The effectiveness of interventions to improve the welfare of people experiencing homelessness: an updated evidence and gap map

Shalu Jain, Monisha Laksminarayanan, Swati Mantri, Sabina Singh and Howard White

Fifth Edition 2023
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Foreword

Until recently there were no evidence tools to help us identify what we know and what we don’t about ending homelessness for good. This was a barrier to using evidence to improve policy and practice. Evidence was scattered around different databases, journals, websites, and in grey literature, and there was no way for people to get a reliable overview of the current knowledge base. To address these challenges, the Centre for Homelessness Impact created two evidence and gap maps (EGMs) that capture what we know about what works and why things work or not on homelessness interventions, in partnership with the Campbell Collaboration. By making relevant studies more accessible, they facilitate evidence-informed decision making. EGMs can also help funders target their resources to fill important gaps in the evidence faster, and in a more strategic and impactful way.

This report presents findings from the fifth update of the effectiveness map, that focuses on causal or ‘what works’ evidence (impact evaluations or systematic reviews). When we released the first map, we found just 221 relevant studies across the entire globe. Five years on the picture has changed significantly – this new edition contains 690 studies. So there’s been a considerable growth in rigorous evidence demonstrating what works to tackle homelessness.

There has also been a significant increase in studies in the UK, from 12 to 65. But UK-based research continues to account for just 9% of the global evidence base (72% are from the USA). While the UK is publishing increasing numbers of Randomised Controlled Trials, only seven have been published since 2016. This needs to change. International studies are useful, but differences in context may mean that approaches that worked elsewhere work less well, or better, here. It is therefore vital that local studies of promising interventions are carried out.

I urge all in the homelessness field to reflect on the findings presented in the EGM and join us in our efforts to improve our understanding of what works, for whom, in what circumstances. Only by embedding reliable evidence and data analysis deep in decision-making processes and structures can we end homelessness for good.

I hope that this report and related digital tools – and its annual sequels – will continue to make a significant contribution to the dialogue and decision-making on homelessness in years to come and lead to more strategic use of, and investment in, reliable evidence.

Ligia Teixeira

Dr Ligia Teixeira is Chief Executive at the Centre for Homelessness Impact
Summary

This is the fifth edition of CHI’s Effectiveness Map, which presents the existing evidence and gaps in literature on effectiveness of various interventions being used to improve the lives and welfare of people experiencing homelessness and those who are at risk of homelessness in high-income countries. These interventions may focus on different aspects, such as health, legislation, prevention, employment, and so on. The evidence and gap map (EGM) from this report suggests what interventions were assessed and whether they were effective towards which outcome. This is done by using an innovative intervention-outcome matrix, which was created specifically for this review. Through this framework, available evidence is categorised based on different categories and sub-categories for different interventions and outcomes used in the studies. As this is an effectiveness map, the studies included here are either impact evaluations or systematic reviews of impact evaluations. Using different filters, the map can also display the studies for a specific country, target population, study design, etc.

This fifth edition of the Effectiveness Map includes 690 studies in total, where 132 new studies are added through this current (2022) update. Over the years of work to systematically arrange the evidence available, a substantially larger body of information is available now through our updated reports to help stakeholders and policy makers take better informed decisions. The first edition of this map had 221 studies and we did not have a lot of new studies (n=39) to add in the second edition. But as the awareness and requirement grew with time for both homeless related studies and a drive towards “what works”, we observed significant growth in the number of newly published effectiveness studies each year. There were large numbers of new studies added to the map with every edition, from the third edition onwards. We have included 168 studies for the current update. However, during data extraction we excluded some of them as they were better suited for the other evidence and gap map, which focuses on process evaluations. This is how the final number of new studies added through the current update was 132. The 690 studies in this latest version edition of the updated map, compares with 221 studies in the first edition (2018), 260 in the second edition (2019), 394 in the third edition and 562 in the fourth edition. There is a huge increase of evidence available now (an increment of more than 212 %) as compared to the first edition of this map. If we compare the evidence available now to the previous edition of this map, there is an increment of 22.7% in the total number of studies available now.

Key observations from the evidence are that a majority of them are concentrated for certain points, which we can consider as hotspots of the map, whereas there are distinct gaps for some of the areas. We say this as 587 out of 690 studies in the map are from the North American region, wherein 494 studies are from the USA alone. Most of the studies focused on health-related interventions (290 studies), services and outreach related interventions (290) followed by accommodation and accommodation-based interventions (250), whereas very few studies were found on legislation or financing. As far as the outcomes are concerned the map has major focus on health-related outcomes (522) followed by outcomes based on housing stability (304) and capabilities and wellbeing (242) as compared to other outcome categories like crime and justice (67). One interesting observation is, there are a good number of new studies added during the current update (20), that assessed economic impacts of these interventions by conducting a full economic evaluation or through assessing costs of inventions. These studies are particularly helpful in informing decisions around budgetary considerations, upscaling of existing programmes, and resource allocation. This report clearly suggests there is a need to diversify the evidence available for homelessness by picking areas that show blank cells in this map. As social issues like homelessness require multisectoral efforts across different sectors, it calls for studies on different aspects of homelessness.

The majority of studies are rated as low in terms of overall confidence in studies after critical appraisal of included studies, which is the case for both systematic reviews and primary studies. The critical appraisal used in the review employs a ‘weakest link in the chain’ principle, meaning one critical weakness reduces the credibility of the study as a whole. This is a conservative view of assessing the quality of primary studies. The low confidence in most studies largely results from the lack of reporting power calculations and high levels of attrition amongst study participants.

