



# **Why interventions to improve the welfare of people experiencing homelessness work or not: an updated evidence and gap map**

Monisha Lakshminarayanan, Ratika Bhandari, Swati Mantri, Sabina Singh

Fourth Edition 2023

## Acknowledgements:

This report is an update of the third edition of the evidence and gap map on why interventions to improve the welfare of people experiencing homelessness work or not. We wish to thank Howard White for providing overall intellectual direction for this map. We acknowledge the support received from Maria Ossa and Matt Ganon from the Centre for Homelessness Impact.

## 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.

### Person-first language

This report uses person-first language, putting a person before their circumstances. This is to avoid defining an individual by homelessness, which should be a temporary experience.

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# Foreword

Until recently there were no reliable evidence tools to help us identify what we know and what we don't about what works when it comes to ending homelessness for good. Evidence was scattered around different databases, journals, websites, and in grey literature, and there was no way for decision-makers to get a quick overview of the existing evidence base. This was a barrier to using evidence to improve outcomes. To address this challenge, the Centre for Homelessness Impact created, in partnership with the Campbell Collaboration, two evidence and gap maps (EGMs) capturing what we know about what works and why things work or not on homelessness interventions.

By making relevant studies more accessible to end users, they facilitate evidence-informed decision making. Because they highlight areas of high policy relevance where evidence is lacking, EGMs can also help research funders target their resources to fill important evidence gaps faster, more cost-effectively, and in a more strategic and impactful way.

This report presents findings from the fourth update of the Implementation Map, which contains studies that analyse why interventions work well or not. When we released the first map, we found 246 relevant studies across the entire globe. Three years and three editions later, the Implementation Map now contains 597 studies, 191 of which have been added since the last edition. UK-based studies have similarly increased by 66%, accounting for 25% of the global evidence base.

However, the majority of the studies included in this update – around 77% – score poorly when it comes to quality. To improve the overall quality of process evaluations in the field, researchers should ensure that the publication of results discusses and discloses ethical considerations, as well as policy recommendations.

Identifying the areas in which evidence is lacking is a crucial part of the Centre's work. The need for greater emphasis on better use of evidence to prevent and tackle homelessness is as abundantly clear as it is urgent. But we must ensure what is available is reliable and actionable.

If we do this, we will continue to improve the life chances of people affected by or at risk of homelessness and accelerate progress towards ending homelessness for good.



Dr Ligia Teixeira  
CEO, Centre for Homelessness Impact

# Summary

**Evidence and gap maps (EGMs) are interactive visual depictions of the available evidence on a specific area of study. The Centre for Homelessness Impact (CHI) has created two separate EGMs: the Effectiveness EGM contains quantitative evidence that suggests 'what works' to tackle homelessness, while the Implementation EGM contains qualitative evidence that suggests why interventions work well or not.**

This report discusses the salient features of the fourth edition of CHI's Implementation Issues EGM. The Implementation Issues EGM contains all qualitative evaluations of homelessness interventions. It organises studies according to: (a) the type of intervention they evaluate, and (b) issues mentioned as barriers or facilitators to successful implementation of that intervention. The third (2022) edition of this map contained 406 studies, and the fourth edition (2023) covers 597 studies (191 of which were published since the last edition). New studies were identified using updated searches conducted in August 2022 and January 2023.

This EGM provides a critical foundation for more effective work to end homelessness, by collating evidence around why homelessness interventions work well or not. This update is similar to previous editions of the map in that the evidence is unevenly distributed by geography or intervention type, and there is a dearth of high-confidence studies.

More than half (approximately 57%) of the EGM's evidence is from North America, and one third (30%) is from Western Europe. The remaining evidence is from the Australasia region. This edition contains 33 newly included studies from the UK, bringing the total number of studies from the UK to 152 (25% of the total).

The evidence regarding implementation issues for homelessness interventions is most heavily concentrated in: (a) accommodation and accommodation-based interventions (273 studies); (b) services and outreach interventions (200 studies); and (c) health and social care interventions (154 studies). The distribution of evidence within each category is also uneven; certain subcategories are highly populated, while others have very few studies.

For example, while there are many studies on Housing First (108 studies), there are only six studies in which hostels appeared as an intervention sub-category. There are visible gaps in the evidence base for interventions related to legislation (26 studies), communications (24 studies) and financing (4 studies). These gap areas indicate a need for qualitative evaluations in the identified areas.

The highly populated areas of evidence indicate the possibility of conducting systematic reviews. CHI has commissioned systematic reviews in areas with concentrations of evidence around interventions for people experiencing, or likely to experience, homelessness. These include published reviews on accommodation-based interventions (Keenan et al., 2021), health and social care interventions (Miller et al., 2020) and discharge interventions (Hanratty et al., 2020). There are also ongoing reviews of case management interventions (Weightman et al., 2022), substance use interventions (O'Leary et al., 2022) and psychosocial interventions (O'Leary et al., 2022). These systematic reviews are critical for ensuring that intervention implementation is based on evidence.

In addition to those mentioned above, plausible areas in which to conduct systematic reviews include those that focus on enhancing the capabilities of people experiencing homelessness, such as education and skills interventions and employment interventions. These two broad cells of intervention are certainly not as populated as other cells of the EGM; however, given that systematic reviews have already been conducted, or are ongoing, for heavily populated cells, they may have the potential to help to address the challenge of homelessness.

The most-reported implementation barriers are issues related to programme administrators and people using services; the most mentioned implementation facilitators are matters related to individuals using services and case/staff workers. The main factors identified in the map that influence implementation are adequacy of resources, buy-in, coordination, communication, and access to non-housing support. Although the map provides a high-level overview of which factors commonly impact implementation, a far more granular understanding of these studies is needed. CHI is addressing this need by commissioning systematic reviews of process evaluations.

The critical appraisal of the included studies suggests that most only allow low confidence in study findings. To assess the critical appraisal, we use the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies, and within that we follow the 'weakest link in the chain' principle. The latter suggests that any single indicator with a weakness reduces the overall confidence in the findings of the study.

The critical appraisal suggests that we can place medium confidence in the findings of less than one fifth of the studies (20%). As many as 77% of the studies were assessed to be of low confidence. Though most included studies describe the research questions, methods, and analysis sufficiently, details pertaining to the relationship between researchers and participants is largely missing. Therefore, the two main reasons identified for low confidence in findings were a lack of disclosure of the relationship between researchers and participants, and insufficient reporting of ethical considerations.

CHI has carried out a consultation exercise to identify priority evidence needs for which evidence is lacking, and then to fill those gaps either directly or indirectly. It is also working to support key stakeholders in undertaking rigorous evaluation of their programmes. CHI believes its contribution to building the evidence architecture for homelessness will help to develop better strategies to tackle this complex social issue.



# 1. Methodology

This is the fourth update of the Implementation Issues EGM, which includes studies on those directly engaging with people impacted by homelessness, such as landlords, healthcare professionals and teachers. Earlier versions covered people experiencing homelessness and those likely to experience homelessness.

## 1.1 Automated searches using machine learning features

We produced two types of evidence and gap maps on homelessness – one on intervention effectiveness, and the other on implementation challenges – both of which seek to support decision-makers in considering evidence on areas crucial to effective intervention implementation. These maps are updated once a year; as a result, the searches are executed simultaneously for both maps. The automated searches for this edition of the implementation issues map were carried out in August 2022, along with searches for the fifth edition of the homelessness map ('Effectiveness').

## 1.2 Systematic search of grey literature

Detailed screening (manual search) of websites and other grey literature supplemented our machine learning searches. Intervention-specific search terms, combined with population and study design search terms, allowed us to locate potential documents for the map. The search dates, filters used, and search engine page numbers in which the studies appeared were meticulously recorded. This edition of the map includes studies searched until January 2023, and we also examined websites used in the third edition. A new addition to our searches this year is the ProQuest database, which was searched in January 2023. Appendix 1 contains this list.

In addition to searching and screening websites, we used 'snowballing' from these sites, thereby identifying further relevant websites, which we searched in the same way. The eligible records brought us to various institutional and organisational websites dedicated to issues around homelessness. We recorded the domain names of websites, indicating the countries in which the organisations and institutions were located, as well as the number of records found, screened and included for each site. The list of websites searched is provided in Appendix 2.

Hand searches (online screening) of all issues of selected journals on homelessness were also performed for the past five years. The list of journals and search dates are provided in Appendix 3.

All searches, including machine learning and grey literature, were imported into EPPI-Reviewer software, and were de-duplicated to remove any identical studies identified by more than one source.

As mentioned above, searches for this edition were carried out alongside searches for the fifth edition. The search results were exported from the Effectiveness Map and merged into the Implementation Issues Map. We carried out the deduplication process again at this stage to check for duplicates of studies included in the previous versions of the Implementation Issues Map.

To locate the duplicates between different versions, we first exported our results from the Effectiveness Map and organised them in a spreadsheet using Microsoft Excel. We downloaded papers contained in previous editions of the Implementation Maps and organised them in the spreadsheet by author name. We then manually examined the two sheets for duplicates and eliminated any duplicate studies.

### 1.3 Screening title and abstract

Screening for the current edition was carried out alongside that for the Effectiveness Map between August and September 2022. A total of 1,651 records were identified from machine learning searches. Grey literature searches resulted in 205 records. After removing 24 duplicates from these searches, 1,832 records went through title- and abstract-level screening. Of these 1,182 studies were excluded, leaving 650 studies to be screened by assessing full texts. In addition to this, we located 32 studies from the ProQuest database search, and 10 studies from hand searches of selected journals in January 2023. In total, we screened 1,864 studies at the title and abstract stage.

### 1.4 Full-text screening

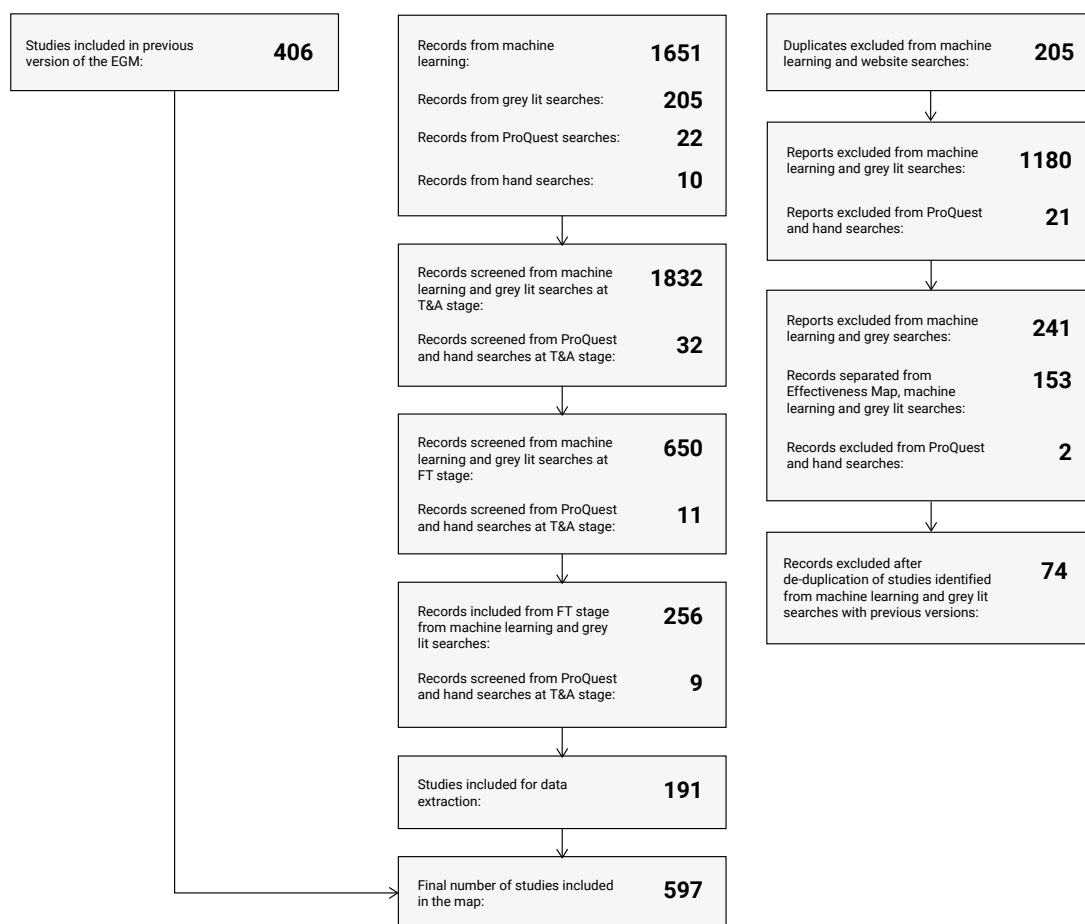
Each record was screened at the full-text stage by two team members from Campbell Collaboration, who examined the studies independently. Their decisions were compared using the 'comparison reports' feature in EPPI-Reviewer. The full-text screening carried out during the update of the homelessness Effectiveness EGM, wherein records were identified using machine learning and grey literature searches, resulting in the inclusion of 256 implementation issues studies. We included 11 studies from ProQuest searches and hand searches of journals at the full-text screening stage.

