Centre for Homelessness Impact

Why interventions to improve the welfare of people experiencing homelessness or at risk work or not: An updated evidence and gap map

Dr. Howard White and Monisha Narayanan

Global Evidence and Gap Map of Implementation Issues

Second Edition

HERIOT WATT UNIVERSITY

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About the Centre for Homelessness Impact

The Centre for Homelessness Impact champions the creation and use of better evidence for a world without homelessness. Our mission is to improve the lives of those experiencing homelessness by ensuring that policy, practice and funding decisions are underpinned by reliable evidence.

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Foreword

Until 2018 there were no reliable tools to help people working towards ending homelessness to identify what we did and didn't know about homelessness interventions, where our understanding could be strengthened and where there were still gaps to be filled. When we launched the Centre in 2018, my first priority was to address this need.

Our Evidence and Gap maps (EGMs), developed with our partners Campbell Collaboration systematically map, for the first time, all of the relevant evidence on homelessness interventions from across the globe. The EGMs provide a birds eye view of the evidence that currently exists on the main homelessness interventions. By highlighting the areas where evidence is either lacking or is sufficient for synthesis, they help commissioners of research target research investments faster and in a more strategic, impactful way.

This report presents the findings of the second edition of the Implementation Issues Map. The new version of the map includes 63 new studies, bringing the total to 275. Critical appraisals were also carried out to assess the credibility and methodological quality of each study.

As with the first edition, the majority of studies come from North America, with 104 studies from the United States and 38 from Canada. 73 are from the UK: a much higher proportion of studies (27%) than in our map of Effectiveness studies (26 = 6.5%), and highlighting how as a country the UK has a rich tradition of qualitative evaluations, but has invested less in impact evaluations.

But quantity is no match for quality, and the EGM shows that the vast majority of the studies included in the Implementation Map (almost 70%) score 'low confidence', showing more needs to be done to improve the quality of the process evaluations being produced. 76 studies (a little over 25%) are of medium quality and just 10 studies (less than 5%) are rated as high quality.

These may seem like disappointing findings, but identifying the areas in which evidence is lacking gives us the opportunity to systematically improve what's available. If evidence is to inform policy-making and practice it should be reliable and actionable.

The need for more and better evidence to prevent and tackle homelessness is as clear as it is urgent. Without change it is hard to see how ongoing efforts to end homelessness across the UK can be successful, and I don't believe that anyone wants to miss the unique opportunity we have across the UK to create a society that leaves no one behind.

When we update the map again in a year's time, we hope to see advances in the balance of causal and non causal evidence available as well as in the quality of the studies being produced.

We look forward to working with you to achieve those ambitions.

Dr Ligia Teixeira
Director, entre for Homelessness Impact

Executive Summary

What is in the 2021 edition of the Implementation EGM?

CHI's Implementation EGM maps out the available evidence across key issues relating to the implementation of homelessness interventions. The map can guide users to relevant evidence, visualising where more research is needed or can be synthesised. The EGM shows that there is a lack of research into the impact of financing, employment, legislation and communication on implementation of interventions. 'Services and outreach' and 'accommodation based' interventions are sufficiently plentiful to synthesise existing evidence.

The 2021 edition added 63 studies to the map. It also excluded 34 studies after rescreening, mostly because those studies were impact evaluations which had insufficient implementation evidence to be included. The 2021 edition therefore hosts 275 studies whereas the 2018 edition hosted 246 studies.

In the first edition of our implementation map, around 56% of the studies included were from North America and 25% from the UK. The proportion of UK-based studies in the new version of the implementation map increased by 2% compared to the previous edition (for a total of 73 studies).

What can the map tell us?

The majority of studies in the Implementation Map come from North America, with 104 studies from the United States and 38 from Canada. Although a minority of studies in the Implementation Map are from the UK (73 = 27%), UK research represents a far smaller proportion of the whole in CHI's Effectiveness Map (26 = 6.5%), highlighting that the nation has a stronger tradition of qualitative homelessness research than it does of quantitative. The majority of the studies in the map (217 = 78%) were published after 2010. Prior to 2014, around 10 studies were published annually, after which there was a sharp increase with 25-30 studies published annually up until 2019. This is good news, as we have also reported a rapid increase in the number of studies conducted each year for inclusion in our Effectiveness EGM.

The overall quality of studies was assessed using a critical appraisal tool* which uses the 'weakest link in the chain' principle, meaning one critical weakness reduces the credibility of the study as a whole. This is a conservative way of assessing the quality of qualitative studies. Note that a low rating may reflect a failure to report rather than an issue in the study — sometimes researchers might fail to explain how they did something, even if they did do it.

* The tool was developed by Campbell Collaboration in association with CHI. It assesses the inclusion of nine crucial dimensions of evaluation including research questions, qualitative methodology, sampling strategy, relationship between researchers and participants, ethical considerations, data collection, data analysis, policy recommendations and recommendations based on the study

While the methodology, data collection, analysis and research questions are all well described in 50-60% of studies, ethical considerations and policy level recommendations are adequately discussed in only 16, and 11% of the studies respectively. The relationship between researchers and participants was only discussed in seven studies (less than 5%). Acknowledgment of such relationships demonstrates an understanding of the potential impact they can have on results. This meant the vast majority of the studies (189, almost 70%) are rated as low confidence in study findings. The findings show the need to improve studies of implementation and process evaluations or the reporting of those studies. 76 studies, a little over one quarter, are of medium quality and just 10 studies (less than 5%) are rated as high quality. To improve the overall quality of process evaluations in this field, researchers should ensure they discuss and disclose ethical considerations, relationships with participants and policy recommendations in addition to other critical elements that are more commonly included.

The map shows that there are some types of interventions that have been thoroughly investigated, while others have received less attention. The most common interventions on the map are in the 'services and outreach' (162 studies) and 'accommodation based' (151 studies) categories, while the least common are in 'communication' (17 studies), 'legislation' (17 studies) and 'financing' (14 studies). This reflects the number of evaluations of these approaches rather than how heavily these interventions are plagued by implementation issues. This distribution of intervention types is similar to the Effectiveness EGM except that the Effectiveness EGM contains more studies relating to health and social care than the Implementation EGM.

Which factors facilitate or hinder implementation?

There are numerous factors equally likely to hinder implementation as they are to facilitate it depending on the context — for example, adequacy of resources is mentioned as a facilitator to implementation in 152 studies and as a barrier in 186 — but this balance of being both barrier and facilitator is not always seen.

Factors such as the housing market (considered a barrier in 83 studies and a facilitator in 20); welfare support (44 as barriers, 23 as facilitators) and the labour market (21 as barriers, 3 as facilitators)are more clearly seen as barriers than facilitators.

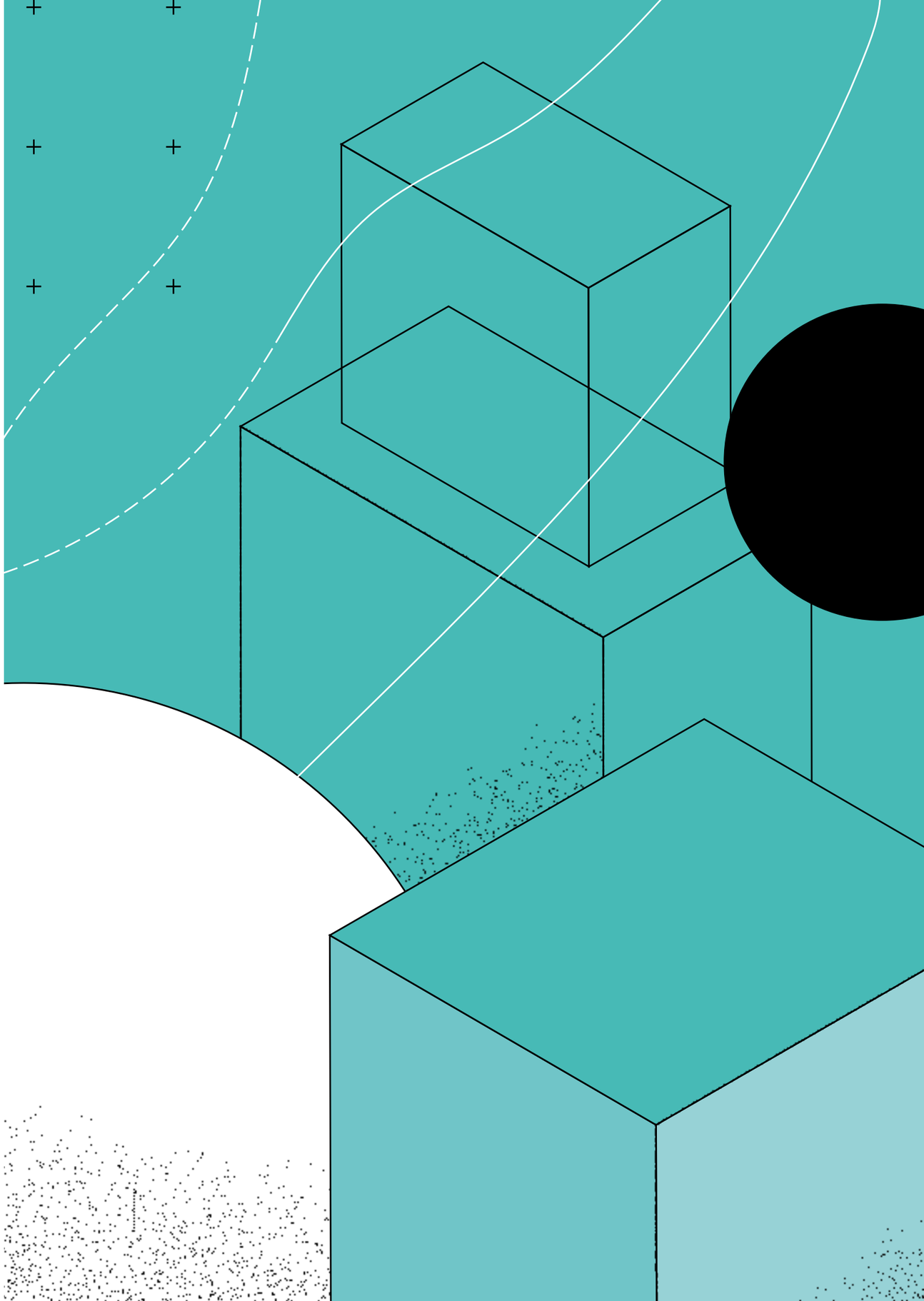
Issues related to Programme Administrators and service users are the most frequently mentioned (in 79% and 70% of studies, respectively). Near the middle of the distribution are issues relating to staff and case workers (46%) and policy-makers and funders (41%). Contextual factors are the least mentioned (38%).