A comprehensive realist evaluation commissioned by the National Institute for Health and Care Research (NIHR) assessed the effectiveness and cost-effectiveness of 52 new specialist homeless hospital discharge schemes (Comes et al 2021). This realist evaluation was conducted by using RAMESES II (Realist And Meta-narrative Evidence Syntheses: Evolving Standards) guidelines. The study hypothesised that safe timely care transfers for patients experiencing homelessness involving multidisciplinary discharge coordination and ‘step-down’ intermediate care would be more effective and cost-effective than standard care. The realist hypothesis was empirically tested in three steps. A first step was based on seven qualitative case studies to compare sites with different types of specialist homeless hospital discharge schemes (n = 5) and those with no specialist discharge scheme (standard care) (n = 2). Data collection for this study included interviews with 77 practitioners and stakeholders and 70 patients experiencing homelessness admitted to hospital. The second and third parts of this realist evaluation involved a ‘data linkage’ process and an economic evaluation. For the data linkage process, more than 3,882 patients were included for data collection from 17 discharge schemes across England.

The study reported specialist homeless hospital discharge schemes employing multidisciplinary discharge coordination and ‘step-down’ intermediate care are more effective and cost-effective than standard care. The study showed a reduction in delayed transfers of care because of specialist care. It also reported 18% lower rates of accident and emergency visits among patients experiencing homelessness discharged at a site with a step-down service versus standard care. Underfunding of such schemes and a shortage of permanent supportive housing and longer-term care and support was cited as an identified barrier. The authors emphasised that high impact changes need to consider robust adult safeguarding.
Introduction

The Centre for Homelessness Impact (CHI), in collaboration with the Campbell Collaboration, has built two different EGMs for homelessness. One of them assesses what works in the field of homelessness, which describes the effectiveness of interventions. The other map highlights how interventions are implemented, exploring barriers and facilitators for successful implementation. The Effectiveness Map, which is the focus of this report, contains studies which evaluate how effective interventions are at improving a range of outcomes. It contains impact evaluations (i.e. quantitative research) or systematic reviews of impact evaluations. The other map, named the Implementation Map (discussed in detail in our Evidence and Gap Maps Implementation Issues Report), contains qualitative research including process evaluations which demonstrate why interventions might be effective or not. Studies with mixed methods may appear in both maps. Both these maps are updated annually.

An Evidence and Gap Map (EGM) is defined as a systematic and visual presentation of the availability of relevant evidence for a particular policy domain. Evidence shown in EGMs is identified by performing systematic searches following a pre-specified, published search protocol. The scope of a map is generally broader than that of a systematic review. Retrieved searches are screened based on pre-defined inclusion and exclusion criteria. Studies that meet the inclusion criteria are then coded for data extraction and analysis purposes. A visually interactive map with the selected codes and filters is then generated with the coded studies, usually using an online software package.

An EGM is a table or matrix which provides a visual presentation of the evidence. In the Effectiveness Map the rows are intervention categories (e.g. prevention, employment) and the columns are outcome categories (e.g. health, housing stability). Both intervention categories and outcome categories are broken down further into sub-categories. For example, the housing stability outcome category is split into two further subcategories of 1) accommodation status and 2) satisfaction with housing.

The Effectiveness Map captures additional elements which describe a study such as study design, geographical location and population characteristics. These characteristics can be applied as 'filters' in the tool so that only studies which apply to the specific groups chosen are shown in the map.

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 which includes an online link to the study itself. A geographical map detailing which regions, countries and cities the evidence base originate from is also available via our Evidence Finder tool.
Methodology

This is the fifth update of the Effectiveness Map. The scope of the map, as captured in the Population, Intervention, Outcome and Study Design (PIOS), remains the same as previous editions except for the change we have made in the population to also include people working with the population affected by homelessness. For earlier versions, we have included people who were experiencing homelessness or were at risk of homelessness, but this fifth edition also included studies on people who are directly engaging with people impacted by homelessness e.g., landlords, healthcare professionals, teachers, etc. The original protocol for the development of the map is here.

Automated Searches using Machine Learning Features

We endeavour to use innovative and advanced methods to update our evidence with every edition of the map. Searches for the current update were conducted by using the automated search feature within the EPPI-Reviewer software instead of individual searches conducted in different databases. The software allows the reviewer to find additional studies using an inbuilt automated (machine learning) search feature. The EPPI-Reviewer study database is based on the OpenAlex dataset, which is a comprehensive research repository. The database, which is updated every two weeks, currently contains more than 200 million records. The automated search feature of EPPI Reviewer is based on machine learning, where the software learns to identify papers related to papers already existing in our review. Existing studies providing the training dataset to the machine.

There are two different evidence and gap maps we have produced on homelessness, the present one on effectiveness of interventions and the other on implementation issues, which seeks to help decision-makers consider evidence about the factors critical to effective implementation of the intervention. Both maps are updated annually. We therefore ran the automated searches to capture studies for both the maps in one go. Also, as we have extended the scope of population in the current update for both maps to include people who engage with individuals affected by homelessness, we wanted to capture these studies as well in our automated searches. To manage this, we have supplemented our training dataset by identifying key studies using Google Scholar and imported these studies into EPPI-Reviewer. This allowed the automated search feature to also look for studies including people engaging with individuals experiencing homelessness. The training dataset of our searches therefore was based on studies from previous editions of both effectiveness and implementation issues maps and new searches done using Google Scholar to have studies including people engaging with homeless people.

Grey Literature Searches

Machine learning searches were complimented with a comprehensive manual search of websites and other grey literature. Systematic search of grey literature, intervention-specific search terms combined with population and study design search terms resulted in a large number of additional studies. We have used the same list of websites for searching grey literature which was searched during the previous edition of this map (4th Edition). The list is given in the Appendix 1.

The search dates and search engine page numbers on which the studies appeared were noted meticulously. We recorded the number of records found, screened, and included for each site.