These 256 studies were separated from the fifth effectiveness edition and merged into the Implementation Map. We identified 74 duplicates during the merging process. The full-text screening of the 11 studies identified from ProQuest and hand search of journals resulted in the inclusion of 9 additional studies. Thus, data extraction for the current update was performed from 191 records. There are a total of 597 studies in this map, including 9 protocols.

## 1.5 Data extraction and critical appraisal of included studies

Data extraction was performed by three independent researchers, as per the framework used for the previous editions of the map, and was compared for differences. A fourth reviewer also participated when required to resolve disagreements. The critical appraisal of included studies was carried out using the CASP checklist for qualitative studies.

**Figure 1: PRISMA flowchart**



Note: T&A = title and abstract; FT = full text.

## 2. An overview of the Implementation EGM

There is a substantial body of evidence regarding implementation issues among interventions for people experiencing, or at risk of experiencing, homelessness. The latest version of the map contains 597 studies – 191 more than the third (2022) edition, which included 406 studies.

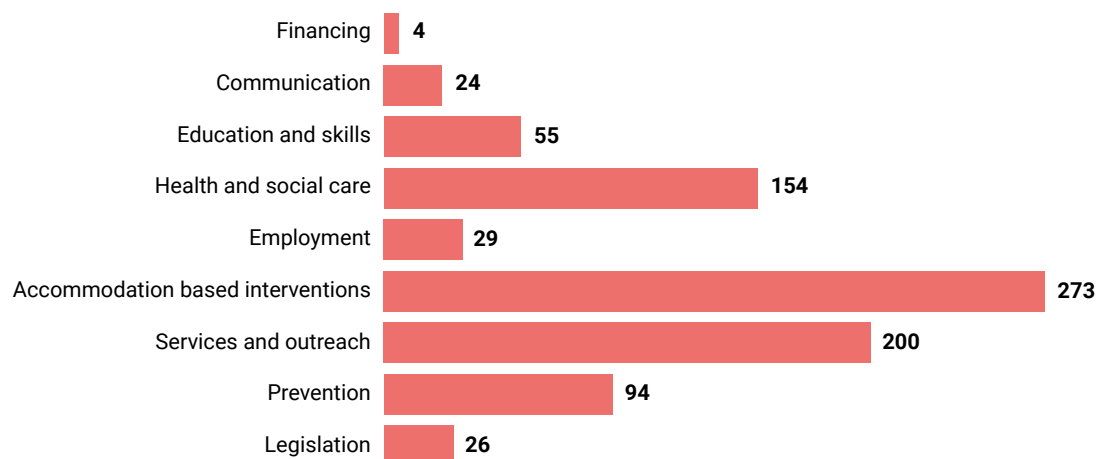
This section gives a broad overview of the map with regard to the number of included studies by intervention categories, regional distribution of studies, and publication year. A comparison is drawn for studies included in this edition of the map with those in the previous edition to draw out any trends or patterns.

### 2.1 Included studies by intervention

Nine intervention categories (legislation, prevention, services and outreach, accommodation-based services, employment, health and social care, education and skills, communications, and financing) and 44 sub-categories were identified for this EGM. Both CHI EGMs (Effectiveness and Implementation) use these intervention categories as primary dimensions in the map. More details on the definitions of these categories, as well as that of the barriers and facilitators, can be found in Appendix 4.

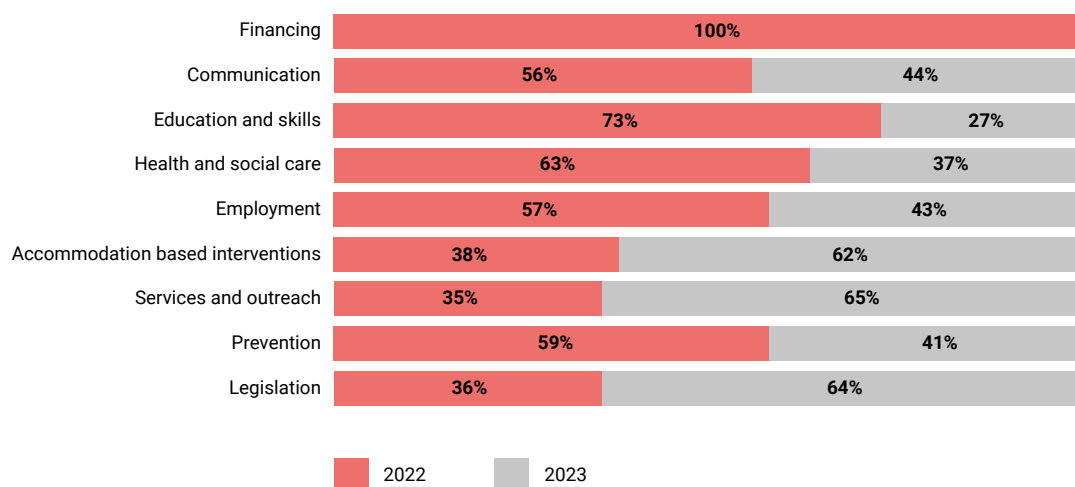
As we see in Figure 2, the evidence on implementation issues of homelessness interventions is heavily concentrated in: (a) accommodation and accommodation-based interventions (273 studies); followed by (b) services and outreach interventions (200 studies); and (c) health and social care interventions (154 studies). The number of included studies of prevention, education, and skills and employment interventions are 94, 55, and 29, respectively. There are visible gaps in the evidence on interventions related to legislation (26 studies), communication (24 studies), and financing (4 studies). The EGM gap areas indicate that there is a need for primary studies in these topics.

**Figure 2: Included studies by intervention categories**



The number of studies evaluating implementation of accommodation-based interventions increased most in this edition of the map, with the addition of 98 new studies. This could be due to increased evaluation of these types of interventions in the wake of the COVID-19 pandemic. This edition of the map has contributed to a 50% increase in evidence relating to finance interventions in the map (Figure 3). Newly included studies evaluating services and outreach, prevention and health, and social interventions accounted for 26% of these types of evaluations in the map. Newly included studies constitute approximately 24% of the less commonly evaluated categories of communication, legislation, and employment interventions. Nine new studies on education and skills interventions were also added to the map in the latest update.

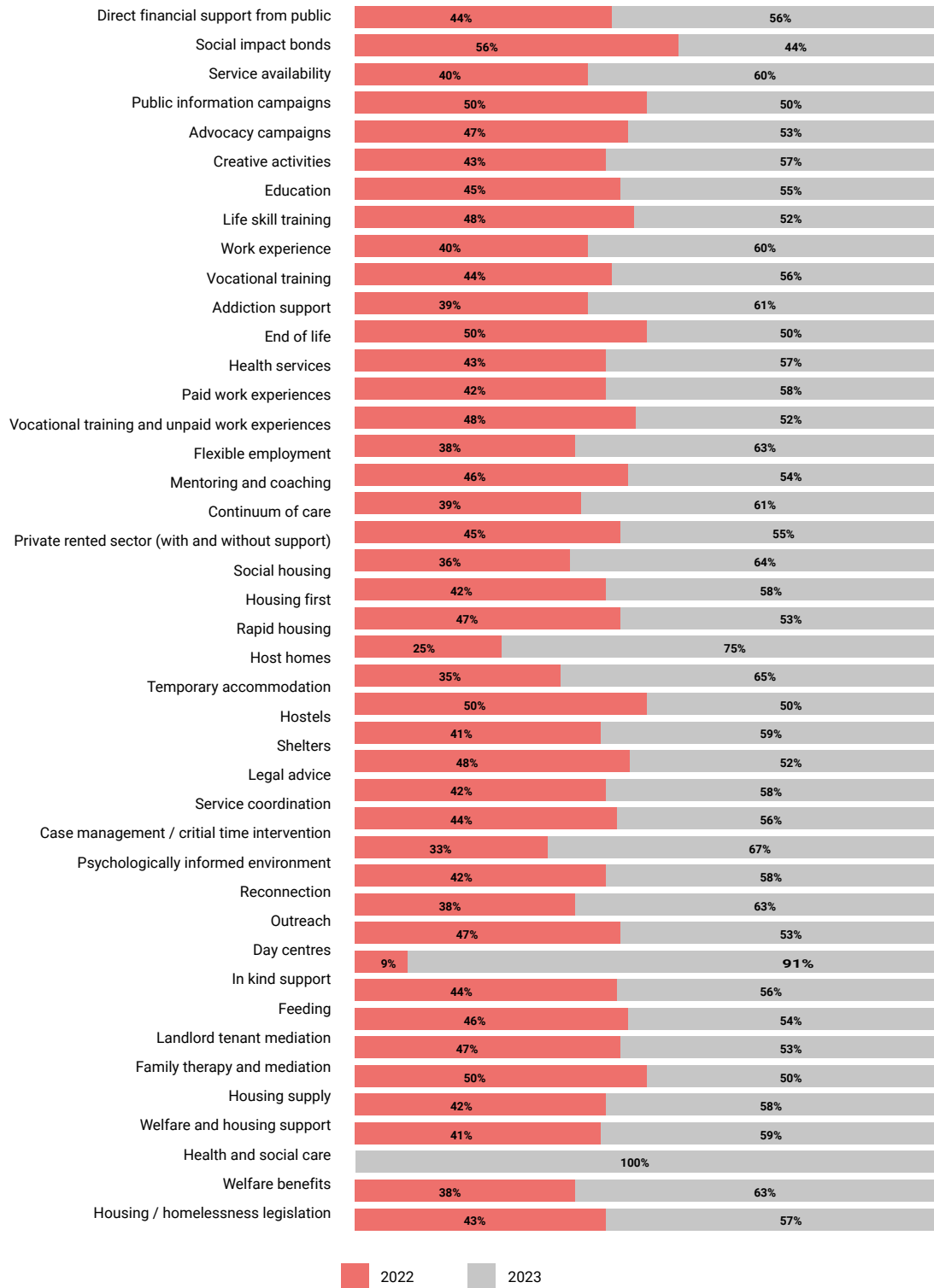
**Figure 3: Distribution of included studies by intervention categories in the third (2022) and fourth (2023) editions of the Implementation EGM**



As seen in Figure 4, the distribution of evidence within each intervention category is also uneven, whereby certain sub-categories are highly populated, while others have very few studies. For instance, while there are many studies on Housing First (108 studies), there are only six studies in which hostels and host homes appeared as an intervention subcategory under the accommodation-based interventions. A detailed description and analysis of the sub-intervention categories is provided in the next section.

