teams, and day centres. It has largely been a successful programme with statistical evidence gathered from George Street Research showing that levels of rough sleeping fell since the programme began.</p>	<p>It has largely been a successful programme with statistical evidence gathered from George Street Research showing that levels of rough sleeping fell since the programme began. <i>The figure reported in October 2003 was more than one third lower than the figure reported in May 2001</i></p> <p>Additionally positive changes in cultural and political attitudes, which raised awareness of the multiple needs among people sleeping rough and placed their needs on local and national agendas were strongly associated with the introduction of RSI.</p>

<p><b>The Individual Budgets pilot</b></p> <p>(Brown, 2013)</p>	<p>The Individual Budgets pilot in Wales was set up across 5 local areas: 1. Cardiff 2. Newport 3. Swansea 4. Bridgend 5. Ynys Mon &amp; Gwynedd.</p> <p>An Individual Budget is a system for organising individualised funding where the person is told, upfront, how much they are entitled to spend. Support workers have access to a budget for each individual (£2,000-£3,000) which they can spend on a wide variety of items (ranging from a caravan to clothing) in order to help secure and maintain accommodation.</p> <p>It focused on the most difficult to house individuals, often rough sleepers, by working with existing support services, which would have access to an Individual Budget approach to help people into sustainable accommodation. Each pilot area aimed to work with 10 clients who would have access to an individual budget of £2,000.</p>	<p>In this specific pilot in Wales, each area was encouraged to develop their pilots in ways, which suited their client group, the existing services and the context of the area. Areas had a budget of around £20,000 and additional funds were available to cover limited management or staffing costs.</p>	<p>Overall, of the 79 IB recipients involved in the pilots, a total of at least 33 (42 per cent) were in a position of having relatively stable accommodation at the conclusion of the pilot. This included 50% in Ynys Mon &amp; Gwynedd, 50% in Bridgend, 41% in Swansea 40% in Cardiff and 29% in Newport</p> <p>Stable accommodation was broadly interpreted to include situations such as: living in some form of low support accommodation, living with partner or supported by their family, living in own accommodation with no or little support etc. It excludes all forms of temporary accommodation such as B&amp;Bs and hostels</p> <p>Of the remaining participants, a large number were accommodated in some form of temporary accommodation.</p>
<p><b>Sharing Solutions programme</b></p> <p>(Batty et al, 2015)</p>	<p>The Sharing Solutions programme began in October 2013 and concluded in March 2015. The programme consisted of eight schemes throughout England set up to pilot, develop and promote new models for establishing successful and sustainable sharing arrangements for tenants in housing need.</p> <p>The programme was targeted mainly at the private rented sector</p>	<p>A number of different models were tested through the programme which. For example, intensive training before moving into independent shared accommodation, accessing former student housing so that this could be used for participants receiving Housing Benefit, peer mentor and lead tenant schemes where more experienced tenants provide support and advice to new tenants and lodgings where</p>	<p>The results indicated that training tenancies are a useful way of introducing tenants to sharing and managing a tenancy in a safe way. Intensive tenancy support, training and thoughtful matching supports tenants and equips them better for the future.</p> <p>Lead tenant models also have merits in different sharing scenarios. Where it had been successful, it enabled better communication between the sharers and the project, allowing personal and</p>