In addition to searching and screening websites, we used ‘snowballing’, which involves tracking the references of the reviewed studies, to identify further relevant sources of information that were then searched in the same way. We also searched some of the journals with studies on Homelessness. Hand searches (online screening) of all the issues for past year (after last searches were performed) of the identified journals was carried out. The list of journals and dates of searches are given as a table in Appendix 2. Citations of selected included records were also screened to identify eligible studies.

Deduplication

All searches including machine learning searches and grey literature searches were imported into the EPPI Reviewer and were deduplicated to remove all duplicate studies identified through different sources. We have also checked for duplicate studies between current searches and studies included in previous maps.

How we resolve duplicates: EPPI reviewer has an inbuilt function to remove duplicates, which is the first step in deduplication. However, this process does not capture all duplicates effectively. Therefore, the following steps were taken to remove further duplicates:

1. Arrange all the references alphabetically in the EPPI reviewer (study titles) and manually search for the duplicate titles. Cross-check duplicate titles against author names. Studies with the same title and author names are checked again by matching PDFs.

2. Arrange all the references alphabetically in EPPI reviewer (short titles based on first author name) and manually search for duplicate short titles. Cross-check duplicate short titles against study title. Studies with the same title and author names are checked again by matching PDFs.
3. Export the list in Excel and repeat the same two steps as above.

4. These processes are performed for multiple rounds by different team members until new duplicates are no longer identified.

Another important point to note about deduplication is that duplicates can be found at any stage of the review process and even though that would be a great thing, it’s not sure that reviewers will find and remove all duplicates before screening. Also, it becomes easier to pick them when studies become fewer in number, so the PRISMA chart given below (Figure 1) shows where we found and excluded duplicate studies during the current update.

Screening at Title and Abstract

In the last edition we used Cochrane Crowd to crowd-source screening of papers at title and abstract. This time the in-house research team of Campbell South Asia performed all the screening. Two independent reviewers screened all the studies based on their title and abstracts using the inclusion and exclusion criteria of this EGM. Disagreements between two reviewers were resolved through discussion. If there was still any disagreement regarding including or excluding a study between the two reviewers, these were resolved by involving a third reviewer.

A total of 1,651 records were identified from machine learning searches. Grey literature searches resulted in 205 records after deduplication. After removing 24 duplicates between grey literature and machine learning searches, there were a total of 1,832 records ready for title and abstract-level screening. Out of these 1,832 studies, 1,182 were excluded during title and abstract screening, leaving 650 studies to be screened by assessing full texts.

Full-text screening

Besides the 650 studies mentioned above, we also had a list of additional studies (n=205) from the Centre of Homelessness Impact (CHI) to be assessed. CHI provided this additional list of studies, based on two ongoing systematic reviews being developed by the organisation. One was on the effectiveness of abstinence-based and harm reduction-based interventions in reducing problematic substance use in adults who are experiencing homelessness in high-income countries, and the other on the effect of case-management interventions in homelessness. The primary source of inclusion in systematic reviews is the last available version of the evidence and gaps maps (EGM). However, additional research was done to capture additional relevant studies, especially those published between the date of the last version of the EGM and the date of the ongoing systematic review, mainly through a call for grey evidence and hand-searching key journals.

After a thorough analysis of the list of additional studies received from the CHI, we found that out of 205 studies, there were 68 which were either included in previously published maps, or in the searches of the current update. We have screened the remaining 137 studies. As these studies were already pre-screened by the CHI team, we have included them all at the title and abstract level and assessed the full texts of these studies. Therefore, including all sources of studies (automated searches, grey literature and CHI list), we had a total of 787 studies for full text screening.

Full texts of all 787 studies were retrieved and screened to check if studies still met the eligibility criteria. Similar to title and abstract screening, full-text screening was also performed by two reviewers independently. Disagreements between two reviewers were resolved through discussion or by involving a third reviewer. As we ran the searches to cover studies both for the effectiveness and also for the implementation issues map, while we assessed the full texts, studies were included either for the effectiveness map or for the implementation issues map, or in some cases, for both the maps.

Out of these 787 studies assessed for full text, there were 118 studies where full texts were not accessible. From accessible full texts, we included 172 studies for the effectiveness map and 256 for implementation issues map. The remaining 241 studies were excluded during full text screening. The reasons for exclusion at full-text screening are given in the PRISMA flowchart (Figure 1). There were four duplicate studies found in this list of studies included after full text screening, which were removed to have a final number of 168 studies to be coded for effectiveness.

Data Extraction and critical appraisal of included studies

The data extraction was done by two independent researchers as per the intervention-outcome framework developed for this EGM. The data extraction done by two reviewers was compared for differences, and disagreements were resolved by discussion. An arbitrator was approached in case no agreement was achieved, and the arbitrator’s decision was taken as final.

Out of 168 studies considered for coding, 36 were excluded during the coding where we found the data was insufficient for coding or a proper control group was not included in the study or that study suited better to be considered for the implementation issues map. In this way, the number of studies finally coded under the effectiveness map was 132.
These 132 studies included with 11 study protocols (ongoing studies). We did code but did not critically appraise ongoing studies as there was incomplete information. Therefore, the total number of studies which were critically appraised using a tool was 121. Separate checklists for primary studies and systematic reviews were used to assess the confidence in the findings of studies.

Out of 121 studies critically appraised, eight were systematic reviews which were critically appraised using AMSTAR-2 tool, whereas 114 studies were critically appraised as primary studies.