The main factors identified by the map are adequacy of resources, buy-in, and coordination and communication. Although the map provides a high-level overview of which factors commonly impact implementation of interventions, a far more granular understanding of these studies is needed. CHI is addressing this need by commissioning systematic reviews of process evaluations. A mixed-methods systematic review focusing on case management is currently underway.

Next steps

The Centre is using the EGMs to identify key areas where we lack relevant evidence. This helps us address some of the gaps by commissioning new trials. Likewise, where there is sufficient evidence in the EGMs, we aim to synthesise existing bodies of evidence through commissioning systematic reviews and adding content to it's other online tools (see CHI's Intervention Tool and Evidence Finder).

The maps are updated annually so the EGMs will capture new developments in the field. The gaps in the Implementation EGM highlight that researchers and commissioners should evaluate the impact of financing, employment, legislation and communication on implementation of interventions. There is sufficient evidence for synthesis in 'services and outreach' and 'accommodation based' interventions.



Contents

Chapter 1

About Evidence and Gap Maps

The challenge of an evidence-informed approach to ending homelessness

Homelessness affects too many people in the UK and across the world. Estimates claim that, on any given night in 2020, 202,300 families and individuals are experiencing 'core homelessness', the worst forms of homelessness1. Effective interventions are therefore required to place and keep people in stable housing, and address any health and wider support needs of people experiencing or at risk of homelessness.

The last decade has seen a growing focus on taking a 'What Works' approach to policy, focusing on presenting evidence about what does and does not work in a given field. The Centre for Homelessness Impact (CHI) is the first What Works organisation for homelessness in the world and is a member of the 13-strong UK What Works Network. To support the use of evidence-informed policy and practice in the sector, the Centre has developed a core range of evidence tools to aid decision-making.

The focus of the 'What Works' movement is to clearly assess what we do and don't know about what is most effective in a given field, in this instance on studies which look at the impact of specific interventions. These "effectiveness studies" often have a comparison or control group, randomly assigned in advance of the intervention.

So far, the 'What Works' movement has largely focused on effectiveness of interventions, limited to the measurable aspects of their ultimate outcomes. But to be effective, an intervention has to be well implemented. Information about implementation is most commonly found in qualitative evaluations that provide in-depth accounts of implementation processes and contexts. This qualitative evidence is essential in helping us understand why things do or do not work.

The Centre is therefore working with the Campbell Collaboration, Heriot-Watt and other partners, to expand and update its two Evidence and Gap maps on homelessness.

These maps capture the available evidence related to (1) the effectiveness of interventions to improve the welfare of persons and families who are homeless or at risk of homelessness (as measured in relevant quantitative studies), and (2) issues arising in the implementation of programmes for persons experiencing homelessness (drawing mainly on qualitative data). This report presents the findings of the second version of the implementation map.

1 1 Albanese, F. (2020) How many people are homeless in England on any given night? Online: Crisis .Available at: https://www.crisis.org.uk/about-us/the-crisis-blog/how-many-people-are-homeless-in-england-on-any-given-night/

These maps are both evidence tools in their own right and, importantly, a building block in the evidence architecture for the field. The maps are intended to offer a valuable resource for the community of policy-makers, funders, practitioners and researchers working to address homelessness. Together, the maps contain close to 700 studies — 394 in the effectiveness map and 275 in this new edition of the implementation issues map — evaluating homelessness interventions from around the world.

The Rise of Evidence-Based Policy and Practice

There has been a substantial rise in quantitative impact evaluations around the world in the last 20 years. For example, in the UK, the Education Endowment Foundation has supported over 150 randomised controlled trials (RCTs) in English schools. In the case of homelessness, however, the effectiveness map contains just under two rigorous quantitative evaluations published globally per year prior to 2000, an average of four per year from 2000 to 2009, and more than 10 per year between 2010 and 2020. Only 15 of the primary studies in this map were from the UK.

With regard to qualitative studies that capture evidence on implementation matters, however, the UK is much better represented, as is discussed in Chapter 2 of this report.

One reason that implementation evaluations matter is that they analyse the context in which interventions occur, and this context can matter for programme effectiveness. We can have more confidence in findings if a programme is found to work in many different places for many different groups. Indeed, if an intervention is found to work in some studies but not others, then having many studies can help us understand where it works and for whom.

For this reason, and mirroring evidence-based medicine, most What Works Centres rely not on single studies of an intervention but on systematic reviews which pull together all available evidence on the effectiveness of that intervention. However, systematic reviews are technical documents. To be used by policymakers they need to be put into more accessible forms, and the What Works movement has been at the forefront of providing new, more digestible ways of presenting evidence.

Figure 1 shows the knowledge brokering pyramid, which rests on the foundations of data (both qualitative and quantitative) and studies (which may be qualitative, quantitative or mixed method). These studies are summarized in systematic reviews.

Both reviews and studies can be put in databases of particular types of evidence (for instance, the Canadian Homelessness Hub is a database of studies of homelessness). Evidence maps, like those CHI and Campbell have produced for homelessness, structure the evidence in a way that makes it more navigable. Using a database or map is better for the user than going to a general search engine such as Google, as someone has curated that evidence product to ensure it only includes relevant studies. Maps and databases then take the user to the actual study.

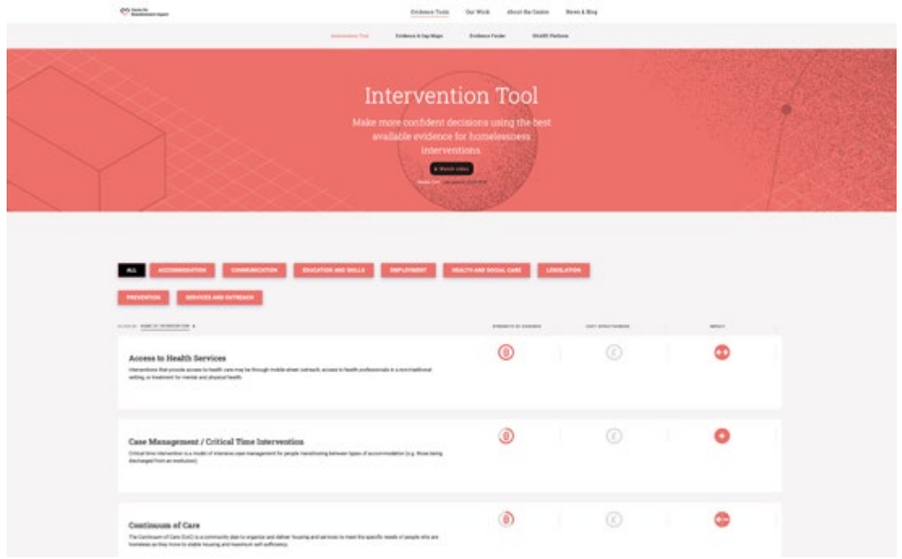
Figure 1 Knowledge brokering pyramid

The top three layers of the pyramid communicate the evidence to the user without requiring the user to look at the academic papers.

Evidence portals make the evidence available in an accessible way to inform the decision of the decision-maker. Guidelines are produced by committees of experts and users taking the evidence into account, giving recommendations to decision makers. Checklists simply inform practitioners what to do based on the evidence.

Following on from the production of the two initial Evidence and Gap maps on Homelessness, CHI developed an Intervention Tool modelled after EEF's Teacher and Learning Toolkit because it is one of the most successful Evidence Portals ever created. The development of these maps marks the first stage in a wider programme of evidence synthesis, that allows us to extend our evidence architecture to the top three rows of the Knowledge Brokering Pyramid.

Figure 2 CHI Evidence Portal – Intervention Tool



What is an Evidence and Gap Map?

An Evidence and Gap Map (EGM) is a presentation of the available, relevant evidence for a particular sector, such as homelessness.

Different types of evidence are needed to address different questions, with each map summarising a specific type of evidence. CHI is supporting two maps: a map of evaluations that measure the impact of certain interventions (the 'what works' or effectiveness map), the third edition of which was published in November 2020, and a map of process evaluations which shows existing evidence regarding implementation of interventions, for which this document is the second edition.