Comparing the sub-categories of 2022 and 2023, it can be observed that the trends in the distribution largely remain the same. The sub-categories of health services, Housing First and case management have the highest number of studies in both editions. Notably, the 2023 edition has a significant raise in the number of studies added to the sub-categories of social housing (39), health services (33) and Housing First (31).

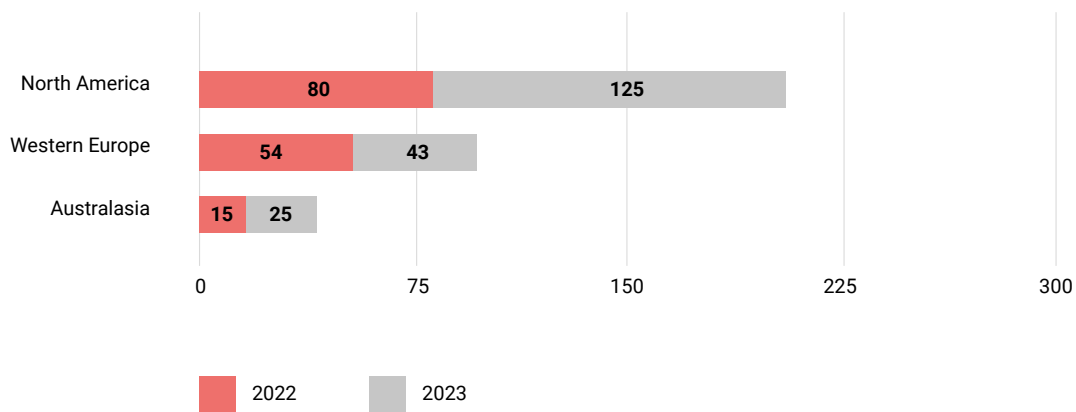
Figure 4: Included studies by sub-intervention category (overall)



## 2.2 Included studies by region and country

As seen in Figure 5, regional distribution suggests that the highest number of studies included in the map includes those from North America (n = 340), followed by Western Europe (n = 183), and the lowest number of studies includes those in Australasia (n = 83). The individual editions of the map (2021, 2022 and 2023) reflect the same trend, with the highest number of studies from North America, followed by Western Europe and Australasia. However, in the present edition, the gap in the number of studies from Western Europe and North America is relatively smaller, indicating that this edition includes more studies from Western Europe compared to the previous editions.

**Figure 5: Regional distribution of included studies**



In terms of geographical distribution of the included studies, Table 1 shows the five countries with the highest number of studies in the map, along with their numbers for the latest and previous editions of the map. The highest number of studies come from the US, constituting approximately 38% of all included studies. The UK comes in second place, accounting for approximately 25%. The number of studies included for Australia and Canada comprise 13% and 20% of the map, respectively.

When compared across the editions, the gap in the number of studies between the UK and Australia is narrower, while that between studies from the US and Canada is wider when compared to the 2022 edition. This implies that the representation of studies from the US and Canada is higher in this edition of the map compared to the previous edition.



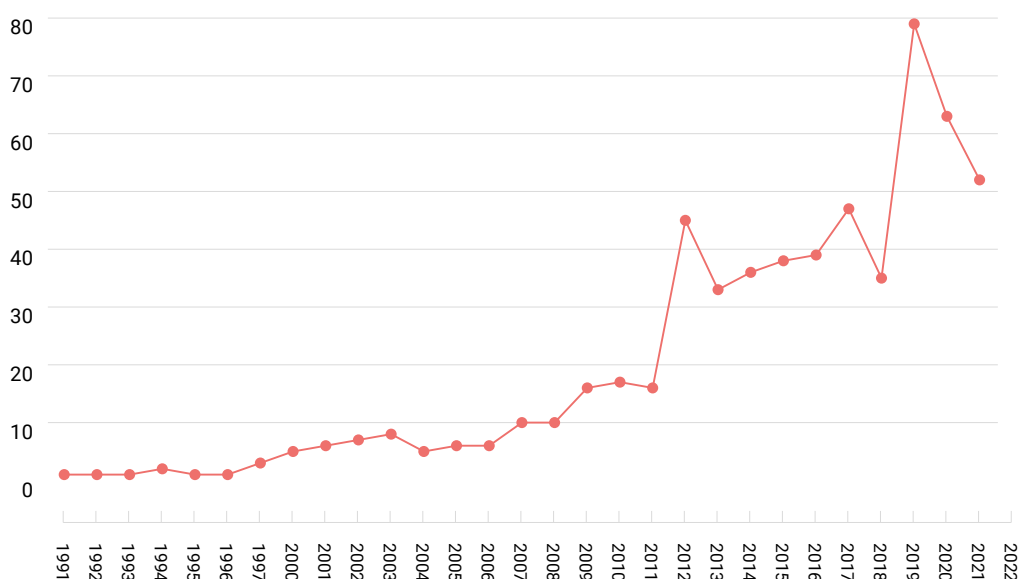
**Table 1: Number of studies for selected countries**

Country	Number of studies in 2022 edition	Number of studies in 2023 edition
US	53	74
UK	38	33
Australia	15	24
Canada	28	52
Ireland	6	3

### 2.3 Included studies by year of publication

The number of studies published each year is increasing rapidly, with occasional dips in certain years. Only three studies were published in the year 2000, while 79 studies were published in 2020. There has, however, been a sudden rise in the number of studies published since 2020; Before 2020 the number never exceeded 50 per year (the highest was 47 in 2018). The highest number of studies published was in 2020 (n = 79), followed by 2021 (n = 63) and 2022 (n = 52). The drop off in the two most recent years is likely not a real drop, but reflects the fact that recently published papers are less discoverable.

**Figure 6: Studies by year of publication**



This section elaborates on the included studies by sub-intervention categories. The distribution of studies under each is also provided for previous and current editions of the map.

## 3. Included studies by sub-intervention categories

As seen in Figure 4, the evidence on implementation issues for homelessness interventions is most heavily concentrated in the sub-intervention category of health services (140 studies), followed by Housing First (108 studies), and case management/critical time intervention (89 studies). This is also indicated in Appendix 5 in the document which states the distribution of included studies by sub-intervention categories presented in this edition of the map

### 3.1 Interventions related to health services

This section describes intervention characteristics of some of the health services interventions for varied sub-categories of homeless populations such as patients, young people, and individuals who face physical and mental health issues along with poverty, homelessness, abuse and addiction. Interventions in the included studies encompass a variety of services such as primary healthcare, palliative services, emergency interventions, antenatal and postnatal care, vaccinations, mental health treatment, oral health services and addiction support. Many of the studies that assessed health services interventions provided substantial descriptions of them.

#### **Primary healthcare**

An intervention delivering bespoke, city-centre primary healthcare services for patients experiencing homelessness – meaning those living in temporary accommodation and hostels, as well as people sleeping rough and ‘sofa-surfing’ – was based on the Faculty for Homeless and Inclusion Health framework (Clark et al., 2020). Its clinic also offered support such as visiting in-reach drug and alcohol support workers, a Hepatitis C clinic, a needle exchange, shower facilities, and some necessities such as donated clothes.

#### **Youth-centred healthcare**

Clarke et al. (2020) assessed a youth-centric approach to delivering comprehensive primary health care to young people affected by homelessness. The 45th Street Youth Clinic was a twice-weekly walk-in clinic for young people experiencing homelessness between the ages of 12 and 23. The clinic’s team included allopathic primary healthcare professionals, practitioners of naturopathy and acupuncture, a mental health therapist, an HIV counsellor, a drug abuse counsellor, outreach workers who formerly experienced homelessness, and nurses. Many of the front desk staff members were reported to be volunteers.

**Figure 7: Faculty for Homeless and Inclusion Health framework**

Source: Clarke et al., 2020, p. 2

The clinic was created as a unique initiative to act as a point of entry to services for a population known to face numerous obstacles to receiving care. Building healthy relationships with these young people was considered crucial to achieving the aim. Instead of expecting the young people to adapt to the intervention, the goal was to integrate the programme's services into their daily life. Housed in a former fire station that had also been converted into a public library, the 45th Street Clinic didn't look like a traditional treatment centre. The programme tried to integrate itself into a network of youth services, while simultaneously being promoted in the neighbourhood as a unique youth programme. The clinic operated in the evenings, when young people were more likely to be available (Clarke et al., 2020).

### Mindfulness and mental health

The SHINE ('Support, Honour, Inspire, Nurture, Evolve') intervention for mothers and children taught mindfulness awareness techniques to those facing issues with their physical and mental health, as well as poverty, homelessness, addictions and abuse (Alhusen et al., 2017). It was used at the PACT Therapeutic Nursery in conjunction with the parent-child play activity known as 'mindful awareness play' to encourage mutual regulation, strengthen family ties, and lessen stress and anxiety.

The meticulously planned weekly exercises were founded on convincing scientific proof that meditation can have a clear favourable impact on immunological and brain function. To provide a predictable structure to the group meeting, specific features were repeated each week (i.e., reviewing group agreements, passing a 'talking stick' for individual comments, and sharing mindful 'victories' parents experienced in the previous week). Each programme included three scheduled formal guided meditations. An informal 'key to mindfulness' practice was also taught every week through interactive exercises, peer teachings, and demonstrations. Each 'key' provided a straightforward technique that parents might use to intentionally pause and self-reflect. The parent received a 'key' tag at the end of the session that matched the day's mindful instruction, which they could keep in their pocket as a reminder to practise mindfulness.

## 3.2 Interventions related to accommodation provision

This section describes the intervention characteristics of some accommodation-based services, such as temporary housing, permanent homes, housing support, and social housing.

### **Permanent housing and care**

Indigenous peoples' experiences of a Housing First intervention – At Home/Chez Soi in Winnipeg, Canada – were explored by Alaazi and colleagues (2015). The goal of the intervention was to provide permanent homes and support to people who, due to mental illness, drug addictions and behavioural issues have had a harder time in accessing existing mainstream homelessness services.

Participants of this project were randomly assigned to experimental and control groups. Those in the Housing First group had access to subsidised rental housing of their choice, as well as optional support services such as counselling, skills training and medical care through two different intervention teams: assertive community treatment (serving participants with high needs) and intensive case management.

### **Housing and individualised services**

In the US, the Cuyahoga County Continuum of Care adapted the Housing First philosophy and provided services to 1,448 households in Ohio. A coordinated intake system was used to identify eligible families and young adults. Special attention was paid to ensuring that clients with multiple service needs and multiple barriers – such as those with mental health needs, recurring episodes of homelessness, substance abuse issues, and others – had access to intensive and individualised services. The programme mobilised a team of community providers, using housing vouchers to accommodate clients as quickly as possible, and provided intensive case management to help clients stabilise and avoid returning to shelters. The ratio of case managers to clients was approximately 1 to 20 (Collins et al., 2020)

### **Housing and care for young people**

The delivery of electronic case management services for young people impacted by homelessness was offered through four sessions provided every 2–3 weeks over a three-month period (Bender et al., 2015). Participants were contacted three times by a case manager – first via mobile phone and then, in cases of no response, via text and another mobile phone call. If there was no response again, the participant was called, texted, and reached through email or Facebook.