After merging these 132 studies included this time with the 562 studies from the previous edition, there were four duplicate entries found. After removing those four duplicates, there are in total 690 studies in the review now. Out of 690 total studies in the review, there are 81 systematic reviews and 609 primary studies. The PRISMA flowchart (Figure 1) clearly presents the studies included during the current update and those which are carried forward from the previous edition.
An overview of the Updated Effectiveness Map

Over the years of work to systematically arrange the evidence available on effectiveness of interventions for people experiencing or at risk of experiencing homelessness, a substantial body of information is available now through our updated reports to help stakeholders and policy makers take informed decisions (Figure 2). The first edition of this map had 221 studies and only 39 were added in the second edition. But from the third edition onwards, there was a large number of new studies added to the map with every edition. The highest number of new studies (168) was added through the fourth edition mostly because of our new and rigorous approach towards grey literature searches. We have included 168 studies for the current update, however, during data extraction we have excluded some of them as they were better suited for the other map which focuses on process evaluations. This is how the final number of new studies added through the current update was 132.

The latest version (5th edition) of the updated map contains 690 studies, compared to 221 studies in the first edition (2018), 260 in the second edition (2019), 394 in the third edition and 562 in the fourth edition. There is a huge increase of evidence available now (an increment of more than 212 %) as compared to the 1st edition of this map. If we compare the evidence available now to the previous edition of this map, there is an increment of 22.7% in the total number of studies available now.

New studies included in current update:

The current update included 132 new studies to the map. There were 11 study protocols (ongoing studies) and 121 completed studies. Key observations from these studies are summarised below.

1. More non-randomised studies than controlled trials
   The study design was dominated by non RCTs including quasi experimental designs and before versus after designs. (See Figure 3, below)

2. Most studies from North America
   Most of the new studies in this update (83%) were from North American countries: USA (91) and Canada (22). (See Figure 4)

3. A focus on drug abuse and mental illness
   Most of the new studies in this update focused on people affected by homelessness who have a history of mental illness (31.8%) and with alcohol or drug issues (30.3%). (See Figure 5)

4. A focus on health and social care intervention
   One in every two of the new studies in this update focused on health and social care intervention (50%). The second most populated category of intervention was accommodation and accommodation-based services (44%). (See Figure 6)
5. A focus on health-related outcomes

Health was a primary focus for most of the new studies added this time, both in terms of intervention and outcomes. Health-related outcomes were assessed for 77% of studies where we have observed. These outcomes were also assessed many times for interventions not directly health related. For example, there were studies which assessed how Housing First helped people impacted by homelessness to receive better health care. A lot of focus was given to seeing whether these housing interventions are helping to reduce the health utilisation by the target population in terms of outcomes such as a reduced number of emergency visits, number of days for hospital stays, better medicine compliance, etc. There was almost a similar number of studies which assessed outcomes based on housing stability (34%) and capabilities and wellbeing (33%). (See Figure 7)
Overall Findings of the updated Review

There are 690 studies in the map after this update. Key findings from the updated map are as summarised below:

Randomised controlled trials make up almost half of studies

The map studies are dominated by randomised controlled trials (RCTs) as they built more than 47% of total studies. If we club all non-RCTs, these contribute 41% of studies in the map and the remaining 11.7% studies are systematic reviews. (Figure 8) There are 642 complete studies while the other 48 are ongoing studies which are study protocols.

The evidence base is predominantly from North America

Most of the studies in the map (587) are from the North American region followed by Europe and Central Asia (106). It is worth noting that there can be multiple regions within one study, e.g., in case a systematic review that included studies from different countries. These will be coded for all those countries. For 1% of studies, information of region was not available.
### Table 1: Regional distribution of studies

<table>
<thead>
<tr>
<th>Region</th>
<th>Systematic reviews</th>
<th>Primary studies</th>
<th>Total</th>
<th>% share of total studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>72</td>
<td>515</td>
<td>587</td>
<td>85%</td>
</tr>
<tr>
<td>Europe and Central Asia</td>
<td>33</td>
<td>74</td>
<td>107</td>
<td>16%</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>17</td>
<td>20</td>
<td>37</td>
<td>5%</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>No Information</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>1%</td>
</tr>
</tbody>
</table>

Map is dominated by studies from USA

As clear from the regional distribution most studies were from the USA (494) and Canada (119) followed by the UK (65).

### Table 2: Country-wise distribution of studies

<table>
<thead>
<tr>
<th>Country</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States of America (USA)</td>
<td>494</td>
</tr>
<tr>
<td>Canada</td>
<td>119</td>
</tr>
<tr>
<td>United Kingdom (UK)</td>
<td>65</td>
</tr>
<tr>
<td>Australia</td>
<td>30</td>
</tr>
<tr>
<td>Netherlands</td>
<td>20</td>
</tr>
<tr>
<td>France</td>
<td>11</td>
</tr>
<tr>
<td>None of the codes above</td>
<td>9</td>
</tr>
</tbody>
</table>
Homeless population with history of mental illness and alcohol/drug issues were a focus of study population

Similar to the new studies found through the current update, the map overall also has a focus on people affected by homelessness who have a history of mental illness (260) and people with alcohol and drug issues (193).

**Table 3: Studies categorised by target population and study design**

<table>
<thead>
<tr>
<th>Study Population</th>
<th>Systematic reviews</th>
<th>Primary studies</th>
<th>Total studies</th>
<th>% share of total studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with history of mental illness</td>
<td>37</td>
<td>223</td>
<td>260</td>
<td>37.7%</td>
</tr>
<tr>
<td>People with alcohol/drug issues</td>
<td>36</td>
<td>157</td>
<td>193</td>
<td>28.0%</td>
</tr>
<tr>
<td>Young people</td>
<td>22</td>
<td>83</td>
<td>105</td>
<td>15.2%</td>
</tr>
<tr>
<td>Families with children</td>
<td>8</td>
<td>53</td>
<td>61</td>
<td>8.8%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>62</td>
<td>75</td>
<td>10.9%</td>
</tr>
<tr>
<td>Veterans/Ex-services</td>
<td>14</td>
<td>54</td>
<td>68</td>
<td>9.9%</td>
</tr>
<tr>
<td>People with complex needs/dual diagnosis</td>
<td>5</td>
<td>35</td>
<td>40</td>
<td>5.8%</td>
</tr>
<tr>
<td>Women and girls</td>
<td>6</td>
<td>35</td>
<td>41</td>
<td>5.9%</td>
</tr>
<tr>
<td>People with existing health conditions</td>
<td>18</td>
<td>42</td>
<td>60</td>
<td>8.7%</td>
</tr>
<tr>
<td>Ex-prisoners</td>
<td>6</td>
<td>15</td>
<td>21</td>
<td>3.0%</td>
</tr>
<tr>
<td>People leaving social care</td>
<td>7</td>
<td>19</td>
<td>26</td>
<td>3.8%</td>
</tr>
<tr>
<td>Discharge from health facilities</td>
<td>4</td>
<td>13</td>
<td>17</td>
<td>2.5%</td>
</tr>
<tr>
<td>HIV patients</td>
<td>6</td>
<td>17</td>
<td>23</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