This Implementation EGM contains evaluations with valuable qualitative evidence on what are called 'barriers' and 'facilitators'. That is, factors which work as barriers to hinder successful implementation of policies and programmes, and factors which facilitate the programme and therefore support its implementation. Making this evidence available is intended to support better design and implementation of programmes, to improve their performance.

The map is a table or matrix which provides a visual presentation of the evidence.

In the case of the Implementation EGM, the rows pertain to broad intervention categories (see Appendix 1, Table 1), namely:

- Legislation
- Prevention
- Services and Outreach
- Accommodation Based Approaches
- Employment
- Health and Social Care
- Education and Skills
- Communication
- Financing

The columns refer to implementation issues (see Appendix 1, Table 2), pertaining to the following five broad categories:

- Contextual Factors
- Policy Makers / Funders
- Programme Managers / Implementing Agency
- Staff / Case Workers
- Recipients

Within each of these broad intervention and implementation categories, there are detailed subcategories, as presented in Appendix 1.

The map also has filters for time and place, allowing the evidence to be restricted to specific countries, regions or years. The online versions of the map are interactive so that users may click on entries to see a list of studies for any cell in the map. Clicking on study names shows the database record for the study with a link to the study.

How can this EGM be used?

The CHI EGMs have been made to inform the commissioning of reviews, identify gaps where new evaluations are needed, and to provide content for CHI's Intervention Tool. The Intervention Tool contains evidence on both effectiveness and implementation issues, and in future will contain evidence on costs from a review of costing studies which has been commissioned.

The purpose of the Implementation Map is to provide a guide to the areas where there is and is not relevant evidence of factors acting as barriers or facilitators to given interventions. The uses of this EGM include:

- Guiding users to available relevant evidence to inform strategy and programme development. The map structures the evidence to guide the user to the area they are interested in and only contains studies that have been screened for relevance.
- Identifying interventions for which there are a lack of primary studies, or for which there are enough studies to conduct a systematic review that has not yet been undertaken
- Giving some insight into the study findings by virtue of flagging which issues are identified as being important.

Most of previous EGMs developed by the Campbell Collaboration in the past have been limited to quantitative effectiveness maps. The homelessness Implementation EGM was the first map of qualitative studies using this approach. It is thus a methodological innovation, and something of a work in progress. It does not cover all relevant qualitative studies on homelessness, but rather focuses specifically on those concerning implementation issues. Future EGMs may cover qualitative research on other matters, such as intervention outcomes or the lived experience of homeless people.

Table 1 compares the two CHI-Campbell homelessness EGMs. The two maps have different content (impact versus implementation evaluations), different frameworks (same row headings but different column headings).

One map is more useful for certain purposes than the other. For instance, the Effectiveness Map may enable a decision-maker to choose an appropriate intervention for their client group. After this, the Implementation Issues Map would allow the decision-maker to focus on evidence about the factors key to effective implementation of their chosen programme.

The meaning of the gaps differs between the two maps. In the Effectiveness Map, gaps are areas in which there are a lack of studies measuring effectiveness of interventions. In the Implementation Map a gap indicates that the issue has not been flagged as an issue – either positively or negatively – in the included studies.

Table 1 Comparison of the effectiveness and implementation evidence maps

	Effectiveness	Implementation evidence
What types of study are included?	Experimental and quasi- experimental quantitative studies of effectiveness	Qualitative evaluations
How many studies are included?	221 in first edition (2018) 260 in second edition (2019) 394 in third edition (2020)	246 in first edition (2018) 275 qualitative evaluations in current edition.*
What do the rows and columns show?	Rows: Intervention categories and sub-categories Columns: Indicator domains and sub-domains	Rows: Intervention categories and sub-categories Columns: Implementation issues (categories and sub-categories)
What is shown in the map?	Which and how many studies report the statistical effects of specific interventions on specific outcomes	Which and how many qualitative studies report specific implementation issues for specific interventions
What is the purpose of the map?	Guide users to evidence Identify clusters of evidence for evidence synthesis Identify gaps where primary studies needed Inform initial information in intervention tool	Guide users to evidence Identify clusters of evidence for evidence synthesis Identify gaps where primary studies needed Inform initial information in intervention tool Identify common implementation issues

Note: * 63 new studies were added, but 34 excluded from the previously included studies on rescreening.

Chapter 2

The Homelessness Implementation Issues Map

What does the Homelessness Implementation Issues Map show? An overview

A main finding for the map is that there are a substantial number of implementation studies. We include 275 implementation studies in this edition of the map.The earlier version of this map published in 2018 included 246 studies.

Analysis of the identified process evaluations showed that there are several target audiences for the reports, which affect their structure and methodology. Whilst some were written for academic journals, others were written for government departments, or commissioned by an implementing agency themselves — some of these reports were written by organisations carrying out the intervention, whilst others employed independent evaluators. This range of audiences, purposes, and authors means the reports adopt a wide range of methods, writing styles, and do not all focus on every aspect of a programme.

We first describe how we located these studies, before exploring how we organised them in the map. We then provide an overview of the map findings.

How did we create the Implementation Issues Map?

What evidence is included?

The implementation EGM maps the issues identified in process evaluations on interventions that aim to improve the lives of those who are homeless or at risk of being homeless.

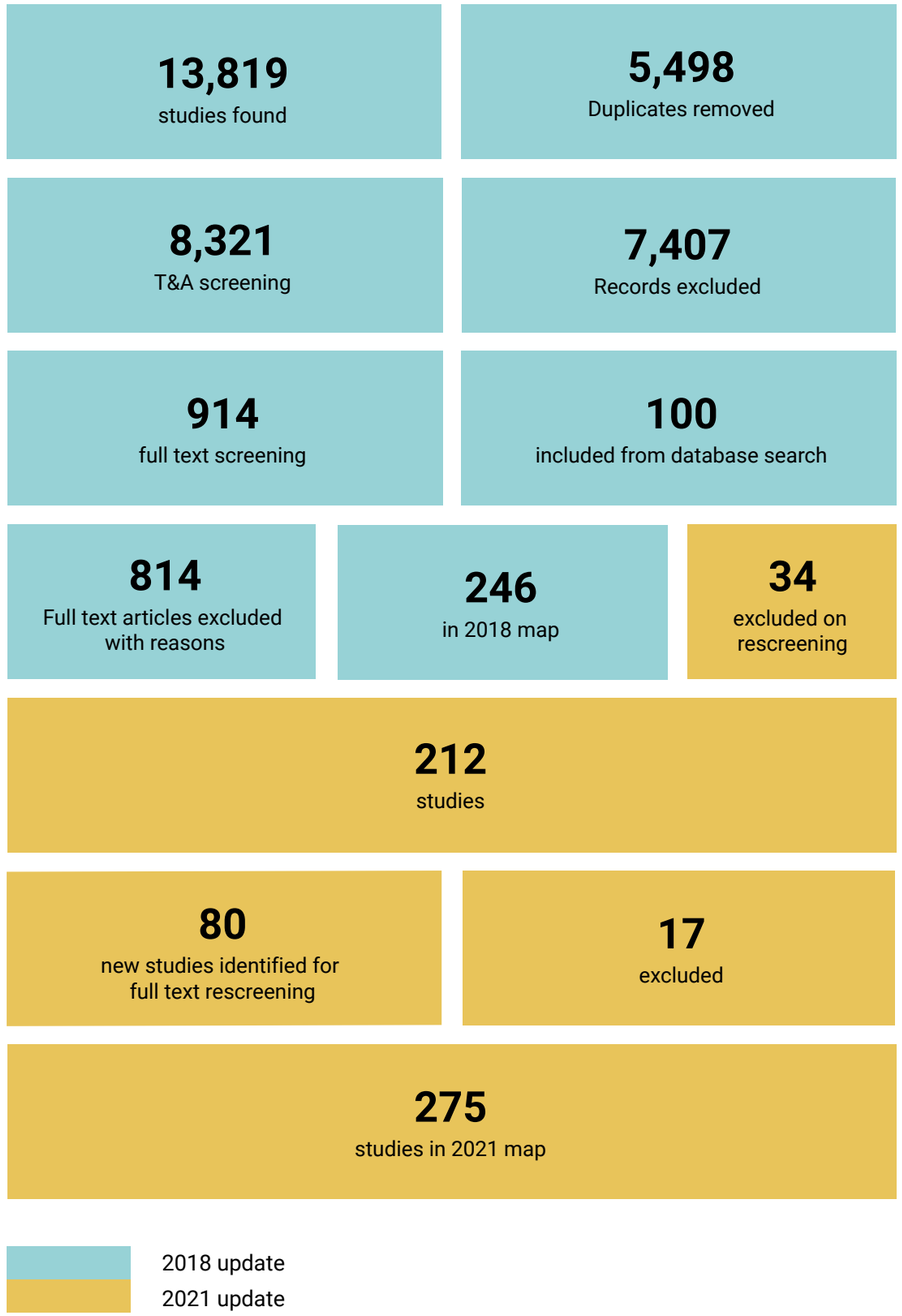
Implementation evaluations typically cover a range of issues, such as describing context, the intervention, and characteristics of the beneficiary population and their perceptions of the programme. For the purposes of the map, we only coded findings related to the implementation issues.