The electronic case management sessions included a set of standardised questions about the youths' current service use, identification of their unique goals (e.g., housing, employment, education, mental health, substance use services), their progress towards goal achievement, challenges they faced in trying to reach their goals, and additional resources required to be successful.

### **Transitional care**

Connect2Care, a mobile outreach team offering assistance for transitional case management, (Garcia-Jorda et al., 2022), provided patients with erratic housing situations with access to extensive case management, transitional care, advocacy, patient navigation, and care coordination services – with registered nurses and health navigators comprising the frontline team.

## **3.3 Interventions related to prevention, services and outreach**

Preventive interventions include welfare and housing support, housing supply, as well as discharge-based services. Welfare and housing support, social housing, and outreach interventions have 68, 67 and 66 studies in this map, respectively.

### **Emergency housing**

One example is emergency rental assistance designed to prevent homelessness during COVID-19 in the US (Aiken et al., 2022). Another is the 'Eviction Prevention in the Community' programme (Ecker et al., 2018), a welfare and housing intervention providing services to tenants facing imminent risk of eviction in Toronto, Canada. It used a blended model of direct and contracted community agency service delivery. The programme's specialised services included: comprehensive case management assistance, assistance securing income supports, money management programmes, system navigation and referral to other services and support, rehousing support and shelter diversion, referrals to community legal support, and navigation/accompaniment to the landlord tenant board.

## Social housing

Northern Healthcare's supported living intervention is an example of social housing, in which occupants were viewed as 'tenants' rather than 'patients' or 'service users', and each was provided with a private bedroom, bathroom and kitchen, as well as a front-door key. The model's main objectives were to treat each person as a unique individual, to support their growing independence, and to promote their rehabilitation. Supporting the tenant in accessing fundamental amenities and in taking care of long-standing unmet social, financial, and health needs was the first step in the process. Tenants who actively participated in the creation of an individual support plan had well-defined goals (Barnes et al., 2022).

## Outreach

The Downtown Street Outreach Initiative used outreach workers to identify and engage with people living on the street. These workers attempted to understand their issues and connect them with appropriate services and support, while also trying to establish connections with other service providers and downtown stakeholders to engage them in discussion about the best methods to satisfy the needs of the people affected by homelessness (Alana LaPerle Project Services, 2012).

As evident in Figure 4, the least-populated sub-intervention areas in the map are work experience, end of life care, flexible employment, public information campaigns, vocational training and social impact bonds. These interventions are merely stated and not elaborated upon in most studies, as they have the least-populated sub-interventions. This draws our attention to the fact that the evidence is unevenly distributed even within broader intervention categories, as the least-represented sub-intervention categories are within broader intervention categories that otherwise represent highly populated areas – but for other interventions.

Some differences are also observed in the 2022 and 2023 editions of the map for various sub-intervention categories. Appendix 5 provides a breakdown of the total number of studies per sub-intervention category, as well as the number of new studies included in this edition of the map per category. The 2023 edition of the map has more studies compared to the previous update of the map for social housing (+29), outreach (+26), welfare and housing (+20), temporary accommodation (+21), in-kind support (+19), and shelters and addiction (+14).

There are several areas where no new studies were found for several sub-intervention categories. The 2023 update has added to certain well-populated sub-intervention categories such as health services (+33), Housing First (+31 studies), case management/critical time intervention (+20 studies) and service coordination (+13).

# 4. Analysis of implementation issues (barriers and facilitators)

## 4.1 Barriers

The aggregate map for the intervention categories and barriers is presented in Table 2. The intervention-barrier matrix in this aggregate map indicates the number of studies which evaluate a given intervention and mention an implementation issue as a barrier to successful implementation. These numbers are instances of a particular barrier appearing in a particular study. It is, however, difficult to view all barriers mentioned in a study; therefore, the interactive evidence and gap map is very useful for such an examination.

Table 2 suggests that all barrier categories appeared most frequently in accommodation-based interventions, followed by services and outreach interventions. The included studies in the map under these two sets of interventions have been also well-studied for perceived barriers from recipients' perspectives.

For instance, in an early implementation evaluation of a Canadian multi-site Housing First intervention, it was noted that the programme recipient experienced challenges in accessing non-housing support due to a lack of staff competency. The authors identified unique challenges of hiring and training culturally competent staff to accommodate the needs of Aboriginal participants. Participants in Toronto suggested that the programme had difficulty meeting the cultural and linguistic requirements of their diverse population (Nelson, 2013, p. 23). To this end, a significant number of recipients reported their inability to completely buy into the programme, and showed distrust for the authorities (Cox, 2021; Choi, 2022; Harris, 2022).

The health and social care interventions mostly capture barriers from the perspective of the programme administrator, manager, or implementing agency, and the programme recipients.

The main barrier identified by implementing agencies is the sufficiency or adequacy of resources (e.g., space, time, staff, budget). For example, permanent supportive housing managers in one of the studies stated that there were insufficient doctors and medical staff to care for a rising number of patients. According to a recipient, the clinic's daily hours of operation were not long enough, while others shared that the physician was infrequently on site.

*'The doctors are only here once a week for a couple hours. If I need to talk to one and like and it's Tuesday, what ...have I got to do, wait till Friday at one o'clock? No. Sorry. That's not going to cut it...I think they should have a nurse on 24 hours a day. It would be better for us because a lot of people have seizures and overdoses in here.'*

– MacKinnon, 2022, p. 24

**Table 2: Aggregate Implementation EGM of included studies for intervention and barriers**

<b>Intervention categories</b>	<b>Contextual factors</b>	<b>Policy makers/ funders</b>	<b>Programme administrator/ manager/ implementing agency</b>	<b>Staff/ case worker</b>	<b>Programme recipient</b>
<b>Legislation</b>	13	11	18	7	20
<b>Prevention</b>	33	24	65	34	53
<b>Services and outreach</b>	78	59	147	87	122
<b>Accommodation-based interventions</b>	109	81	182	114	177
<b>Employment</b>	12	8	18	11	16
<b>Health and social care</b>	33	26	82	59	77
<b>Education and skills</b>	12	8	24	19	25
<b>Communication</b>	8	11	15	9	13
<b>Financing</b>	2	2	1	1	2



## 4.2 Facilitators

As with the barriers, Table 3 shows the aggregate map of the intervention-facilitator matrix. It is evident from the table that studies evaluating interventions related to accommodation-based interventions, services and outreach, and health and social care interventions mention the programme manager, staff case workers and recipients' most frequently as facilitators to implementation. The table also indicates that facilitators related to recipients appear in more than 90% of included studies.

For recipients the biggest facilitator was the emotional acceptance of the programme followed by housing-related security whereas for the staff case worker it was their technical skills and communication/engagement with the programme recipient that resulted in effective take-up of an intervention. For instance, in the case of Housing First programme in 8 European countries, wherein the staff reported that "It's not one worker who is in charge of a case, but multiple workers who are in charge of the same case" and "getting time and space to carry out our work, to adapt to the client's freedom, discretionary space" (Gaboardi, 2022: 15) that facilitated the process.

**Table 3: Aggregate Implementation EGM of included studies for intervention and facilitators**

Intervention categories	Contextual factors	Policy maker/ funders	Programme administrator/ manager/ implementing agency	Staff/ case worker	Staff/ case worker
Legislation	19	12	14	9	8
Prevention	28	28	61	60	65
Services and outreach	46	80	147	146	156
Accommodation-based interventions	71	93	153	172	202
Employment	7	9	21	18	21
Health and social care	21	30	67	109	108
Education and skills	8	12	24	32	43
Communication	7	14	19	17	17
Financing	1	1	2	1	4

When analysing barriers and facilitators, it was common to find that many factors served as both a barrier and a facilitator; for example, contextual factors were identified as both a facilitator as well as a barrier in the implementation process of an intervention. The recipients’ access to non-housing support in most cases was a barrier that determined the buy-in of the recipient into a programme.

### 4.3 In-depth examination of barriers and facilitators: insights from included studies

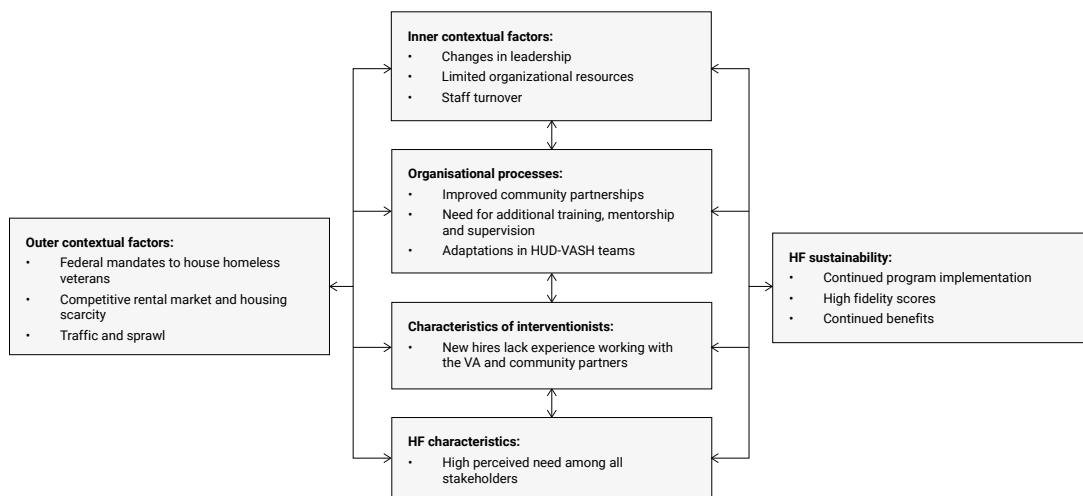
#### Barriers to implementation

This section conducts an in-depth examination to provide specific examples from the five barrier categories. The examples reported here encompass the perspectives of clients, service providers, and implementing agencies.

#### 1) Contextual factors: housing market and welfare support

Both housing and welfare support were commonly cited contextual barriers. For example, an evaluation of sustaining Housing First as a permanent supportive housing programme for veterans with experience of homelessness, it was reported that contextual factors such as paucity of the housing market negatively affected the permanent-housing programme (Fletcher et al., 2022). This is particularly interesting from the stakeholders’ perspective. As we see in Figure 8, the authors differentiate between inner and outer contextual factors on Housing First core components to bring forth the challenges faced by recipients.

**Figure 8: Integrated sustainability framework adapted for Housing First** **Source:** Fletcher et al. 2022, p.379



Note: HUD-VASH = Department of Housing and Urban Development-VA Supportive Housing; VA = Veterans Health Administration; HF = Housing First.

Along with inadequate availability of housing support, studies on implementation of programmes related to COVID-19 also suggest that welfare support is a primary challenge. For example, in a study examining challenges experienced during COVID-19 vaccination efforts, healthcare providers and housing programme staff who delivered healthcare and other services to veterans experiencing homelessness during the SARS-CoV-2 pandemic cited inadequate access to and uptake of welfare support to improve vaccine acceptance among the target population (Balut et al., 2022). As we discuss later in the report, this was also due to mistrust of authorities and low buy-in by recipients in any programme.