**Most assessed interventions**

The map now is highly populated (290) by interventions based on services and outreach like case management, outreach, etc. The same number of studies (290) are based on health and social care-related interventions like many studies assessed the effectiveness for interventions that provide physical and mental services and also interventions related to addiction support. The other common interventions assessed in these studies are related to accommodation and accommodation-based services (250) including popular interventions like Housing First and social housing. (Figure 13) Other intervention categories like prevention (102), education (86), employment (38), etc are also assessed but in a relatively lower number of studies. Areas where we see a significant dearth of evidence are related to financing (5) and legislation (8).

**Table 4: Studies assessing different intervention categories**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>No. of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and outreach</td>
<td>290</td>
</tr>
<tr>
<td>Health and social care</td>
<td>290</td>
</tr>
<tr>
<td>Accommodation and accommodation-based services</td>
<td>250</td>
</tr>
<tr>
<td>Prevention</td>
<td>102</td>
</tr>
<tr>
<td>Education and skills</td>
<td>86</td>
</tr>
<tr>
<td>Intervention</td>
<td>No. of studies</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Employment</td>
<td>38</td>
</tr>
<tr>
<td>Legislation</td>
<td>8</td>
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<tr>
<td>Communications</td>
<td>8</td>
</tr>
<tr>
<td>Financing</td>
<td>5</td>
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Figure 9: Studies categorised and sub-categorised for interventions.
Studies categorised by outcome

Similar to the new studies added this time, the overall map has a major focus on health-related outcomes (522) followed by outcomes based on housing stability (304) and capabilities and wellbeing (242) as compared to other outcome categories like crime and justice (67).

Table 5: Studies assessing outcome categories

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No. of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>522</td>
</tr>
<tr>
<td>Housing stability</td>
<td>304</td>
</tr>
<tr>
<td>Capabilities and Wellbeing</td>
<td>242</td>
</tr>
<tr>
<td>Employment and income</td>
<td>118</td>
</tr>
<tr>
<td>Cost</td>
<td>101</td>
</tr>
<tr>
<td>Crime and justice</td>
<td>67</td>
</tr>
<tr>
<td>Public attitudes and engagement</td>
<td>2</td>
</tr>
</tbody>
</table>

Critical Appraisal and overall confidence in studies:

We assessed the confidence in studies for methodological rigour and reporting norms.

Systematic reviews:

Most of the systematic reviews were rated as low confidence (74.3%). Around 19% of included systematic reviews also had high confidence. The remaining 6.8% were rated as medium confidence. (See Figure 15)

Primary studies

As far as primary studies are concerned, we have assessed the confidence in studies by using a tool that appraises studies based on seven items related to 1) study design, 2) blinding, 3) power calculations, 4) attrition, 5) description of the intervention, 6) outcome definition, and 7) baseline balance. Each of these seven items is rated as implying high, medium or low confidence in study findings. Overall quality is assessed using the ‘weakest link in the chain’ principle: our confidence in study findings can only be as high as the lowest rating given to any of the critical items (which are numbers 1, 4, 6 and 7).

Based on this assessment, overall confidence in studies was rated as low for 66% studies, medium for 18% studies and low for remaining 16% studies (See Figure 16). As clear from the figure given below, the most common reasons for low rating were related to blinding and attritions.
Confidence in Primary studies rated through critical appraisal.

Included studies by year of publication

We can observe a continuous gradual increase in the number of studies being published in this area with time. If we categorise the number of studies included in the map by the year of publication, the highest number of studies was published in 2020 (82 studies, 12% of total studies in the map). However, the graph also indicates a decline in the number of studies since 2020 as there are 60 studies from 2021 and only 28 from 2022. We can assume the number of studies to be fewer for 2022 as the searches for this update were run in August 2022 and therefore the number of studies given for 2022 will not reflect total studies for this year but will be clear only from the next edition of this report. Though this graph may provide an indication of studies published for a particular year, it is worth mentioning this graph provides information on studies included in this map (only those published studies that met the inclusion criteria for this review) and not the total studies published on homelessness for that year.
Description of updated Evidence and Gap Map (EGM)

There are 690 studies in the map and there are distinct cells in the map showing where the evidence is concentrated and where there is a significant gap in the literature.

Major Evidence Gaps identified

There are some blank cells which means there is a gap in evidence as no study was found related to the matrix generated through the particular intervention and outcome category of that specific cell. For instance, there is no study in the map that assessed the effectiveness of an intervention related to legislation and outcomes related to crime and justice. There are only two studies in the map that included outcomes related to public attitudes and engagement, as such cells related to this outcome in the map show a clear gap in evidence.

Evidence Hotspots

The evidence is rich for cells related to health and social welfare except for the "end of life care" sub-category where only a few studies were found. The most populated cells are those where interventions and outcomes were both related to health. Studies related to accommodation interventions are quite well distributed throughout different outcome categories. They were more concentrated for outcomes related to health and housing stability. Similarly, studies related to services and outreach are well distributed throughout different outcome categories but more concentrated for outcomes related to health and housing stability.