The framework

The intervention categories are the same as those used for the Effectiveness Map. These categories went through several stages. The first set of categories were based on those used in a systematic reviews of interventions to improve housing stability.2 These categories were substantially revised on the basis of inputs by a network of homelessness researchers in the United Kingdom. As is standard practice for evidence synthesis, these categories were piloted against a set of thirty studies for the effectiveness map resulting in further revisions by the Campbell Collaboration research team. They were subsequently further revised by CHI based on user feedback on the two maps (Table 1).

The implementation issues categories were developed through an iterative process. An initial set of categories was developed by the Campbell Collaboration team based on the implementation science framework presented by Greg Aarons and colleagues.3 These categories were piloted against identified process evaluations independently first by the Campbell Collaboration/ Queen's University Belfast team, and then by the Heriot-Watt University research team.

Figure 3 PRISMA Flowchart



2 Munthe-Kaas H, Berg RC, Blaasvær N. Effectiveness of interventions to reduce homelessness: a systematic review. Campbell Systematic Reviews 2018:3 DOI: 10.4073/csr.2018.3.

3 Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a Conceptual Model of Evidence-Based Practice Implementation in Public Service Sectors. Administration and Policy in Mental Health, 38(1), 4–23. http://doi.org/10.1007/s10488-010-0327-7

Populating the map

The Implementation Issues Map is based on a review of the global evidence from a systematic search of electronic databases, selected websites and journals, and expert consultation.4 The search strategy is described in more detail in the next section.

The initial search identified nearly 13,819 potentially relevant studies, which reduced to just over 8,300 once duplicates were removed (see Figure 3).

These studies were screened for relevance against our inclusion criteria. This meant the study had to be a process evaluation of interventions to improve the welfare of homeless individuals or families, or those at risk of homelessness.

The screening was a two-stage process. All records were screened by title and abstract, leaving 914 studies to be screened for full text. Of the 246 studies included in the first edition of the map 34 have been excluded from this edition based on rescreening. Of 80 new studies identified for full text screening for this update 63 were added to the map, leaving a total of 275 process evaluations. The previously included but now excluded studies are largely impact evaluations. They had insufficient implementation evidence for inclusion. Some of them were implementation lessons with expert opinion and not evaluations of specific interventions. In order to pay more attention to the particular process that facilitated or hindered interventions we excluded 34 records from the previous report.

4 The map is restricted to evidence from high-income countries, since the context for homelessness in low- and middle-income countries is very different as are the interventions adopted to address it.

5 http://homelesshub.ca/

Search strategy

There were two parts to the search strategy. The first was a comprehensive database search, which included:

- Step 1-The database search was more focused on academic papers such as EMBASE, OVID, SCOPUS and ERIC.
- Stage 2-Search of evidence and gap map databases such as 3ie, Campbell and Cochrane
- Stage 3-Systematic Review databases such as Cochrane and Campbell

The key words for the database search included terms for study design (e.g. “quasi experiment*” or quasi-experiment* or “random* control* trial*” or “random* trial*” or RCT or (random*) and for homelessness. The latter included generic terms (homeless persons/or homeless youth), population categories (evict* or homeless* or "housing excl*" or “residential stability” or runaway* or “Run away from home” or “Running away” or “Ran away” or “Going missing” or “Bag lady” or Houseless* or Unhoused or “without a roof” or Roofless or Destitut* or “Skid row*” or “sleepers out”), and specific programmes (e.g. “Housing first” or “Pathways to Housing” or “Homeless Veterans Reintegration Program” or “Access to Community Care and Effective Services and Support).

In addition to the above, additional websites were searched for grey literature, including those of bilateral and multilateral organizations. A major source of these studies is the Canadian Homeless Hub.5 We also searched the websites of government departments (e.g. Housing and Urban Development in the United States) as well as state or county governments in Australia, Canada, the United States, the United Kingdom, and major cities in these countries. In addition, the websites of homelessness agencies, such as Crisis, Homeless Link, Shelter in the United Kingdom and Mission Australia were searched. For these searches we either navigated to the relevant page listing studies, or searched the site as a whole or the publications page using a simple search string of “homeless evaluation”. The website results were screened online, with the proposed included studies checked by a second screener.

The update

For the update we searched for evaluations from the database search for the latest update of the effectiveness map. We also searched the websites described above a second time. This process identified 80 studies. Of these we included 63 after further screening and coding.

During preparation of this update of the map we recoded the interventions, and so also rescreened the already included studies. Of the 264 studies from the first edition we excluded 34. These studies were either impact evaluations with too little implementation evidence to be included, or papers discussing interventions but not explicitly based on evaluative evidence.

We anticipate that the release of the updated map and this report will result in more process evaluations being sent to us for inclusion. We strongly encourage such submissions (using the 'Submit a Study' on the map) to strengthen the evidence base.

About the screening and coding process

To minimise the risk of missing studies or incorrectly including others, the screening was conducted by two researchers independently. Any discrepancies in their answers were discussed, and referred to a third party if they could not agree.

Contextual coding was also conducted by two researchers working independently on the first thirty studies. They recorded the details of the study, including the intervention category it refers to, the indicators it measures, and other study data. After these first reports, consistency was achieved and the remainder of studies were coded by only one member of the team.

For quality assurance for this edition we re-screened each study for inclusion. As described above, this resulted in previously included studies being excluded.

Coding of reports to identify the implementation issues was conducted by the two researchers independently. Coding for the new edition of the map included critical appraisal of the included studies, which is described below. Quality control procedures were put in place to ensure consistency of interpretation, with the team meeting regularly to discuss any issues.

How to read the map

For each study included in the map we noted the pages on which different implementation issues were identified as being important in either supporting or hindering successful implementation of the intervention. Therefore, the heavily populated cells in the map – meaning the ones with larger bubbles – mean that many reports identified that issue as being important for that intervention category.

In contrast, where a cell has a small bubble or none at all it means that few or no studies identified the issue as being important for that intervention.

A large number of studies in a cell is a result of two factors: (1) the issue being mentioned in many reports, and (2) the number of reports for that intervention category.

For example, there are sixty six studies in the map related to case management, more than for any other intervention sub-category. Thus, these rows of the map are heavily populated. The most populated cell on this map is 'adequacy of resources' as a constraint to successful implementation. This is mentioned in 188 studies.

To illustrate the point that importance is measured by the relative, not absolute, number, consider 'adequacy of resources' for social housing. It is mentioned as an issue in 13 out of 19 studies of social housing. This means inadequacy of resources is flagged as an issue in 68% of studies for social housing. This is exactly the same proportion as for Case Management, despite the lower absolute number of studies mentioning the issue.

How should we interpret this finding? Of course, adequacy of resources is an issue almost by definition. The finding means that in nearly three-fifth of cases, the lack of adequate resources (mainly suitable housing) was a sufficiently severe problem to be picked out in the process evaluation. Whilst it may seem obvious to say that programmes need adequate resources, these findings show that the majority of programmes nonetheless run into resource constraints. Hence, programmes designed to assist people to locate and move into housing will be hampered if housing is not available.

What are the main implementation issues?

Across the 275 studies in the map, there are 2,164 instances of factors supporting implementation of the interventions under evaluation, and1, 546 instances of factors hindering it. These figures equate to eight supporting factors and six hindering factors per study, or 14 factors per study. Thus, a first finding is that no single factor alone is responsible for success or failure of any intervention. Multiple factors usually come into play, reflecting the complexity of implementation.

The implementation issues are unevenly spread across the five categories identified. Issues related to Programme Administrators are mentioned in the vast majority of cases (79% of possible cases) followed by issues related to the recipient or service users (seventy percent of cases). The least commonly mentioned issue is contextual factors, but they are still mentioned in 38% of cases. Issues related to staff / case workers and policy-makers and funders are in the middle with 46% and 41% respectively. Given the varied nature of interventions, this is not surprising. However, it draws attention to the complex interplay of different structural forces and agents in any programme implementation.

Turning to analysis of the specific issues, a clear finding is that many issues are equally likely to be factors which hinder

implementation as support it. For example, adequacy of resources is mentioned as a supportive factor in 152 of the 275 studies, and a hindering one in 186 studies - so clearly it is often identified as both a help and hindrance within the same study. This may be because some parts of a programme are better resourced than another, or because some resources are available, such as staff, but others are not, such as suitable housing. Similarly, buy-in of the recipients of program procedures is mentioned as a help in 113 reports and a hindrance in 109 .This warrants further investigation to understand the nature of such issues, which can be further explored in the systematic reviews.

However, this balance of being both barrier and facilitator is not always seen. This is clearly the case for contextual factors which mostly hinder successful implementation. The housing market was stated as hindering implementation in 83 studies, welfare support in 44 and the labour market in 21, compared to helping implementation in just 20,23 and three reports respectively. The exception was the legal context which was seen to help in 44 reports, but be a hindrance in 26. Given the varied contexts of the reports, this provides a clear directive to investigate what does and does not support delivery of different programmes in different contexts. However, it is clear that, as already mentioned, the lack of suitable housing alternatives can limit programme effectiveness.

Table 2 summarises the data according to how frequently an issue is mentioned. The main issues which emerge are:

- Adequacy of resources, which can be a support if present and a hindrance if not. The adequacy of resources refers to space, time, staff, and budget. A common example is the caseload of case workers, with low case loads needed if case workers are to effectively support transitions out of homelessness. It may also refer to how good a specific service or facility is, particularly in relation to the client group they are serving. For instance, the service may have been created for those with low support needs, but be in high demand from potential users with high support needs. This leads to an inadequacy of resources to serve the people most requiring the intervention. Finally, a programme may completely lack a service that is required to help their target group.