While access to and absence of welfare support was identified as a barrier, it is important to highlight the experience of discrimination faced by potential participants and recipients from service providers. For instance, Gorton and colleagues (2004) stated that people impacted by homelessness experience discrimination by general physicians and their practices, which impacts the healthcare they receive. In their study on the experience of people seeking treatment and services from the national health service in London, participants reported that the welfare context did not make a difference when they felt labelled and stereotyped by healthcare professionals who grouped them together under the 'aura of homelessness', irrespective of their health conditions. One participant stated that, 'The stigma sticks to you – no matter how long it is. "He's only a dosser." This is what you hear. How many times have we heard that?' (Ibid., p. 7).

The feelings of prejudice and labelling were echoed specifically in cases concerning groups experiencing alcoholism and substance abuse, or even minority groups. In a study exploring how supportive housing is experienced by sexual and gender minority groups in the US, cycles of marginalisation experienced by the client could be reinforced by service providers, if not adequately trained. A provider in one of the studies stated:

*'Incarceration is kind of just, I guess, a by-product of their life circumstances. It's just what they do for survival, being sex workers, or stealing, or drug addiction because of inability to deal with life situations...Any time you don't have a source of income to be able to take care of yourself, you gonna survive by any means necessary...For those that are sex workers, they have to look a certain way, they have to be appealing. So of course they gonna go to a store and they gonna shoplift, they gonna do stuff to keep up their appearance.'*

– Dopp, 2022, p. 13

## 2) Policy makers/funders: collaboration and inadequacy of resources

Collaboration with external agencies emerged as a strong limiting factor in studies across different settings. In a study assessing permanent supportive housing in the US, participants appreciated the ease of access to medical and mental health services; however, as services were assumed to be optimised by virtue of co-location with Veterans Health Administration healthcare, their permanent supportive housing providers often did not link them with non-veteran social services as assertively as desired. This lack of collaboration was indicated by a loss of participants' interest and accessibility in the programme (Jacobs et al., 2022, p. 3).

In another study exploring how providers apply a harm reduction practice in a Norwegian Housing First project, harm reduction was found to comprise most of the follow-up work for service providers, pointing to a lack of collaboration and adequate resources. The authors

(Andvig et al., 2018) undertook a thematic analysis wherein policy guidelines were observed as a barrier to implementation of the practice: 'We don't follow service provision contracts, we do everything... Doing "everything" could include actions ranging from carrying out garbage and shopping for food with service users to conversations about existential topics' (Ibid, p. 8).

### **3) Programme administrator/manager: inadequacy of resources and identification of service users**

Lack of adequate resources was understood to be a prevalent barrier across different settings, experienced by both participants and service providers. In Gorton and colleagues' study on the experience of populations affected by homelessness receiving healthcare support from the national health service in London, recipients reported that they routinely came across staff who were 'frustrated with the limitations of the system and wanted to be able to provide a better service than they had the resources to provide' (Gorton et al., 2004, p. 9).

Referrals and identification of recipients were identified as critical aspects of delivering any intervention. A study among service providers in Australia's New South Wales (NSW) region suggested that referral networks may also be 'person-based rather than service-based, [though] this may be expected to change over time as awareness of the service grows' (Robyn Kennedy Associates, 2013, p. 25). This was particularly challenging in cases with indigenous populations, wherein clients stated that participants were encouraged to refer and enrol when someone from their composite population was on the other side of the table.

Managers stated that they 'did have an Aboriginal admin person working here who used to make a lot of referrals but she is no longer here' (Robyn Kennedy Associates, 2013, p. 25). Factors such as this also potentially resulted in insufficient promotion and awareness of any service, thus emphasising what a service provider suggested in the case of the NSW Homelessness Action Plan 2009–2014: 'Better communication is needed so that feedback is provided on client outcomes. [We] need to maintain linkages with referral partners' (Robyn Kennedy Associates, 2013, p. 32).

### **4) Staff/case worker: staff skills and lack of engagement with other agencies**

For a staff/case worker, building rapport and communication with the programme recipient is understood to be an important factor that facilitates implementation of any intervention. To this end, language barriers, in particular when dealing with a population from a different socio-cultural background, was cited in some cases. For instance, in the NSW Homelessness Action Plan (2009–2014) programme – which sought state-wide reform of the homelessness service system to achieve better outcomes for people who experience homelessness or are at risk of homelessness – it is seen that staff or case worker incompetence negatively affected programme uptake among Aboriginal people (Robyn Kennedy Associates, 2013).

Inadequate staff training was widely reported in included studies, particularly in interventions targeting minority groups and marginalised populations. In a study on supportive housing for sexual- and gender-minority individuals with criminal justice histories, a primary challenge

identified by the provider was staff capabilities in treating sensitive cases:

*'We've created a small network of culturally competent LGBT substance use and co-occurring providers. That network is about three providers right now. There are lots of agencies out there that say "Oh yeah, we treat 'em!," you know, like that's something significant, but they have little or no competency... and we had to go through our own personal journey to get there [with our competency].'*

– Dopp, 2022, p. 10

In such cases, staff sensitivity and commitment to the programme also become crucial in ensuring positive service delivery. A client in this study stated that to avoid discrimination and negative experiences with review providers:

*'It would be help[ful] to know of companies and people who understand and accept [transgender people]. It's like [the case manager] might say "I'm going to send you over to this company"... but the company has no familiarity with LGBTQ.'*

– Ibid., p. 10

Lacking staff skills are also reflected in their lack of communication and engagement with other agencies. This factor further impeded the implementation of any service in housing and housing support for populations affected by homelessness. In a study on identifying the challenges experienced by individuals with a traumatic brain injury and mental health and/or substance use (Estrella et al., 2021), the authors identified that systems of care were siloed and organised around clinical diagnoses, which made service delivery challenging.

The authors stated that 'siloes between hospital and community services meant service providers in community housing programmes generally did not know if their clients had experienced traumatic brain injury and therefore could not adapt their services accordingly' (Ibid., p. 10). It is important to note here that the perspective of service providers also suggested that such a fragmented system countered their ability to 'provide optimal services/supports, and for service users, limiting or delaying their access to required services' (Ibid.).

##### **5) Programme recipients: personal safety concerns and buy-in**

In cases of female participation in any intervention, safety concerns were reported to result in poor experiences or low participation. For instance, the Veterans Health Administration in the US works towards ending veteran homelessness through its permanent supportive housing initiative: the Department of Housing and Urban Development-VA Supportive Housing programme. Its units on the Veterans Health Administration campus facilitate access to housing and supportive services, but safety concerns were identified as a barrier, mainly by female programme recipients. They reported a need to ensure women's safety for their uptake of the intervention, and reported sexual harassment from other tenants and a desire for gender-specific additional safety precautions. Two participants noted:

*'The situation about the sexual harassment ... how many of those women are living on VA benefits that have to do with military sexual trauma ... they bring in an extra security guard so the women [on] staff feel safe, but he leaves at 5.'*

– Jacobs et al., 2022, p.3.

*'For a long time I didn't feel safe living there. . .between the people who are doing drugs and the people who are acting crazy when they came out of their unit trying to talk to me. And in the beginning, there was more than a few instances of men saying inappropriate things to me, sexual remarks or questions or offerings.'*

– Ibid.

While programme accessibility and security related to mobility to housing emerged as a limiting factor in some cases, the primary barrier in other studies included trusting authorities or service providers themselves, which affected programme buy-in among potential clients.

Interventions related to the implementation of health services reported a particularly high number of participants displaying mistrust of authorities. A study exploring the uptake and use of electronic cigarettes provided to smokers accessing homeless centres in the UK suggests that 'psychological and emotional vulnerability of many of our participants and mistrust with the authorities' affected uptake (Cox, 2021, p. 24).

Another participant stated, 'I thought, "Oh this [is] definitely a government initiative. They're going to run a test on the homeless...maybe they've got a dodgy batch of [e-liquid] and they just want to see if it takes anyone out before they put them up for sale' (Ibid., p. 23). There was also concern around anonymity and private details being shared with authorities: '...if I thought my information was being shared, then I wouldn't take part' (Ibid.). Such emotions from service users into any programme were hindered by limited client self-disclosure to providers (Dopp, 2022; End Homelessness Winnipeg, 2022; Cox, 2021; Estrella et al., 2021).

### **Facilitators of implementation**

This section conducts an in-depth examination to provide specific examples from the five categories of facilitators. The examples reported here encompass the perspectives of individuals using services, service providers and implementing agencies.

#### **1) Contextual factors: facilitating entry into housing markets and welfare support**

While both of these factors comprised the bulk of identified barriers, they were also identified as enabling factors in many studies. For instance, in an NSW Homelessness Action Plan intervention providing long-term accommodation and support for women and children experiencing domestic and family violence, the individual's entry into the housing market acted as a facilitator. The intervention acted as a bridge, facilitating women's access to markets. Women with access to the markets were able to sustain their tenancies. The NSW evaluation also reported facilitating clients' access to private markets as a supporting factor (Gomez-Bonnet et al., 2013).

Examples of welfare support facilitators include: a provisional hospital discharge fund for people experiencing homelessness in the UK (Homelessness Link, 2015), personalised budgets for people sleeping rough in London (Hough and Rice, 2010) and supplemental rental assistance for facilities to assist homeless programmes (US Department of Housing and Urban Development, 1994). The Stewart B. McKinney Homeless Assistance Act (Biggar, 2001) and the HUD Section 811 Project Rental Assistance Programme (Pinkett, 2018) are examples of included studies that cite 'law' as a facilitator in the contextual factor category.

## 2) Policy makers and funders: leadership, culture and commitment

The most frequently mentioned facilitator in the policy makers and funders category is buy-in, which is characterised by the leadership culture, and commitment embodied by a programme. In a Housing First Pathfinder evaluation, a strong political commitment to Housing First at national and local levels, as well as a high level of buy-in from many important housing providers in the Pathfinder area, was cited as a facilitator.

It was uniformly agreed that the Scottish government's public declaration of support for Housing First played a significant role in its development and mobilisation within the Pathfinder areas. To cite from the study:

*'There's been a real commitment from [the] Scottish Government... There's been a real commitment that this is what we're going to be doing... I think that seems to have filtered down. Not necessarily all the way down, but far enough down for the wheels to start to change. I think because of that coming down from the top there has been local buy-in.'*  
(Stakeholder, Dundee)

– Johnsen et al., 2021, p. 41.

In a study of the factors that made a difference in meeting the needs of students affected by homelessness, it was stated that district leaders worked diligently to establish systems of support for them. According to liaisons who work in high-poverty districts, the leadership was aware of the numerous difficulties that students from low-income backgrounds frequently encountered – with regard to attendance, behaviour, and academics, as well as in meeting basic needs like food or hygiene – and has implemented programmes or policies to support all students in need (Robson, 2016).

In the same study, liaisons acknowledged superintendents of their districts for their prioritisation of student needs and ensuring that funds were available to support increased staff, programmes and/or services. Below are examples of similar reactions from two liaisons:

*'We have social workers in each building. They're all paid through [special education] and general dollar funds for the district, so it's a commitment from the superintendent to have them in the buildings.'*

– Robson, 2016, p. 94

*'We have a superintendent who truly is a student first. She will not make a decision that will make an adult happy simply to avoid a union issue. She sees the need in our community for a community resource, a wraparound care team. She just sees the need and is willing to find the resources to meet that need.'*

– Robson, 2016, p. 94

### **3) Programme administrators/ managers/ implementing agencies**

In the At-Home/Chez Soi project, it was reported that the operational components of implementation benefited from steady and effective host agency leadership, which also enabled teams to tolerate changes in team leaders. A congruent host agency culture was also reported to be crucial in ensuring that the model's conceptual components were put into practice and upheld (Nelson et al., 2013).