The Evidence Base for Effectiveness Research in the UK

Overview of UK level Evidence

As given above in Table 2, there are 65 studies from the UK in this updated map. In those 65 included studies, there are 27 systematic reviews and 39 primary studies. The report on studies conducted by NIHR includes both a systematic review and a primary study, hence both study designs are counted separately and that is why the total number of reports included is 65. The remaining 11 were before versus after designs.

A comprehensive realist evaluation commissioned by NIHR assessed the effectiveness and cost-effectiveness of 52 new specialist homeless hospital discharge schemes. This realist evaluation was conducted by using RAMESES II (Realist And Meta-narrative Evidence Syntheses: Evolving Standards) guidelines. The study hypothesised that safe timely care transfers for patients impacted by homelessness involving multidisciplinary discharge coordination and 'step-down' intermediate care would be more effective and cost-effective than standard care. The realist hypothesis was empirically tested in three steps. The first step was based on seven qualitative case studies to compare sites with different types of specialist homeless hospital discharge schemes (n = 5) and those with no specialist discharge scheme (standard care) (n = 2). Data collection for this study included interviews with 77 practitioners and stakeholders and 70 patients impacted by homelessness who were admitted to hospital. The second and third parts of this realist evaluation involved a 'data linkage' process and an economic evaluation. For the data linkage process more than 3,882 patients were included for data collection from 17 discharge schemes across England.

The study reported specialist homeless hospital discharge schemes employing multidisciplinary discharge co-ordination and 'step-down' intermediate care as more effective and cost-effective than standard care. The study showed a reduction in delayed transfers of care because of specialist care. They also reported 18% lower rates of accident and emergency visits among patients affected by homelessness discharged at a site with a step-down service versus standard care. Underfunding of such schemes and a shortage of permanent supportive housing and longer-term care and support were cited as identified barriers. The authors emphasised that high impact changes need to consider robust adult safeguarding.

Key observations from the UK level evidence base are as follows.
The number of studies published from the UK is increasing

There is a sharp increase in the number of studies being published from the UK on homelessness effectiveness from 2017 onwards. The highest number of studies from the UK in the map was published in 2021 (12 studies) and 2020 (11 studies). As is the case for the overall map, the number of studies from the UK for 2022 is lower (four studies), but it does not represent all the studies published this year as searches were done in August 2022.

We have studies from 1995 to 2022 in the map, and the studies published in the past five years makes around 70% of all studies in the map which shows the recent increase in the number of studies being published lately.

Homeless population with history of mental illness and alcohol/drug issues were a focus of study population

As is the case of the map overall, studies from the UK also have a focus on people experiencing homelessness with a history of mental illness (25) and people with alcohol and drug issues (20). Studies focusing on women and girls, people with a disability, survivors of domestic violence or abuse, etc are relatively lesser in number.

<table>
<thead>
<tr>
<th>Target Population</th>
<th>No. of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with/history of mental illness</td>
<td>25</td>
</tr>
<tr>
<td>People with alcohol/drug issues</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
<tr>
<td>People with existing health conditions (excluding HIV)</td>
<td>10</td>
</tr>
<tr>
<td>Young people</td>
<td>9</td>
</tr>
<tr>
<td>Veterans/Ex-services</td>
<td>7</td>
</tr>
<tr>
<td>Ex-prisoners</td>
<td>6</td>
</tr>
<tr>
<td>Families with children</td>
<td>6</td>
</tr>
<tr>
<td>Elderly</td>
<td>4</td>
</tr>
<tr>
<td>People with complex needs/dual diagnosis</td>
<td>4</td>
</tr>
<tr>
<td>People leaving social care</td>
<td>3</td>
</tr>
<tr>
<td>Women and girls</td>
<td>3</td>
</tr>
<tr>
<td>Discharge from health facilities</td>
<td>2</td>
</tr>
<tr>
<td>HIV patients</td>
<td>2</td>
</tr>
<tr>
<td>Target Population</td>
<td>No. of studies</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Migrants</td>
<td>2</td>
</tr>
<tr>
<td>Survivors of domestic violence/abuse</td>
<td>2</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>1</td>
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</tbody>
</table>

Table 6: Target population studied (UK only)

If we look at the matrix of population studies for intervention, many studies focus on interventions related to service and outreach among people with alcohol or drug issues (14) and people with a history of mental illness (17). Another focus area is interventions related to health and social care, mostly studied among people with alcohol or drug issues (13) and people with existing health conditions excluding HIV (8).

Evidence on certain interventions and Outcomes dominates the map

Trends for UK-level evidence resonate to that of the overall map as the most studied interventions in UK-level studies are also interventions based on services and outreach like case management, outreach, etc (30). The second most studied intervention category is health and social care related interventions (29). The other common interventions assessed in these studies are related to accommodation and accommodation-based services (19) including popular interventions like housing first and social housing. Other intervention categories like education (10), prevention (6), employment (3), etc are also assessed but in a relatively lower number of studies. Areas where we see a significant dearth of evidence are related to financing (2) and communication (2) and gaps for studies on legislation (no study).

If we look at the outcomes in these studies, outcomes related to health are assessed in the highest number of studies (55), followed by outcomes related to capabilities and wellbeing (29). There are also a good number of studies (23) that assessed outcomes related to housing stability.
Critical Appraisal and overall confidence in studies from the UK

Systematic reviews

Most of the systematic reviews were rated as low confidence (76%). Just 20% of included systematic reviews also had high confidence. The remaining 4% were rated as medium confidence.