- Buy in is often mentioned as both a help and hindrance, appearing across all four categories of stakeholders: policy- maker / funder, programme administrator, staff / case worker, and recipient:

    - At the policy-maker level, buy in includes political commitment at both national and local government levels. For instance, a programme may be commissioned as a key part of a government strategy. Alternatively, an implementing agency may have acquired funding from a private source and find a lack of political buy-in makes it difficult to deliver elements of the service.

    - In the staff/case worker category, case workers may be ideologically in favour of a programme such as Housing First and therefore work hard to achieve the aims. In contrast, they may have reservations of a programme such as Reconnections and therefore show less commitment to achieving its aims.

    - For recipients, buy-in refers to emotional acceptance of the programme. For example, whether a programme recipient feels accepted and supported by staff, and whether the proposed outcomes of their participation fits with their priorities. For instance, if permanent accommodation is a key goal of a service user then they will likely buy-in to the philosophy of Housing First. However, if a service user prioritizes seeking treatment for a health condition but is offered only employment-based support then they are unlikely to buy-in to the programme. This would also likely occur if a service user felt discriminated against by a service, and therefore did not trust its aims and objectives.

- Coordination and communication are important, showing up in several diverse categories such as a case worker's communication with recipient; adequacy of information received by recipient; and the implementing agency's referral route, alignment with existing procedures, contract arrangements, data sharing, and partnership-working. These findings point to the need for new initiatives to be designed taking into account the existing landscape of available services to ensure effective and efficient service delivery and avoid duplication. Indeed, implementing agencies and staff need to ensure they communicate effectively with service users.

The extent to which we can explore these issues is limited by the fact that mapping does not analyse the content of what the report has to say about each issue. Instead their purpose is to quickly map what evidence is available across key issues.

However, for illustrative purposes, Box 1 summarises findings from the process evaluations of programmes for people being discharged from prison. As stated in the box, the main issues in the implementation of discharge programmes are timely action, and the importance of good partnerships with effective communication.

The systematic reviews which are being commissioned by CHI to develop the Intervention Tool dig deeper into these issues. They draw on the content of both maps and draw insights that have been used to further develop the Centre's Intervention Tool.

Table 2 Implementation issues supporting and hindering implementation

	Contextual	Policy maker / funder	Programme administrator	Staff / case worker	Recipient
(a) Support					
Rarely mentioned (<10%)	Labour market, housing market and welfare Support			,	
Sometimes mentioned (10-29%)	Law	Contracting arrangements and Framework provision	Referral route, alignment with existing procedures and monitoring and data sharing	Buy in	Adequacy of information provided
Often mentioned (30-69%)		Leadership buy- in,	Leadership buy in, identification of recipient, adequacy of resources and partnership/collaboration	Communication with recipient, communication with other agencies, emotional skills and technical skills	Buy in, access to non-housing support, housing-related security and accessibility
Mentioned very frequently (>=70%)					
(b) Hinder					
Rarely mentioned (<10%)	Labour market and law			Emotional skills	
Sometimes mentioned (10-29%)	Welfare support	Leadership buy-in, contracting arrangements and framework provision	Buy in, identification of recipient, Referral route, Alignment with existing procedures and partnership	Buy in, communication and engagement with recipient, communication with other agencies and technical skills	Access to non-housing support, Housing related security and adequacy of information provided
Often mentioned (30-69%)	Housing Market		Data monitoring and sharing and adequacy		Buy-in and accessibility.
Mentioned very frequently (>=70%)					

Box 1

Implementation issues in prison discharge programmes

This summary is based on five reports: two of discharge programmes in the UK, one from Australia, and two reports from one programme in the United States.

The main issues in the implementation of discharge programmes are timely action; the importance of good partnerships and communication between different agencies; and effective communication with programme recipients. Planning for housing on discharge should begin on entry into custody. Partnerships are needed between the various service providers, and also possible landlords after discharge, with timely and effective communication about client history, discharge plans and behaviour post release.

To avoid discharging into homelessness, or situations which increase the likelihood of homelessness, preparation for discharge should begin early, preferably with a housing assessment made on entry. Where the person in custody had housing prior to entry, the assessment is the basis for a plan of what needs to be done to sustain the housing during custody. Housing sustainment may involve one or both of ensuring rent, where possible, is paid during custody and the person in prison maintains family relationships.

Where housing is not available, a number of steps are taken to identify housing. One issue is to ensure that the team responsible for housing has full information on the client and their case

and criminal history as this affects the availability of housing. Case workers can play an important role as intermediaries with housing providers. In the case of public sector housing they can argue against the client being ruled as ineligible for local authority housing, as they voluntarily chose to become homeless by committing a crime, which has been an issue in the United Kingdom. For private sector providers, case workers play an important part in persuading private landlords to accept tenants they may be reluctant to otherwise take on. Building a relationship between the team responsible for rehousing and private landlords has helped programmes be successful by increasing the range of available housing.

Clients being discharged from prison need a broader range of services than finding a home. An assessment of service needs should be made whilst they are still in prison; connections made to relevant services; and the discharge date communicated. The majority of dischargees at risk of homelessness have alcohol or substance abuse problems and will need appropriate services to either maintain abstinence (if this was reached whilst in prison) or to manage their addictions once released.

Whilst social networks are important, existing connections may not be supportive to the individual's progress. A decision, involving the client, needs to be made regarding whether to relocate the client away from these networks to make a fresh start.

Clients are best accompanied on discharge. Most need help negotiating the various bureaucracies they need to engage with, which may involve very basic tasks such as form filling for those lacking functional literacy. Supervision can also help prevent re- engaging in problem behaviours.

Clearly this support all needs to be delivered in a timely manner. Partnership and communications are important, and staff turnover may undermine these. Finally, flexibility helps since different clients have different needs.

Other dimensions of the map

The studies are spread unevenly by intervention category and geography: see Figures 5 and 6. A study may cover multiple interventions. For example, the Homelessness Review conducted for Birmingham City Council covers a range of interventions,7 and there are a few studies which cover more than one country. For instance, The Housing First Europe report covered five test sites in five countries, with additional information from another five.8

The most common intervention category is 'services and outreach' which includes service coordination, case management and outreach interventions. A total of 162 studies (nearly fifty nine percent of the studies) come under this category.

Next most common are 1) accommodation-based interventions (e.g. housing first), 2) health and social care and services (e.g. physical, mental health services), and 3) prevention (such as welfare and housing support), which occur in 17 percent of the studies.

These results differ from those in the effectiveness map which is dominated by health studies – reflecting the greater use of quantitative impact evaluation, especially randomised controlled trials, in health sciences as compared to social sciences. However, the distribution of interventions is similar to the last implementation issues map in which most studies focused on accommodation-based interventions.

The majority of studies in the Implementation Map come from North America, with 104 studies from the United States and 38 from Canada (Figure 6). A minority (73 studies) are from the UK.

The majority of the studies in the map (217 = 78 percent) are published since 2010. This reflects the fact that as these are grey literature then older studies are less likely to be discoverable.

Currently the map only includes studies in the English language, so there is a clear bias toward Anglophone countries. We welcome submission of non-English studies.

Figure 5 Distribution of studies by intervention category

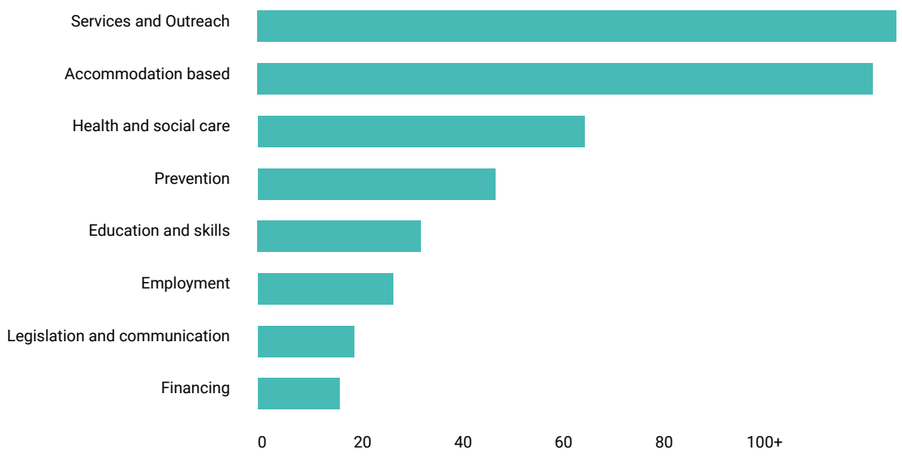
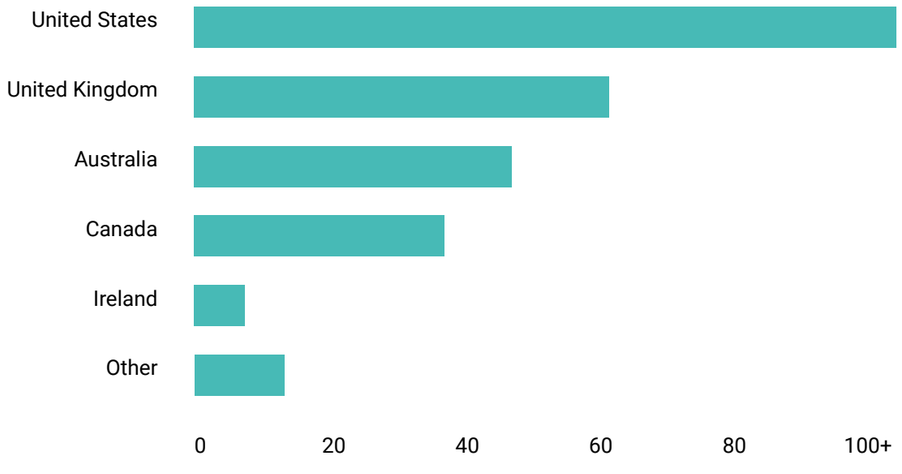


Figure 6 Number of studies by country



6 Directorate for People, Commissioning Centre of Excellence (2017) Homelessness Review 2016/17, Birmingham City Council.