Similarly, in a multi-site Housing First intervention for people experiencing homelessness with mental illness, leadership aided implementation significantly. Participants mentioned team leaders, site coordinators, and others as having abilities that made implementation easier. They were described as leaders who had good decision-making abilities to provide clear guidance and encourage a culture of shared learning and respect among staff, and as having in-depth knowledge of the Housing First model. Service users stressed the benefit of hiring staff who possessed the proper mix of technical and interpersonal abilities (Nelson et al., 2013).

In another evaluation, members of the advisory board were committed to making a meaningful difference in the lives of disadvantaged and marginalised people, a group often with complex needs that can be difficult to access. Members of executive and day centre staff noted the generosity, passion and dedication of designers, donors and volunteers involved in the implementation.

Implementation of many programmes were also reported to be successful due to efficient collaboration and partnerships among implementing agencies and other organisations. For instance, in a transitional housing programme for forensic patients discharged into the community, the partnerships developed between the hospital and community agencies in both cities were perceived as a strength. City B partners noted that they had come to better understand and appreciate each agency's strengths, responsibilities, and ways of working:

*'There has been a tendency in the past for hospitals to say that community agencies don't understand their patients and for community agencies to say that hospitals don't get our realities. We have been able to work together for the benefit of the patients. In the end, we have been able to appreciate and grow. That is a main benefit.'* – Cherner et al., 2013, p. 172.

### **4) Referral route for identification of stakeholders**

Early identification and adapting the target route to locate stakeholders both help to facilitate smoother implementation. In a care transfers intervention for patients experiencing homelessness after hospital discharge, a key mechanism to achieve patient in-reach was the 'homeless ward round', in which clinicians from the homeless team identified and supported



and engaged patients located across the hospital site (Cornes et al., 2021).

In a study targeting people with HIV who experienced homelessness, the centralised intake system was one of the programme's major strengths. Across the interviews, key informants agreed that having a centralised intake system was more effective. In particular, the state-wide intake system was seen by all informants as a means of integrating services and screening clients for eligibility for various programmes.

*'We go through a process, the...process of centralised intake...they kind of categorise you in terms of intensity or the seriousness of your homelessness and they put you in a category. They make a call to agencies accordingly.'*

– (Courtenay-Quirk et al., 2022, p. 6).

#### **5) Use of robust data and monitoring mechanisms**

Making decisions that are data-informed and evidence-based was a priority for implementers. Strong data were perceived by leaders as essential in monitoring programme- and systems-level outcomes and identifying gaps and areas for service improvement.

'It's data [and] information management, it's evaluation, it's research. So not only do we talk about what research and evaluation we're doing in each of our communities, but we often take that to a higher realm and say, how can we do this together?' –Worton, 2020, p. 10.

#### **6) Staff/case workers: efficient communication and engagement**

Case workers' skills, and the ways in which they communicated and connected, were deeply valued by stakeholders. According to person using the services of a specialist homelessness service programme:

*'They've always been there, and I've always been able to rely on them and go back to them when I need to for that support and to help me get back on my feet. So it's definitely been a big part of my life for the last four years and the caseworkers that I've been given in the last few years they've just been wonderful.'*

– Valentine et al., 2017, p. 35.

When asked where he thought he would be without the casework support he was receiving, one young man responded, 'on the streets most likely' (Valentine et al., 2017, p. 35).

In one downtown street outreach initiative, an outreach worker became an advocate, advisor and source of information for the people he connected with on the street. The workers were equipped to provide immediate, short-term and long-term services (Alana LaPerle Project Services, 2011).

#### **7) Programme recipient: access to non-housing support and services**

Access to non-housing support is reported to be the strongest facilitator, particularly when considering the challenges experienced during COVID-19. In a study on veterans experiencing homelessness related to COVID-19 in the US, providers and housing staff

reported that access to vaccines in closer vicinities facilitated their access and also increased participants' uptake of the programme (Balut et al., 2022).

To avail themselves of any programme benefits aimed at the homeless population, recipients were required to meet an eligibility criterion. Access to funding, brokerage, and medical aid was essential in this regard. This was seen to be of specific significance for recipients/participants who identified as women. In a study on the Homelessness Action Plan project in Australia, we found examples of access to brokerage enabling female participants to establish and maintain tenancies. One participant reported:

*'Well we didn't have anything. Before I went on the programme we didn't have anything so getting a house was even harder because we had nothing to put in the house. So just getting everything set up for the house so that we could have our own house and be all set up and get on with our lives.'*

– Breckenridge, 2013, p. 31.

Another study assessing hardships and supportive factors for unhoused families led by single mothers in the US showed that participants positively described their acquisition of various training and skills during their time within the transitional housing shelter:

*'You know because when I went to the rehab, it was all about how to live life sober, and then so once you have, so once you're sober and everything, it's like then what? This place [Housing Facility] gave me different tools and helped me...to be able to be a good mom and you know, a productive member of society, to do what people do, or supposed to do you know.'*

– Brott et al., 2022, p. 12.

Factors such as programme accessibility, information accessibility and consistent service availability facilitated recipients' emotional acceptance of the programme and 'increased independence and sense of autonomy' (Toombs, 2021, p. 102). Such a strength-based approach also affirmed participants buy-in of any programme. One example is the Housing Outreach Programme Collaborative for youth experiencing homelessness in Toronto, Canada (Toombs, 2021). Participants reported that the structure of the programme made them 'feel respected and increased their likelihood of engaging in programming' (Toombs, 2021, p. 103). One participant stated:

*'You don't have to stick in the same pathway, you can make it [the programme] your own. It's like you're not always going to go straight, there's going to be bumps all along the road. So the support was since, that's one thing I liked about the HOP-C.'*

– Ibid.

In the case of a study on youth in housing and community programmes in Canada, self-esteem was the most-reported outcome of the collective activities organised by the implementing agency. Participants asserted that resource availability and access to training had a positive effect, shaping participants' emotional buy-in of the programme (Bourbonnai, 2019):

*'Community workers really trusted me, it's very rewarding for me...it really helped me ...I did not just do the tenants committee, it went much further than that. Exchanges were really fun, I found it fun that [in] my opinion is worth something, that I was not just the little young representative, but that they consider me as I am.'*

– Bourbonnai, 2019, p. 40

When analysing barriers and facilitators, it is common to find that many factors act as both, such as contextual factors that supported the take-up of an intervention while also hindering the implementation process. Or, for instance, recipients' access to non-housing support in most cases was a barrier that determined their buy-in to a programme. Discussion of both the enablers and barriers from different perspectives of the stakeholders (managers, staff and recipients) offered an opportunity for in-depth analysis from all vantage points.

In the next section, we present the critical assessment of the included studies, which further strengthens the intent of this map.

## 5. Critical appraisal of the included studies

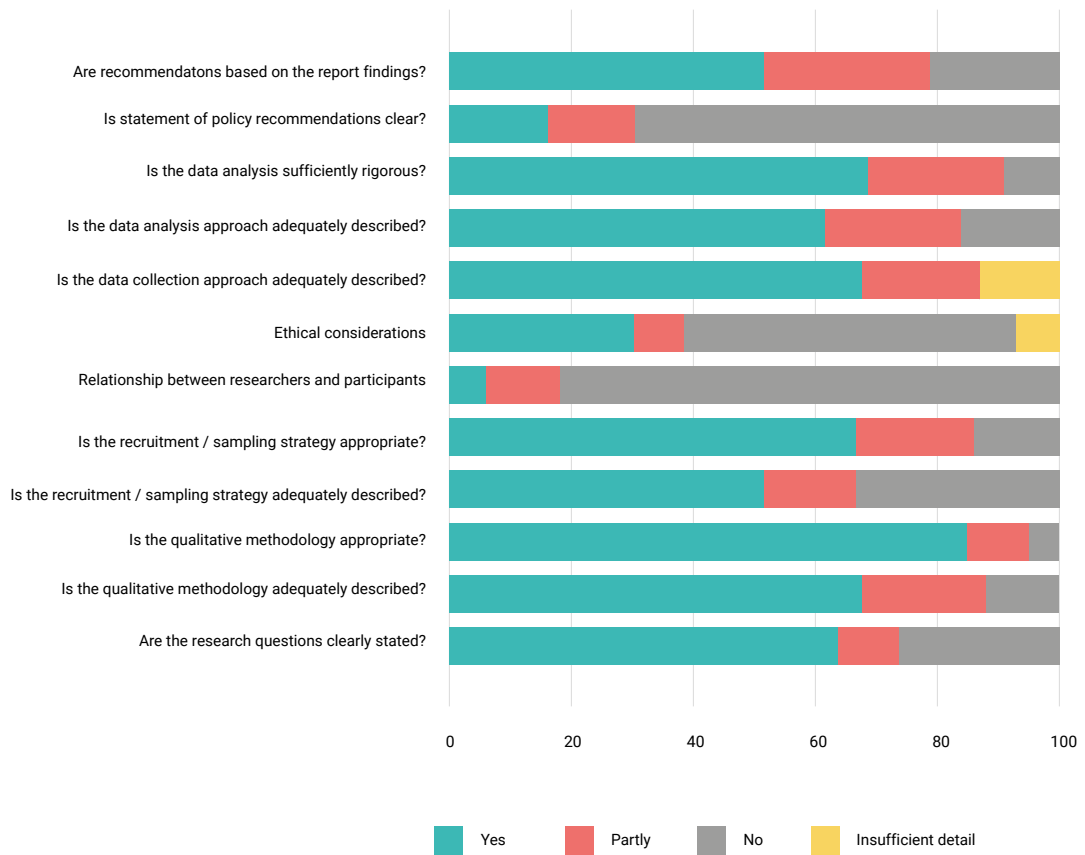
Critical appraisal of the studies was carried out using the CASP checklist for qualitative studies, which includes research questions, methods, ethics in the research process, analysis, and policy recommendations, and related questions for the reporting of study findings. Systematic reviews included in the map were assessed using the AMSTAR (A Measurement to Assess Systematic Reviews) 2 checklist. Seven critical and nine non-critical domains comprise the domain-based AMSTAR 2 rating system.

This confidence in study findings is assessed using the CASP checklist, which has twelve questions on the clarity of reporting of research questions, methodology, sampling strategy, relationship between researcher and participants, ethical considerations, data collection, analysis, policy recommendations and coherence between recommendations and study findings. A total of 77% of included studies were assessed as low confidence with regard to their study findings. Approximately 20% of included studies were assessed as medium confidence, while less than 4% of studies were assessed as high confidence.

Each study is assessed for each of these indicators, and a low score on any one is enough to classify a study as low confidence in its reporting of findings. The principle of the 'weakest link in the chain' often leads to a study being classified as low confidence, even if it might have high scores in all other items. The map includes two systematic reviews, both of which were assessed as low confidence in their reporting of findings using the AMSTAR 2 checklist.

Figure 9 shows the distribution of responses in the included studies for each item on the CASP checklist. Although most included studies describe the research questions, methods and analysis sufficiently, few details are provided on the relationship between researchers and participants, and ethical considerations were not sufficiently reported. These two reasons largely accounted for many studies qualifying as low confidence in their findings.

**Figure 9: Distribution of responses for critical appraisal of included studies**



# 6. Implementation evidence base in the UK

This section describes the characteristics of included implementation studies conducted in the UK, such as the number of studies from the UK, year of publication, analysis of interventions, and sub-intervention categories. A brief analysis of the barriers and facilitators observed in the included studies conducted in the UK is also given.