	<p>(PRS) and at individuals who were receiving Housing Benefit and only eligible for the Shared Accommodation Rate (SAR) of the Local Housing Allowance (LHA). However, the programme also encompassed partnerships with social sector housing organisations and individuals for whom sharing could be a more viable financial option or a more preferable social option.</p> <p>The programme provided assistance for around 200 clients over a 15-month period.</p>	<p>participants are housed in homes with spare rooms.</p> <p>A dedicated Sharing Solutions Officer was appointed who monitored the performance of the eight pilot projects, providing them with advice and support, organising conferences, disseminating good practice and (latterly) producing a good practice toolkit.</p>	<p>practical issues to be identified quicker. It also enabled better relationships between the tenants and the landlord.</p> <p>Similarly, the peer mentors also thrived because there was a well-resourced programme of support for them and individual staff who could dedicate time to their development and training needs. Recruiting people with the right skills and knowledge was important.</p> <p>By January 2015 the programme had provided accommodation to 172 clients and at the time publishing only 19 of these tenancies had ended for negative reasons</p>
<p><b>Accommodating homeless families in apartments in the private rented sector.</b></p> <p>(Zierler et al, 2013)</p>	<p>The project offered assisted housing in temporary accommodation for homeless families in Vienna. Through the scheme families in household sizes from two to ten persons lived in separate, fully furnished apartments within one building, with on site support through a multi-professional team.</p> <p>The team consisted of 1.5 social workers, 1.5 social advisers (staff that support users concerning daily routine issues), one real estate manager, 0.5 maintenance staff and one team manager. Each family worked mainly with one subgroup consisting of one social worker and one social adviser.</p>	<p>Support was provided in three main phases:</p> <p>Securing income - The first step was to secure the family's income. Whether it was settlement of debts, application for social security benefits or unemployment benefits, support was given concerning contact with the appropriate authorities and organising necessary documents. More than two thirds of participants received this support.</p> <p>Household budgeting - Families were introduced to the sub-goal of paying the user fee for the apartment at the start of each month in advance. If successful, a savings target was agreed with the family. The payment of user fees and the amount of the savings, along with</p>	<p>Over a three year period 69 families have stayed in the programme, 60 Families have left and of them 60% were housed in a private rented apartment, 23.3% were relocated within the Vienna homelessness system and 16.7% dropped out.</p> <p>The mean duration of stay ranged between 3 months and a maximum of 15 months. Reasons for not meeting the time target of eight months stay included families needing more time to secure income, health issues, longer period of house hunting given expectations of families and finding cooperative landlords.</p>

	<p>The goal was that families learn to manage their household budgets and gain knowledge and skills concerning housing and move into an apartment in the private rented market within a maximum period of eight months.</p>	<p>managing other household payments, was reviewed monthly.</p> <p>Apartment search - After five months and a saving amount of at least €1200 each family got an initial training on house hunting, conducted by the real estate manager who was part of the team. The specifications of the desired apartment were formulated and families received important information concerning house hunting and concluding a contract. A family was able to meet the real estate manager on several occasions to review their search profile and prepare for the meetings with real estate agents and landlords. Depending on the ability of the users, they searched independently after the initial phase. Available financial assistance for deposit, commission and rent can be applied for at the social benefit centre.</p>	
<p><b>Rapid Response-Housing Demonstration Programs</b></p> <p>(Finkle et al, 2016)</p>	<p>Rapid response rehousing is designed to enable households to exit shelter quickly by assisting them in finding a housing unit in the community and subsequently providing them with a short-term housing subsidy (not to exceed 18 months) along with a modest package of housing-related services designed to stabilise the household in anticipation of the conclusion of rental assistance.</p> <p>In the current Rapid Rehousing Demonstration (RRHD) project twenty-three communities were awarded funds in 2009 by the U.S. Department of Housing and Urban</p>	<p>RRHD offered families rapid rehousing and a package of temporary assistance.</p> <p>There was quite a lot of variability in services provided across sites, for example the length of RRHD assistance provided, the depth of rental subsidy provided and the frequency of case management required for program participants:</p> <p>Additionally, 5 grantees implemented rapid re-housing that offered only short-term rental assistance; 13 grantees offered only long-term rental assistance; and the remaining 5 grantees provided both short- and long-</p>	<p>Of the 450 families for whom data about data about housing destination was available 90% were living in permanent housing or permanent supportive housing at the time the RRHD assistance ended.</p> <p>Nearly a quarter (24%) of participants for whom data was available on housing mobility were living in the same unit 12 months after exiting the RRHD program. However, more than three-fourths (76%) had moved at least once during the 12 months after RRHD program exit.</p> <p>Additionally, families whose heads of households were of the ages 18 to 24</p>