Primary studies

Based on critical appraisal of primary studies, overall confidence in studies was rated as low for 65.7% of studies, high for 25.7% of studies and medium for the remaining 8.6% of studies. (Figure 16) The most common reasons for low rating were related to blinding and attritions.
### Appendix 1:

#### Organisational/institutional websites searched

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<tr>
<td></td>
<td>The Deck thedeck.org.au</td>
</tr>
<tr>
<td></td>
<td>FACS Western Australia <a href="https://bit.ly/36pM6TH">https://bit.ly/36pM6TH</a></td>
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<td>Queensland <a href="https://bit.ly/3vcdsHh">https://bit.ly/3vcdsHh</a></td>
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<tr>
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<td>Australian Institute of Family Studies <a href="https://aifs.gov.au/publications/search?f%5B0%5D=sm_vid_Tags%3AHousing%20and%20homelessness">https://aifs.gov.au/publications/search?f%5B0%5D=sm_vid_Tags%3AHousing%20and%20homelessness</a></td>
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<td>-------------</td>
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<td></td>
<td>Homeless Hub (Dissertations) <a href="https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;%5B0%5D=field_resource_type%3A262">https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;%5B0%5D=field_resource_type%3A262</a></td>
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<tr>
<td></td>
<td>Inn from the cold <a href="https://innfromthecold.org/">https://innfromthecold.org/</a></td>
</tr>
<tr>
<td></td>
<td>University of Ottawa <a href="https://uniweb.uottawa.ca/#!psychology/themes/999:246/publications">https://uniweb.uottawa.ca/#!psychology/themes/999:246/publications</a></td>
</tr>
<tr>
<td><strong>UK</strong> (16 Aug, 2022)</td>
<td>Centre for Housing Policy, York <a href="https://www.york.ac.uk/chp/">https://www.york.ac.uk/chp/</a></td>
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<tr>
<td></td>
<td>Joseph Rowntree Foundation <a href="jrf.org.uk">jrf.org.uk</a></td>
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<td>Shelter <a href="shelter.org.uk">shelter.org.uk</a></td>
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<td></td>
<td>Social Care Institute for Excellence <a href="https://www.scie-socialcareonline.org.uk/">https://www.scie-socialcareonline.org.uk/</a></td>
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<td></td>
<td>St. Mungos <a href="mungos.org">mungos.org</a></td>
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<td></td>
<td>The National Lottery Community Fund <a href="https://www.tnlcommunityfund.org.uk/">https://www.tnlcommunityfund.org.uk/</a></td>
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<td>HUD Program Evaluation Division <a href="https://www.huduser.gov/portal/research/eval.html">https://www.huduser.gov/portal/research/eval.html</a></td>
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## Appendix 2:

### List of hand searched Journals

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<td>Health &amp; Social Care in the Community</td>
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<td>27, Aug, 2022</td>
</tr>
<tr>
<td>Housing Policy Debate</td>
<td><a href="https://www.tandfonline.com/loi/rhpd20">https://www.tandfonline.com/loi/rhpd20</a></td>
<td>27, Aug, 2022</td>
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<td>Housing Studies</td>
<td><a href="https://www.tandfonline.com/loi/cho20">https://www.tandfonline.com/loi/cho20</a></td>
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<tr>
<td>Parity</td>
<td><a href="https://search.informit.org/journal/par">https://search.informit.org/journal/par</a></td>
<td>28, Aug, 2022</td>
</tr>
</tbody>
</table>

## Appendix 3:

### List of Included studies (690)

- Adair Carol E, Kopp Brianna and Distasio Jino ; Hwang Stephen W; Lavoie Jennifer ; Veldhuizen Scott ; Voronka Jijian ; Kaufman Andrew F; Somers Julian M, LeBlanc Stefanie R; Cote Sonia ; Addoriso Sindi ; Matte Dominique ; Goering Paula ; (2016). Housing Quality in a Randomized Controlled Trial of Housing First for Homeless Individuals with Mental Illness: Correlates and Associations with Outcomes. *Journal of Urban Health-Bulletin of the New York Academy of Medicine*, 93(4), pp.682-697.
- Arnold E M, Swendeman D and Harris D ; Fournier J ; Kozina L ; Abdalian S ; Rotheram M
J.; (2019). The Stepped Care Intervention to Suppress Viral Load in Youth Living With HIV: Protocol for a Randomized Controlled Trial. JMIR Research Protocols, 8(2), pp.e110791.

Ashwood J S, Patel K and Kravitz D; Adamson D M; (2019). Evaluation of the Homeless Multidisciplinary Street Team for the City of Santa Monica. : RAND.


Aubry T, Tsemberis S and Adair C E; Veldhuizen S; Streiner D; Latimer E; Sareen J; Patterson M; McGarvey K; Kopp B; Hume C.; (2015). One-year outcomes of a randomized controlled trial of housing first with ACT in five Canadian cities. Psychiatric services (Washington and d.C.), 66(5), pp.463-469.

Aubry T, Goering P and Veldhuizen S; Adair C E; Bourque J; Distasio J; Latimer E; Stergiopoulos V; Somers J; Streiner D L; Tsemberis S.; (2016). A Multiple-City RCT of Housing First With Assertive Community Treatment for Homeless Canadians With Serious Mental Illness. Psychiatric services (Washington and d.C.), 67(3), pp.275-281.

Aubry T, Bourque J and Goering P.; Crouse S; Veldhuizen S; LeBlanc S; Cherners R; Bourque P E; Pakasad; Bradshaw C.; (2019). A randomized controlled trial of the effectiveness of Housing First in a small Canadian City. BMC Public Health, 19, pp.1154.

Aubry T, Bricic V, Saad A and Magwood O; Abdalla T; Alkhateeb Q; Xie E; Mathew C; Hannigan T; Costello C; Thavorn K; Stergiopoulos V; Tugwell P; Pottie K; Bloch G.; (2020). Effectiveness of permanent supportive housing and income assistance interventions for homeless individuals in high-income countries: a systematic review. The lancet. Public health, 5(6), pp.e342-e360.