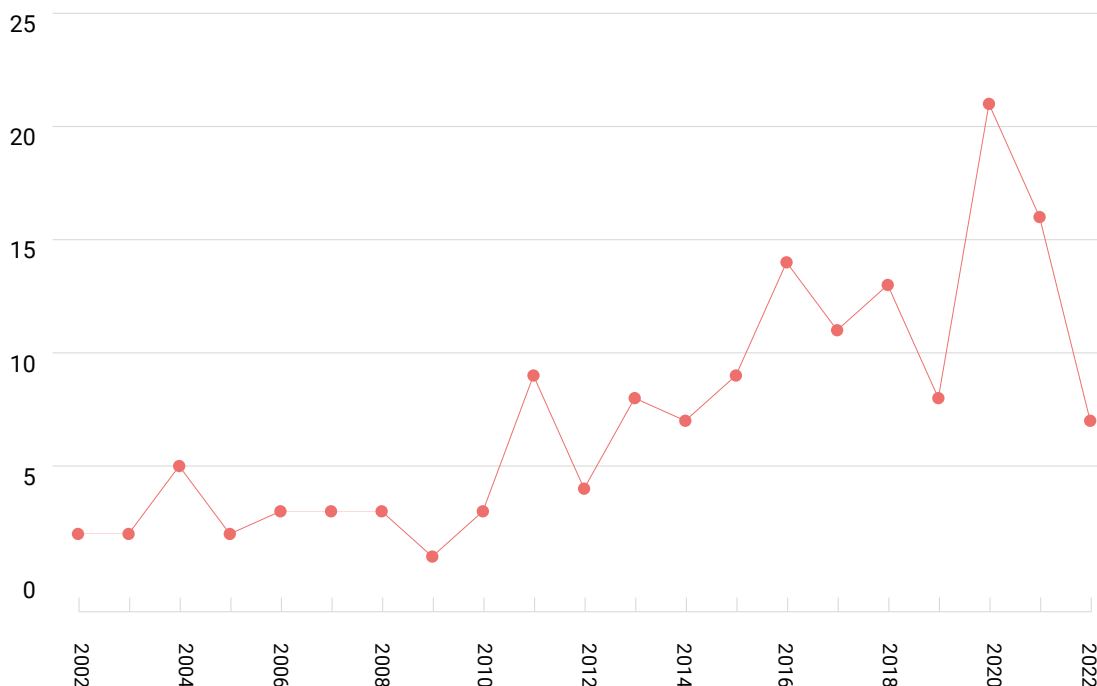
## 6.1 Number of studies

The total number of studies from the UK in this map is 152 (26%). While the previous edition contained 119 studies from the UK, 33 studies from the UK were added in this update of the map.

## 6.2 Years of publication

As we see in Figure 10, there is an upward trend in the number of included studies in the implementation map published in the UK since 2002. However, an occasional dip in the number of studies is also observed for certain years. In 2020 and 2021, there was a sudden increase in the number of studies, with 21 and 16 studies published from the UK, respectively.

**Figure 10: Included studies by the publication year**



## 6.3 Geographical distribution

The third edition of the map had 34 studies from London, followed by Birmingham (11) and Scotland (10). In this fourth edition, 12 of the newly included studies were based in London, followed by Scotland (4), Edinburgh (3) and Wales.

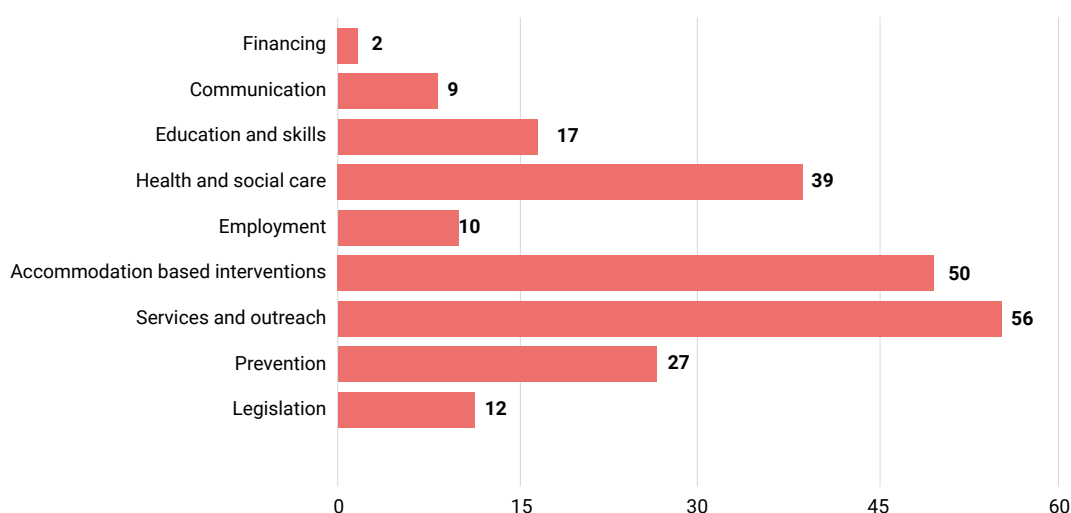
## 6.4 Intervention and sub-intervention categories

The distribution of included studies from the UK in this edition by intervention categories suggests that services and outreach interventions constitute the highest proportion of all studies (n = 56), followed by accommodation-based interventions (n = 50) and health and social care interventions (n = 39).

As observed in Figure 11, the trend is similar to overall global evidence on implementation issues of interventions for homelessness; however, in the 2022 and 2023 map editions, accommodation-based interventions represent the highest number of studies, followed by services and outreach.

The number of studies from the UK under the intervention categories of legislation (n = 12), employment (n = 10), communication (n = 9) and financing (n = 2) are low for the overall map. The number of studies under the communications and employment interventions in the overall map are, however, not as low as in the included studies from the UK.

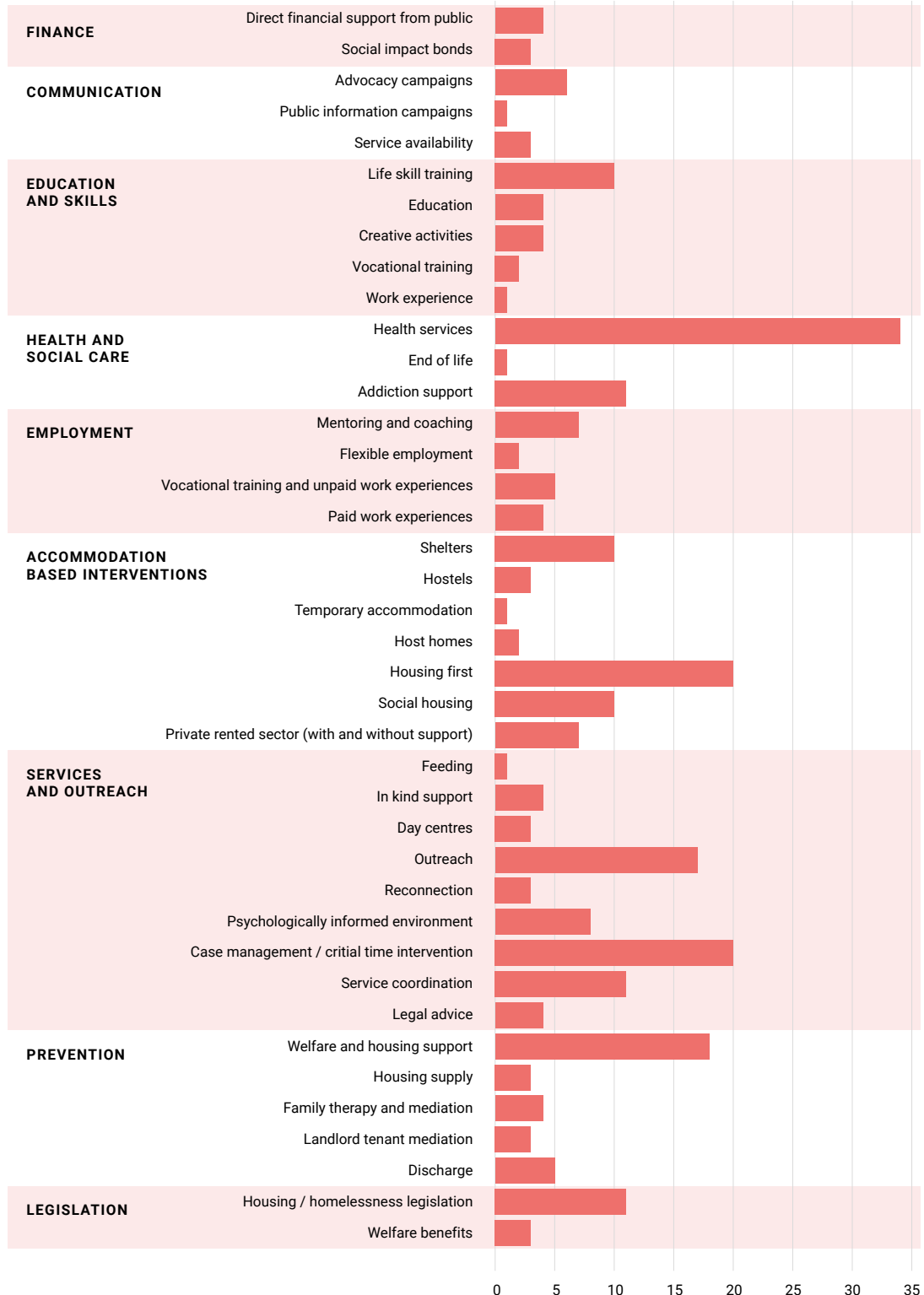
**Figure 11: Included studies by intervention categories (UK)**



When we analyse the sub-intervention categories for studies from the UK (Appendix 6), we find that health services (within health and social care interventions) are highest in number (n = 34), followed by case management/critical time interventions (n = 20) (within services and outreach interventions). Other sub-intervention categories with a fair number of studies include Housing First (n = 20), welfare and housing support (n = 18) and outreach interventions (n = 17).

Some sub-intervention categories with the lowest number of studies included: service availability, work experience, vocational training, end of life care, housing supply, temporary accommodation, host homes, day centres and feeding interventions.

**Figure 12: Distribution of included studies by sub-intervention categories in the UK**





## 6.5 Barriers

Barriers that negatively affected the effectiveness of interventions to reduce homelessness were found across a range of areas. These were more widely located in barriers related to programme managers and intervention recipients. Fewer studies explored the contextual factors such as the housing market, the labour market, welfare support, and legislation.

**Table 4: Aggregate Implementation EGM of included studies for intervention and barriers (UK)**

Intervention	B1. Contextual factors	B2. Policy makers/ funders	B3. Programme administrator/ manager/ implementing agency	B4. Staff/ case worker	B5. Programme recipient
Legislation	7	5	9	5	7
Prevention	9	10	18	12	15
Services and outreach	22	21	41	30	39
Accommodation-based interventions	21	20	34	20	33
Employment	2	2	7	5	4
Health and social care	6	7	20	19	16
Education and skills	2	3	7	8	7
Communication	4	3	5	6	4
Financing	1	1	1	1	2

## 6.6 Facilitators

The most frequently mentioned issues that facilitated programme implementation were programme recipients, staff/case workers and programme managers. Most facilitators associated with recipients included access to non-housing support such as medical, financial, or training support, followed by programme buy-in.