	<p>Development (HUD) to implement the programme.</p>	<p>term assistance, depending on family needs. Across sites, there were 490 study participants in total.</p>	<p>were significantly less likely (63%) to remain in the same permanent housing unit relative to households with older heads of households. Families accompanied by three or more children were also significantly less likely (51%) to remain in the same unit.</p> <p>About 10% of participants had experienced at least one episode of homelessness within a year of exiting the program. Again, families who returned to homelessness were more often headed by young parents—between 18 and 24 years of age</p>
<p><b>Ecologically based intervention with substance abusing mothers.</b></p> <p>(Slesnick and Erdem, 2013)</p>	<p>The ecologically based pilot programme explored the impact of an integrative approach targeted at substance-abusing mothers living in shelters in the U.S.</p> <p>Participants rented an apartment of their choosing and the project paid the first three months rent and utilities. Housing was non-contingent on drug abstinence or treatment attendance.</p> <p>Support services (case management and Community Reinforcement Approach (CRA) were offered for six months. In the CRA clinicians and participants work collaboratively on identifying individual goals. The focus is to help individuals find healthier, more adaptive ways to meet their social and emotional needs than using substances. It is comprised of a broad group of behavioural interventions</p>	<p>The ecologically based intervention integrates independent housing, case management services, and substance abuse counseling. The participants received three months of utility and rental assistance of up to \$600 per month for three months. The housing was not contingent on mother's substance abuse or attendance in treatment services. Additionally, up to 26 case management sessions and up to 20 CRA sessions were offered to the mothers over a period of 6 months.</p> <p>The case management component focused on assisting mothers to meet their basic needs and obtain government entitlements and employment.</p> <p>Additionally, the counselling component of CRA explored the function of using substances and aimed to reinforce non-substance using, adaptive behaviours through communication skills training, relapse prevention, and refusal skills</p>	<p>The service was found to have been partially successful. Whereas substance-abusing mothers in the treatment group had demonstrated a faster improvement in independent living than had those in the control group at the three and six month follow up, this difference declined significantly at nine months for the intervention group, whereas the control group remained the same at both time points.</p> <p>The decline was found to coincide with the cessation of support services indicating the need for longer-term support given the severity of needs faced by this vulnerable group so as to sustain improvements.</p>

	The study included 60 homeless mothers recruited from shelters.	training. The project therapists provided all intervention components and worked closely with the mothers always on-call for potential crises and urgent needs.	
<b>No Second Night Out Pilot</b>  (Hough, 2011)	<p>The No Second Night Out pilot was implemented across ten central London boroughs: Brent, Camden, City of London, Hammersmith and Fulham, Islington, Kensington and Chelsea, Lambeth, Southwark, Tower Hamlets and Westminster.</p> <p>It aimed to provide a rapid response to new rough sleeping, to link those who migrate into central London back into services where their local connection means they are most likely to sustain a life away from the streets and provide a single service offer based on the assessment of each individual's needs.</p>	<p>It consisted of a dedicated 24-hour assessment hub facility, staffed by a team of assessment workers (who provide the single service offer) and reconnection workers (who liaise with services, negotiate and advocate on a client's behalf, and where necessary accompany individuals returning to local services). The 'hub' was a place of safety where people can be assessed any time day or night in an environment away from the street.</p> <p>The pilot also included a 24 hour telephone rough sleeping referral line and website, to support public reporting of rough sleepers as well as working closely with outreach teams to provide a consistent response to new rough sleepers. Finally, it also aimed to expand the remit of the London Street Rescue service to ensure there is capacity to respond to new rough sleepers at all times.</p>	<p>The pilot project was quite successful in its first 6 months- Of the 656 rough sleepers that attended the hub, 64% had a positive departure, that is a move into some form of accommodation or reconnection to another area. About 20% refused the single offer and 16% abandoned the hub.</p> <p>Most people who had a positive departure went on to temporary accommodation whilst they waited for more permanent accommodation. A large number went on to be reconnected to other boroughs, which highlights the shortage of appropriate accommodation for people to move on to.</p>

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