7 Busch-Geertsema V., 2013, Housing First Europe: Final Report, GISS Bremen, Germa

Taking a closer look at the Implementation Issues Map

Table 3a shows the aggregate map for barriers, showing the intervention-barriers matrix at category level.

Table 3a Aggregate implementation issues map: barriers (no. of studies)

	Contextual factors	Policy makers/ funders	Program administrator/ manager/ implementing agency	Staff/ case worker	Recipient of program
Legislation	5	10	12	4	10
Prevention	13	14	28	16	26
Services and Outreach	54	47	99	59	91
Accommodation based interventions	55	48	96	54	84
Employment	5	6	10	6	10
Health and social care	7	16	36	21	28
Education and skills	6	7	17	10	12
Communication	5	8	12	7	10
Finance	2	1	2	2	3
TOTAL number of studies[1]	106	113	218	128	192

1 The total number of studies does not equal to the sum of the rows, given that a single study can be counted in several rows.

As noted above, a high number in a cell esults both from an issue being flagged and the number of studies in that intervention category. The highest number of studies is in the services and outreach intervention row. This is not because these interventions are disproportionately plagued by implementation issues, but because there are more evaluations of these approaches. Using the data in Table 3a, we can analyse which intervention categories do have a disproportionate share of the different implementation issues.

This analysis shows that contextual factors, such as the labour and housing markets, are relatively less important for health and social care and communications, as well as staff issues for communications. These contextual factors matter more for accommodation-based interventions, employment and education and skills approaches.

Issues related to programme managers, which are broken down below, are relatively more important for health and social care and communications. Recipient issues are also a barrier for communications, but less of an issue for legislation.

Performing the same analysis for facilitators (Table 3b) shows some similar findings. Again, contextual factors are less important for health and social care and communications. Recipient (service user) issues are an important success factor for communications.

Table 3b Aggregate implementation issues map: facilitators (no. of studies)

	Contextual factors	Policy makers/ funders	Program administrator/ manager/ implementing agency	Staff/ case worker	Recipient of program
Legislation	11	11	7	5	5
Prevention	12	19	29	22	32
Services and outreach	30	76	101	95	111
Accommodation based interventions	30	81	99	80	103
Employment	5	9	15	12	12
Health and social care	9	24	37	42	41
Education and skills	5	12	15	16	18
Communication	4	12	15	12	11
Financing	2	1	3	2	3
TOTAL number of studies	69	171	217	193	233

Intervention sub-categories

The most common types of intervention showing up in the intervention sub-categories are in services and outreach with 66 studies of case management, 30 of service coordination, 28 of outreach. In addition, there are 11 examples of day centres and nine of legal advice.

This is followed by accommodation-based interventions. There are 57 studies of housing first, 23 of shelters, 19 of social housing and private rented sector and 15 of temporary accommodation. Under health and social care, there are fifty studies of physical and mental health services and eight of addiction support.

The Quality of Studies Included in the Map

To assess the confidence in the study findings, critical appraisal has been carried out for all studies included in the map. This is done using a checklist, commonly referred to as a tool. Critical appraisal is the assessment of study quality using an explicit and transparent assessment criterion.

The critical appraisal tool used in this map was developed by the Campbell Collaboration in association with CHI. It contains questions relating to nine crucial dimensions of evaluation. Each of these is marked as implying Yes, Partly or No. The tool is given Appendix 3.

Overall quality is assessed using the 'weakest link in the chain' principle. This approach is preferred in critical appraisal to giving a score, since once critical weakness may undermine the whole study no matter how well it does on the other items. Hence, the confidence in study findings can only be as high as the lowest rating given to any of the critical items

Key domains of the studies were assessed to understand the study quality.

The 9 items of assessment include:

- Research Questions
- Qualitative methodology
- Sampling strategy /recruitment method
- Relationship between the researches and the participants
- Ethical considerations
- Data collection
- Data Analysis
- Policy recommendations
- Recommendations based on the study

Figure 7 Number of studies by overall quality (Based on critical appraisal)

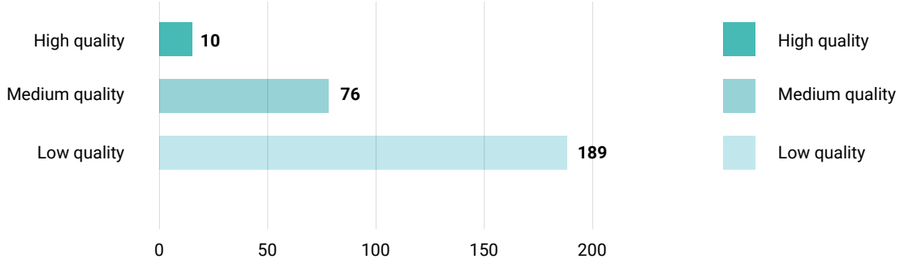
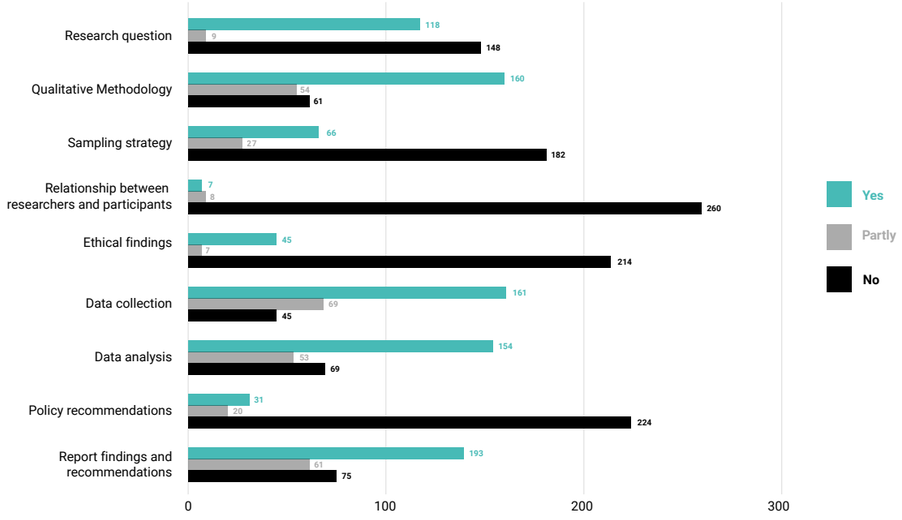


Figure 7 shows the overall results of the critical appraisal of the 275 included studies. The vast majority of the studies – 189 (almost seventy percent) - are rated as low confidence in study findings. Seventy six studies, a little over one quarter, are of medium confidence and just 10 studies (less than 5 percent) are rated as high confidence.

The most commonly well described dimensions in the studies are methodology and data collection and analysis which are explained in 160, 161 and 154 studies, respectively. This is followed by research questions which are positively assessed in 118 (51 percent) of the studies respectively. The sampling method or recruitment strategy employed is discussed in only around one quarter of the cases (66 studies). Ethical considerations and policy level recommendations are adequately discussed in 16% and 11% of the studies respectively. The least commonly highly rated category is the relationship between the researchers and the participants, which is given merely in seven studies (less than 5%).

It must be remembered that the assessment is based on what study authors report that they did. Hence a low rating may reflect a failure to report rather than an issue in the study. The findings show the need to improve studies of implementation and process evaluations or the reporting of those studies.

Figure 7 Responses by assessment criteria dimensions



Where are the gaps?

The gaps in the map signify issues which are not mentioned as implementation factors in the process evaluations. A gap may occur either because: (i) the issue is actually unimportant, or (ii) the issue may or not be important, but no one has looked at it. The map cannot tell us which of these is the case.

Contextual issues, especially the labour market, was rarely flagged as a supporting factor. They are more commonly mentioned as barriers to successful implementation.

On the other hand, the soft skills of communication with other agencies and emotional skills of case workers are not often mentioned as barriers, but do appear as important facilitators.

Chapter 3

Next Steps

This resource allows policy makers, practitioners and researchers to access the available relevant evidence on which homelessness programmes work and how to ensure that they work. It also assesses the quality of the evidence base.

The Centre for Homelessness Impact is a committed ‘one stop shop’ for evidence for policymakers and practitioners in the sector. Working with the Campbell Collaboration, the Centre produced two maps of evidence on homelessness: the first on quantitative ‘effectiveness’ measures; the second, in collaboration with Heriot-Watt University, on qualitative ‘implementation’ issues.