Bani-Fatemi A, Noble A and Wang W; Rajakulendran T; Kahan D; Stergiopoulos V; Malta M.; (2020). Supporting Female Survivors of Gender-Based Violence Experiencing Homelessness: outcomes of a Health Promotion Psychoeducation Group Intervention. Frontiers in psychiatry, 11, pp..

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Barker S. (2019). Peer Support and Homelessness : University of Southampton, pp.. Available at: https://eprints.soton.ac.uk/427593/.

Part 5: Updated Evidence and Gap Map of Effectiveness


Basu A, Kee R and Buchanan D; Sadowski L.; (2012). Comparative cost analysis of housing and case management program for chronically ill homeless adults compared to usual care. Health services research, 47(1pt2), pp.523-543.


Bovell-Ammon A, Mansilla C and Poblacion A; Rateau L; Heeren T; Cook JT; Zhang T; de Cuba SE; Sandel MT.; (2020). Housing Intervention For Medically Complex Families Associated With Improved Family Health: pilot Randomized Trial. Health affairs, 39, pp.613-621.


Bradley C, Penney C and Michelson D ; Day C ;. (2020). 'Every day is hard, being outside, but you have to do it for your child': mixed-methods formative evaluation of a peer-led parenting intervention for homeless families. PubMed, 25, pp.860-876.


Part 5: Updated Evidence and Gap Map of Effectiveness

Cabassa Leopoldo J, Stefancic Ana and Lewis-Fernández Roberto; Luchsinger José A; Weinstein Lara Carson; Guo Shenyang; Palinkas Lawrence A; Bochicchio Lauren; Wang Xiaoyan; O'Hara Kathleen; Blady Michael; Simiriglia Christine; McCurdy Monica Medina; (2021). Main Outcomes of a Peer-Led Healthy Lifestyle Intervention for People With Serious Mental Illness in Supportive Housing. Psychiatric Services, 72(5), pp.555-562.


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Chan B, Edwards S T and Devoe M; Gil R; Mitchell M; Englander H; Nicolaidis C; Kansagara D; Saha S; Korthus P T.; (2018). The SUMMIT ambulatory-ICU primary care model for medically and socially complex patients in an urban federally qualified health center: study design and rationale. Addiction Science & Clinical Practice, 13, pp.27.


Chavez L J, Slesnick N and Holowacz E; Luthy E; Moore L; Ford J; Kelleher K.; (2020). Virtual Reality Meditation Among Youth Experiencing Homelessness: pilot Randomized Controlled Trial of Feasibility. JMIR mental health, 7(9), pp.e18244-e18244.

Chavez Laura J, Kelleher Kelly J; Burgericia C; Brickeloff Brittany and Famela Rui; Ford Jodi L; Feng Xin; Mallory Allen B; Martin Jareed; Sheftairi Ariele H; Walsh Laura; Ylizman Tansel; Slesnick Natasha, (2021). Housing First Combined with Suicide Treatment Education and Prevention (HOME + STEP): study protocol for a randomized controlled trial. BMC Public Health, pp..


Chiu Y C J, Eissenstat S J; Misrok M and Conyers L M; (2020). Foundations for Living: evaluation of an Integrated Employment and Housing Program for People Living With HIV. Rehabilitation counseling bulletin, , pp..


Pedersen C. (2020). Renaissance social services supportive housing outreach team program: an outcome evaluation. Dissertation abstracts international section a: humanities and social sciences, 81, pp... 


Clarke G N, Herinckx H A; Kinney R F; Paulson R I; Cutler D L; Lewis K and Oxman E; (2000). Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: findings from a randomized trial of two ACT programs vs. usual care. Mental health services research, 2(3), pp.155-164.


Collins Susan E, Grazzioli Véronique S; Torres Nicole I; Taylor Emily M; Jones Connor B; Hoffman Gail E; Haelsig Laura and Zhu Mengdan D; Hatsukami Alyssa S; Koker Molly J; Herndon Patrick; Greenleaf Shawn M; Dean Parker E; (2015). Qualitatively and quantitatively evaluating harm-reduction goal setting among chronically homeless individuals with alcohol dependence. Addictive Behavior, 45, pp.184-190.

Collins S E, Clifasefi S L; Nelson L A; Stanton J and Goldstein S C; Taylor E M; Hoffmann G; King V L; Hatsukami A S; Cunningham Z L; Taylor E; (2018). Randomized controlled trial of harm reduction treatment for alcohol (HART-A) for people experiencing homelessness and alcohol use disorder. Alcoholism-Clinical and Experimental Research, 8(4), pp.199A-199A.


Collins C C, Fischer R and Crumpton D; Lalich N; Liu C; Chan T; Bai R; (2020). Housing instability and child welfare: examining the delivery of innovative services in the context of a randomized controlled trial. Children and youth services review, 108, pp.104578-104578.


Collins S E, Suprasert B and Doerr S A M; Gliane J; Song C; Orfaly V E; Moodliar S C; Taylor E M; Hoffmann G; Goldstein S C; (2021). Jail and Emergency Department Utilization in the Context of Harm Reduction Treatment for People Experiencing Homelessness and Alcohol Use Disorder. Journal of urban health-bulletin of the New York Academy of Medicine, 98, pp.83-90.


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Corne Michelle, Aldridge Robert W and Biswell Elizabeth ; Byng Richard ; Clark Michael ; Foster Graham R; Fuller James ; Hayward Andrew ; Hewett Nigel ; Kilmister Alan ; Manthorpe Jill ; Neale Joanne ; Tinelli Michela ; Whiteford Martin ; (2021). Improving care transfers for homeless patients after hospital discharge: a realist evaluation. *Health Services And Delivery Research*, 9(17), pp.1-186.


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