This report focuses on the second of these maps which is of implementation evidence regarding factors affecting programme performance, which we call the implementation issues evidence map. This map provides a valuable snapshot of the available evidence on implementation issues identified in homelessness interventions. All studies included in this map have also been critically appraised.

Though the map does not analyse what the reports say, it does provide initial, high-level insight on what the issues are and a strong platform to develop the Centre’s Intervention Tool.

The two maps (effectiveness and implementation) together give access to over 500 evaluations relating to homelessness. There are considerable bodies of evidence in some areas, less in others, and comparatively few systematic reviews.

A primary purpose of the maps is as a first building block for the Centre to construct an evidence architecture for the field and as an important step toward creating the Intervention Tool. This will be an aid to decision-makers, providing a clear visual summary of what the evidence says.

Ideally all entries in the Intervention Tool should be based on high quality systematic reviews which review evidence on both effectiveness and implementation. As the required reviews will

take time to develop and the Centre is committed to providing end users content they can use as quickly as possible, we have created evidence summaries to allow us to populate the Tool whilst waiting for these reviews. To inform the evidence standards behind the Intervention Tool the Centre has commissioned a review of those used by other What Works evidence portals which will be published later this year.

To better populate the Intervention Tool, the Centre will work with the Campbell Collaboration, Campbell UK and Ireland, Heriot-Watt and Cardiff Universities amongst others to produce a series of systematic reviews for key interventions. The EGMs have been used to identify these first reviews. We are still consulting as to the topics for these reviews which might be on Housing First, discharge programmes, and cost effectiveness.

We invite submissions for the EGMs so we can update them. We plan to update both evidence maps regularly, and also to review the intervention framework that is used to structure them (see Appendix 1) in light of the feedback received. These are very much 'living' products intended to evolve as our knowledge increases.

Appendices

Appendix 1

Description of interventions and issues

General note: Included interventions are those which have a primary objective of improving the welfare of persons experiencing homelessness, or of reducing the likelihood of homelessness amongst those at risk of homelessness. The map does not capture general correlates or determinants of homelessness, or of policies which may unintentionally affect homelessness either positively or negatively, e.g. Universal Credit in the United Kingdom.

This list is still undergoing consultation and so may be revised.

Table 1 Interventions

Category	Sub-category	Description
Legislation	Housing / homelessness legislation	Legislation pertaining to availability of / access to housing, or the rights of those experiencing homelessness.
	Welfare benefits	Legislation for welfare programmes to help people experiencing homelessness, or to help prevent people who are at risk of becoming homeless from losing their home.
	Health and social care	Legislation for access to health and social care to help people experiencing homelessness, or to help people who are at risk of becoming homeless.
Prevention	Welfare and Housing Support	State contribution towards housing costs and other welfare payments and services, whether directly made to tenants or indirectly paid to service provider (e.g. landlords - examples in the UK: Local Housing Alliance, Universal Credit, etc; US: vouchers) from the state or non-state actors. This includes other welfare benefits such as childcare if studied in the context of homelessness
	Housing supply	Policies promoting the development of new housing supply that is affordable and accessible (whether for social or private purposes) - this includes the construction, conversion of homes, and repurposing. Interventions comprise changes to legislation, financing mechanisms and other support for developers and those conditioning units for these purposes.
	Family mediation and conciliation	Counselling and mediation of conflicts, usually between young people and their family so they may avoid becoming homeless or reduce other risky behaviours. (Landlord-tenant mediation is a separate category)
	Landlord/tenant mediation	Mediation between landlords and tenants to encourage landlords to accept tenants with history of homelessness, substance abuse etc and to address conflicts. This may include, but is not limited to mediation around arrears, noise and substance abuse, damage to property, eviction, etc. Mediation with neighbours is also included here.
	Discharge Interventions	Provision of services, including accommodation, to people being discharged from institutions (care, hospitals, prison, armed forces) to avoid people being discharged into homelessness. This may include coordination between agencies, accommodation, and other services tailored to their needs. It refers to both interventions whilst in the institution and community-based interventions focused on recently discharged persons.

Category	Sub-category	Description
Services and Outreach	Direct feeding	Provision of food in street settings to people experiencing homelessness.
Services and approaches	In-kind support (exc. food)	Provision of clothing, hygiene products, household items etc., but excluding food
	Day Centres	Centres open only during the day to provide food and services for people experiencing homelessness. This code is used if the day centre itself is being evaluated in the study rather than being the setting for the intervention.
	Outreach	Outreach refers to work with people sleeping rough or in temporary or unstable accommodation. Outreach workers go out, including late at night and in the early hours of the morning, to locate people who are rough sleeping or work with day centres, shelters etc. The role of outreach teams varies but usually outreach workers seek to engage with people and check their immediate health and wellbeing, collect basic information about their situation, facilitate access to emergency accommodation or other accommodation (such as hostels or Housing First), and inform them about day centres and other services they might have available. Outreach models vary and may include enforcement (e.g. police officials) to remove people from the streets or enforce specific behaviours.
	Reconnection of people experiencing street homelessness	Reconnecting people experiencing homelessness (rough sleepers) or at risk of homelessness (e.g. dischargees) to their 'home' location (usually another city, state or country where they have networks, access to services, etc) by providing the cost of transport for relocation.
	Psychologically informed environments (PIEs)	Psychologically informed environments are interventions designed to take into account the psychological profile of the client. Community Reinforcement Approach (CRA) is included here.

Category	Sub-category	Description
Services and approaches	Case management (inc. Critical Time Intervention)	Individual-level approach to ensure coordination of services. The case worker (can be social worker or dedicated case worker from another agency) works directly with the client to ensure that the client has access to all applicable services e.g. health, training and social activities. A specific application of the case work approach is critical time intervention (CTI) which provides a person (or family) in transition between types of accommodation and at risk of homelessness with a period of intensive support from a caseworker. The caseworker will have established a relationship with the client before the transition – for example, before discharge from hospital or prison. Critical time intervention involves three stages: (1) direct support to the client and assessing what resources exist to support them, (2) trying out and adjusting the systems of support as necessary, and (3) completing the transfer of care to existing community resources.
	Service coordination, co-location or embedded in mainstream services	System-based approaches to ensuring coordination of service delivery. Coordination may refer to ensuring communication between relevant services. Coordination also includes providing services in the same location or adjacent to mainstream services. Co-location refers to multiple services being available in the same physical location (e.g. housing and job search services in the same location) . Embedded refers to services being integrated in the same place (e.g. housing and other services within a hospital context). A specific example is coordinated assessment. Refers to case workers making broad assessments of people at risk as homelessness on different factors that affect their risk. Try to ensure different services employ the same assessment tools to standardise practice.
	Veterinary services	Access to veterinary services for pets of people experiencing homelessness
	Legal advice	Legal assistance and advice delivered away from primary service/office to the homeless population.

Category	Sub-category	Description
Accommodation Based Interventions	Shelters	Homeless shelters are a basic form of temporary accommodation where a bed is provided in a shared space overnight. One of the key features of a homeless shelter is that it is transitional and an option for those homeless who are not yet eligible for more stable accommodation. Shelters are not usually seen as stable forms of accommodation as the individual must vacate the space during daytime hours with their belongings. One of the key differences with hostels is the need to vacate the premises during the day.
	Hostels	Hostels for homeless people are designed provide short-term accommodation, usually for up to two years depending on available move-on accommodation. Typically shared accommodation projects with individual rooms and shared facilities including bathrooms and kitchens. Hostels have staff on site 24 hours a day and during the daytime provide support to residents on issues including welfare benefits and planning their move from the hostel into more medium to long-term accommodation
	Temporary accommodation	Temporary accommodation includes a range of housing options which are more stable than shelters or hostels, such as transitional housing and residential programmes.
	Host homes	Emergency Host homes are emergency short-term placements in volunteers' own homes in the community for people who are homeless or at risk of homelessness. Hosting services are often aimed at young people with low support needs, but exist for other groups too, such as people who have been refused asylum.
	Rapid Rehousing	Rapid rehousing places those who experiencing homelessness into accommodation as soon as possible. The intervention provides assistance in finding accommodation, and limited duration case work to connect the client to other services

Category	Sub-category	Description
Services and approaches	Housing First	Housing First offers accommodation to homeless people with multiple and complex needs with minimal obligations or conditions being placed upon the participant. Housing First provides safe and stable housing to all individuals, regardless of criminal background, mental instability, substance abuse, or income.
	Social housing	Housing that is provided in the social sector. It may sometimes be provided alongside support services, this may be temporary or permanent. Examples of support that may be provided are health and money management (excluding Housing First and Rapid Rehousing). This is based on an institutional setting.
	Private Rental Sector (with and without support)	. Housing that is provided in the private rental market where the tenant is fully responsible. This may or may not include additional support services as the focus is on the type of tenancy agreement (private).
	Continuum of Care	An approach to accommodation whereby people experiencing homelessness move through different forms of transitional accommodation until they are deemed 'housing ready' (e.g. stopped substance abuse) and allocated independent settled housing.
Employment	Mentoring, coaching and in-work support	Mentoring and coaching to support job search including activities like practice interviews, review CVs, etc and on the job support for work performance.
	Flexible employment	Employment which can accommodate needs for the person experiencing homelessness.
	Vocational training and unpaid work experiences	Unpaid job placement or vocational training to provide work experience for people experiencing, or at risk of, homelessness.
	Paid Work experiences	Paid job placement to provide work experience for people experiencing, or at risk of, homelessness.

Category	Sub-category	Description
Health and social care	Health services (physical and mental)	Providing direct access to, or facilitating access to, physical and mental health services for people experiencing homelessness.
	End of life	End of life care for people experiencing homelessness.
	Addiction support	Services for people experiencing, or at risk of, homelessness who have substance misuse problems (including alcohol and other substances)
Education and skills	Life and social skills training	Life and social skill training including socio-emotional skills, financial literacy (money management), tenancy management, and how to deal with ones home; for people experiencing or at risk of homelessness
	Mainstream education	General education at all levels for people experiencing, or at risk of, homelessness including children in families at risk of or experiencing homelessness.
	Homelessness awareness programmes in schools	School-based programmes to raise awareness of homelessness [Not interventions to help school aged children attend school; these are under mainstream education).
	Recreational and creative activities	Recreational, social (e.g. social clubs) and creative (e.g. theatre) activities for people experiencing homelessness
Communication	Advocacy campaigns	Campaigns by 3rd sector organisations which aim to improve awareness of the general public of homelessness, its causes, and its solutions, and promote rights of the homeless.
	Public information campaigns	Campaigns by government organisations which aim to improve awareness of the general public of homelessness, its causes, and its solutions, and promote rights of the homeless.
Communication	Service availability	General communication activities to raise awareness amongst people experiencing homelessness, or at risk of homelessness, of the services available to them. Does not include case management, discharge etc which provides information or connects individuals to services.
Financing	Social Impact Bonds	Performance-based financing for organizations commissioned to provide services to people experiencing homelessness. Not these are not interventions in themselves, but payment mechanisms for service deliverers.
	Direct financial support from public	Money given directly by individuals to those experiencing or at risk of homelessness

Table 2 Issues

Category	Sub-category	Description
Contextual factors	Housing market	Housing market conditions (quantity, quality, price)
	Labour market	Labour market conditions, such as amount and type of employment available, and factors affecting those who are homeless or having conditions correlated to homelessness.
	Welfare support	Factors related to welfare support (availability, type, value, timing) and restrictions.
	Law	Laws directly affecting people experiencing homelessness or at risk of homelessness.
Policy maker / funder	Buy-in (Leadership, culture, priorities, commitment to programme)	The support of the leadership, organisational culture and incentives.
	Contracting arrangements with external agencies	Restrictions, incentives etc. arising from contractual arrangements.
	Framework provision (e.g. policies and guidelines)	Organisational policies, guidelines and requirements (formal or informal).
	Buy in (Leadership, culture, priorities)	Understanding and support from programme staff and managers
	Identification of recipient / targeting mechanism	Process, rules, procedures, both de jure and de facto, used to identify programme beneficiaries
	Referral route (e.g. defined agency or contact)	Process, rules, procedures, both de jure and de facto, used to refer programme beneficiaries
	Sufficiency/ Adequacy of Resources (space, time, staff, budget	Availability (quantity and quality) of resources of all kinds
	Alignment with existing protocol/ procedures/ guidelines	Whether a project or programme is well aligned with existing procedures etc.
	Monitoring data/ Data sharing	Availability, collection, and usefulness of monitoring data
	Partnership/ collaboration with external agencies	Formal and informal working arrangements with other agencies

Category	Sub-category	Definition
Staff/case worker	Buy-in (commitment to program)	Understanding and support from delivery (implementation) level staff / case workers
	Communication and engagement with programme recipient	De facto and de jure arrangements for and occurrence of communication with programme recipients by staff / case workers
	Communication and engagement with other agencies	De facto and de jure arrangements for and occurrence of communication with other agencies by staff / case workers
	Emotional skills (Awareness, building trust, taking a personalised approach)	Level of emotional intelligence and skill displayed by staff / case workers
	Technical skills (capabilities, training)	Technical capacity of staff / case workers to perform their jobs, and support for that capacity
	Buy-in (emotional acceptance of programme)	Acceptance of the support offered by the project or programme by intended recipients
	Access to non-housing support (medical, financial, training etc.)	Access to non-housing support services necessary for programme implementation to be successful

Category	Sub-category	Definition
Staff/case worker	Housing-related security	Provision to stay in appropriate housing to prevent a recurrence of homelessness
	Adequacy of information provided	The quantity and quality of the information provided about the programme to intended beneficiaries
	Accessibility (time and place)	Accessibility of the services provided by the programme in terms of time and space

Appendix 2

Data tables

No. of studies by intervention sub-category

Legislation	17
Housing/Homelessness/vagrancy legislation	11
Health and social care legislation	0
Welfare benefits	6
Prevention	46
Welfare and Housing Support	16
Housing Supply	3
Family therapy and mediation	7
Landlord-tenant mediation	6
Discharge	14for
Services and outreach	162
Feeding	5
In Kind Support	2
Day Centers	11
Outreach	28
Reconnection	7
Psychologically informed environments	4
Case management / Critical time intervention	66
Service coordination	30
Legal Advice	9
Veterinary services	0
Accommodation based interventions	**151**
Shelters	23
Hostels	1
Temporary Accommodation	15
Host Homes	2
Rapid Rehousing	7
Housing first	57
Social Housing	19
Private Rented Sector (With and Without Support)	19
Continuum of Care	8
Employment	**31**
Mentoring and coaching	12
Flexible employment	3
Vocational Training and unpaid work experiences	8
Paid Work experiences	8
Health and social care	**58**
Access to health services (mental and physical health)	50
End of life care	0
Addiction support	8
Education and skills	**29**
Life skill training	12

Education	10
Creative activities	7
Homelessness awareness programs in schools	0
Communication	**17**
Advocacy campaigns	11
Public information campaigns	3
Service availability	3
Financing	**14**
Social Impact Bonds	6
Direct Financial support from public	8

No. of studies by barriers and facilitators sub-categories

No.of studies by implementation issues

Contextual Factors	**174**
Housing Market	83
Labour Market	21
Welfare Support	44
Law	26
Policy Makers and Funders	**175**
Buy-in (Leadership, culture, priorities, commitment to programme)	70
Contracting arrangements with external agencies	50
Framework provision (e.g. policies and guidelines)	55
Program administrator/ manager/ implementing agency	**618**
Buy in (Leadership, culture, priorities)	80
Identification of recipient /targeting mechanism	81
Referral route (e.g. defined agency or contact)	55
Sufficiency/Adequacy of Resources (space, time, staff, budget	186
Alignment with existing protocol/ procedures/ guidelines	55
Monitoring data/Data sharing	87
Partnership/collaboration with external agencies	74
Staff/ case worker	**209**
Buy-in (commitment to program)	41
Communication and engagement with programme recipient	66
Communication and engagement with other agencies	33
Emotional skills (Awareness, empathy, building trust, taking a personalised approach)	21
Technical skills (capabilities, training)	48
Recipient of program	370
Buy-in (emotional acceptance of program)	108
Access to non-housing support (medical, financial, training etc.)	70
Housing-related security	55
Adequacy of information provided	48
Accessibility (time and place)	89

Contextual Factors	**90**
Housing Market	20
Labour Market	3
Welfare Support	23
Law	44
Policy Makers and Funders	**257**
Buy-in (Leadership, culture, priorities, commitment to programme)	112
Contracting arrangements with external agencies	65
Framework provision (e.g. policies and guidelines)	80
Program administrator/ manager/ implementing agency	**747**
Buy in (Leadership, culture, priorities)	125
Identification of recipient /targeting mechanism	106
Referral route (e.g. defined agency or contact)	79
Sufficiency/Adequacy of Resources (space, time, staff, budget	152
Alignment with existing protocol/ procedures/ guidelines	58
Monitoring data/Data sharing	77
Partnership/collaboration with external agencies	150
Staff/ case worker	508
Buy-in (commitment to program)	79
Communication and engagement with programme recipient	146
Communication and engagement with other agencies	95
Emotional skills (Awareness, empathy, building trust, taking a personalised approach)	95
Technical skills (capabilities, training)	93
Recipient of program	544
Buy-in (emotional acceptance of program)	113
Access to non-housing support (medical, financial, training etc.)	181
Housing-related security	94
Adequacy of information provided	68
Accessibility (time and place)	88

Appendix 3

Critical appraisal tool

		Response			
1	**Are the research questions clearly stated?**	Yes	Partly	No	
2	**a. Is the qualitative methodology adequately described?**	Yes	Partly	No	>> 4
	b. Is the qualitative methodology appropriate to address the research questions?	Yes	Partly	No	
3	**a. Is the recruitment/sampling strategy adequately described?**	Yes	Partly	No	>> 6
	b. Is the recruitment/sampling strategy appropriate to address the research questions?	Yes	Partly	No	
4	**Has the relationship between researchers and participants been adequately considered?**	Yes	Partly	No	
5	**Have ethical considerations been sufficiently considered?**	Yes	Partly	No	Insufficient detail
6	**Is the data collection approach adequately described?**	Yes	Partly	No	Insufficient detail
7	**a. Is the data analysis approach adequately described?**	Yes	Partly	No	>>11
	b. Is the data analysis sufficiently rigorous?	Yes	Partly	No	
8	**Is there a clear statement of policy recommendations or implications of the research?**	Yes	Partly	No	
9	**Are the findings or recommendations based on the report findings?**	Yes	Partly	No	

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