**Table 5: Aggregate Implementation EGM of included studies for intervention and facilitators (UK)**

Intervention	F1. Contextual factors	F2. Policy makers/ funders	F3. Programme administrator/ manager/ implementing agency	F4. Staff/ case worker	F5. Programme recipient
Legislation	9	7	8	6	6
Prevention	9	11	19	22	22
Services and outreach	14	28	46	44	48
Accommodation- based interventions	14	24	38	38	39
Employment	3	1	7	5	6
Health and social care	6	7	18	33	29
Education and skills	2	4	7	12	15
Communication	5	5	7	7	5
Financing	1	1	2	1	2

From the perspective of the staff/case worker, having effective communication was the most-noted facilitator. The analysis broke this into two separate categories: communication with the programme recipient (n = 82) and communication with other agencies (n = 48). Likewise, staff members' emotional skills were also found across many studies, with 61 studies noting this as a facilitator for interventions.

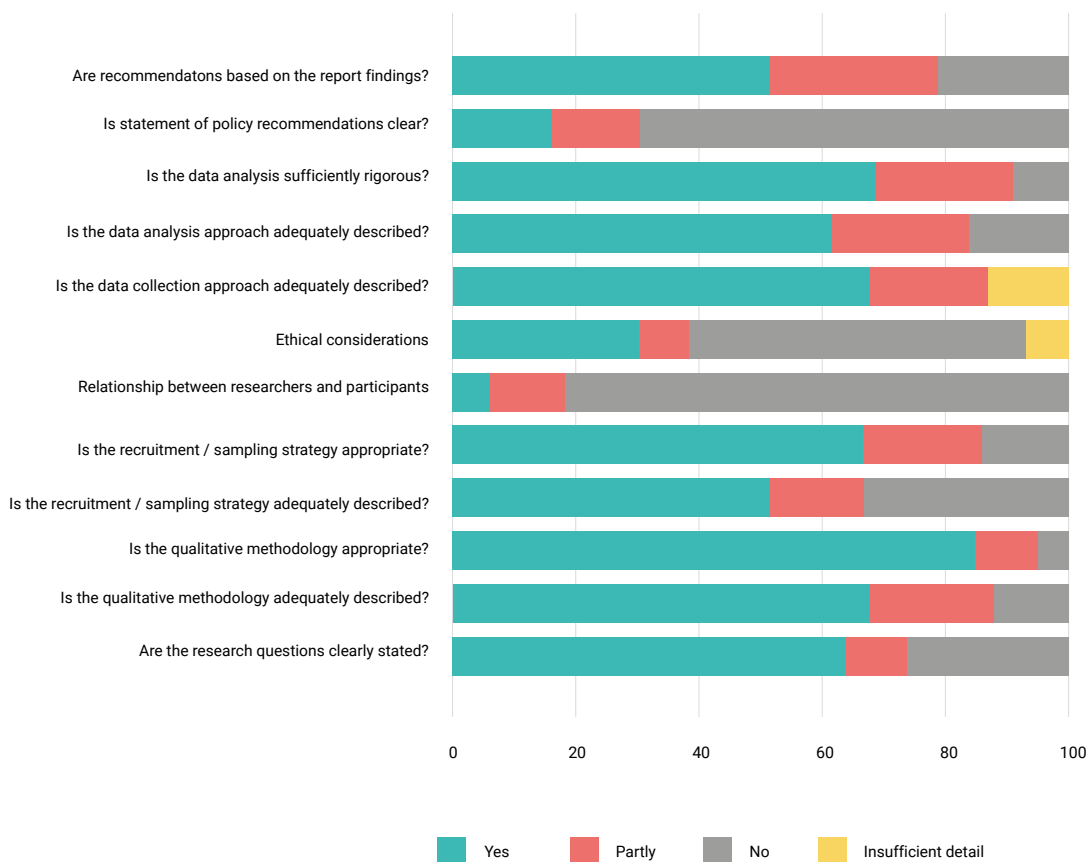
## 6.7 Confidence in findings

A total of 77% of included studies were assessed as low confidence with regard to their findings. Approximately 21% were assessed as medium confidence, while only approximately 3% were assessed as high confidence. An assessment of confidence in the findings was not carried out for four studies from the UK, as they were protocols.

Further analysis suggests that many studies sufficiently describe the research questions, methods of data collection, and analysis, but there is not enough description of the relationship between researchers and participants. Other areas where the reporting of studies lacked sufficient description was the category of ethical considerations undertaken in the research studies as well as the statement of policy recommendations based on the research results.

Since we follow ‘the weakest in the chain’ principle, even a low score on one of the questions leads to a study being assessed of low confidence, the same may be accounted for a higher number of studies being assessed of low confidence in their findings and mostly on account of insufficient description of the relationship between researchers and participants.

**Figure 13: Distribution of responses to CASP checklist for included studies (UK)**



# Appendices

## Appendix 1: Search strings for each intervention category in the EGM

### 1. Legislation

#### **1.1. Housing/Homelessness Legislation**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Housing/Homelessness Legislation)

#### **1.2 Welfare benefits**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Welfare benefits OR Rent subsidies OR housing vouchers OR legal assistance)

#### **1.3 Health and social care legislation**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Health and social care legislation OR Medicaid OR Medicare)

### 2. Prevention

#### **.1 Welfare and Housing Support**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Housing OR Housing Schemes OR Homelessness Prevention OR Welfare schemes OR welfare benefits OR Rent subsidies OR housing vouchers OR disability benefits OR rental assistance OR housing options OR rent supplements)

#### **2.2 Housing supply**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Housing OR Housing Schemes OR Housing Programmes)

### **2.3 Family mediation and conciliation**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Family mediation and conciliation OR Family based therapy OR ecologically based family therapy OR motivational enhancement therapy OR community reinforcement approach OR family resilience programme OR Relationship-based intervention OR family contact)

### **2.4 Landlord-tenant mediation**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Landlord-tenant mediation OR Neighbour mediation)

### **2.5 Discharge interventions**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Discharge interventions OR Reentry OR prisoner re-entry OR transitional programme OR transitional supportive housing OR reintegration programme OR independent living OR independent housing OR community housing OR respite care OR medical respite OR homeless patient aligned care OR community follow up OR progressive independence model OR community care OR reintegration OR transitional programmes OR progressive independence model)

## **3 Services and Outreach**

### **3.1 and 3.3**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Houseless OR Homeless OR Roofless OR Rough sleep\*) AND (AND (Direct feeding OR Soup Runs OR Malnutrition interventions OR Day Centre intervention))

### **3.2**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (in-kind support interventions OR Non-Food items support OR Hygiene products OR Clothing or Household items supply) AND (Homeless Or Houseless OR Roofless OR People experiencing homelessness OR Rough sleepers)

**3.4 (Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND**

(Outreach access and recover OR assertive outreach OR street team OR multidisciplinary street team OR intensive outreach OR community prevention)

**3.5 and 3.7 Reconnection and CTI done (no need to run again)**

**3.6 (Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND**

(Assets-based programmes OR strength-based programmes OR Assets-based interventions OR strength-based interventions OR psychologically informed environments)

OR strength profiling)

**3.8 (Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (residential treatment OR non residential treatment OR specialist integrated care OR coordination of care OR intergovernmental OR integrated housing services)**

**3.9 (Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Veterinary services for pets of homeless OR Interventions for pets of homeless OR pet care interventions) AND (Homeless OR houseless OR Rough sleepers OR pets of Rough sleepers)**

**3.10 (Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Legal advice OR legal assistance OR limited legal assistance OR unbundled legal assistance OR legal interventions) AND (Homeless Or Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)**

## **4. Accommodation and accommodation-based services**

### **4.1-4.4**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Accommodation and accommodation-based services OR Shelters OR Hostels OR Temporary Accommodation OR Host Homes OR Housing Placement OR Housing support) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

### **4.5 Rapid Rehousing**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Rapid rehousing) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

#### **4.6 Housing First**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Housing First) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

#### **4.7 Social Housing (with or without support)**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Social Housing OR Supportive housing OR Scattered-site housing OR permanent supportive housing OR abstinence contingent housing OR parallel housing services OR chronic care model OR community housing OR Residential treatment OR Rocking chair therapy OR congregate housing OR group home placements OR personalised housing OR onsite care)

#### **4.8 Private rental sector (with or without support)**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Independent housing OR apartment living OR independent housing OR independent living OR community housing) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

#### **4.9 Continuum of care**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Continuum of care OR continuity of care) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

### **5. Employment**

#### **5.1 Mentoring, coaching and in-work support**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Employment interventions OR Mentoring OR Coaching OR In-Work Support OR Individual Placement and Support OR Lifestyle coaching, OR employment pilot) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

#### **5.2 Flexible employment**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Employment interventions OR Flexible employment) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

### **5.3 Vocational training and unpaid work experiences**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Employment interventions OR Vocational training OR unpaid work experiences OR

Work therapy OR therapeutic workplace OR Work skills training OR vocational rehabilitation OR housing and work support OR work support OR Pro-bono work) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

### **5.4 Paid work experiences**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Employment interventions OR Paid work experiences OR Paid internship)

AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleeper

## **6. Health and Social care**

### **6.1 Physical and mental health**

#### **6.1.1**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Health and Social care interventions OR Physical Health Services OR sexual health OR sexual risk behaviors OR HIV treatment OR tuberculosis OR hepatitis OR influenza OR cancer screening OR smoking cessation OR risk detection OR medical respite OR consultation model OR adherence to medication OR onsite care OR referral primary medical care)

#### **6.1.2**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Mental Health Services OR Hospital-based rehabilitation OR psychiatric rehabilitation OR dialectical behavioral treatment OR nurse-led, motivational intervention OR motivational intervention OR Contingency management OR cognitive behavior\* therapy OR behavior\* day treatment OR motivational enhancement therapy OR mindfulness OR community-based counselling OR stepped care)

### **6.2 End of life care**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People



experiencing homelessness OR Rough sleepers) AND (End of life care interventions OR End of life planning OR Palliative care OR respite care OR Hospital care)

### **6.3 Addiction support**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Addiction support interventions OR Therapeutic communities OR harm-reduction OR methadone OR opioid substitution therapy OR faith-based addiction treatment OR abstinence contingent housing OR overdose training OR managed alcohol programme OR smoking cessation OR alcohol abuse OR comprehensive approach to rehabilitation OR harm reduction treatment for alcohol OR methamphetamine treatment OR community health OR naloxone Or supervised consumption facilities)

## **7. Education and Skills**

### **7.1 Life and social skills training**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND education and skills interventions OR life skills training Or Social skills training OR emotional skills training OR financial literacy OR money management training Or tenancy management)

### **7.2 Mainstream education**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND education interventions OR classroom interventions)

### **7.3 Homelessness awareness programmes in schools**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Homelessness awareness programmes in schools OR Awareness Campaigns OR Homelessness awareness interventions)

### **7.4 Recreational and creative activities**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Recreational OR Social OR creative activities OR social clubs OR Theatre)

## 8. Communication

### **8.1 Advocacy Campaign**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Advocacy Campaign OR Rights of homeless campaign)

### **8.2 Public information campaigns**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Public information campaigns OR government-run campaigns)

### **8.3 Service availability**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Service availability communication interventions OR Service availability information interventions)

## 9. Financing

### **9.1 Social Impact Bonds**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Social Impact Bonds)

### **9.2 Direct financial support from public**

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Financial assistance OR emergency financial assistance OR cash transfers OR personalised budgets OR hardship payments OR financial incentives)

## Appendix 2: Organisational/institutional websites searched

Country/Region (with dates searched in parentheses)	Websites searched (Organisation/ Institution name and URL)
Australia (16h August, 2022)	<p>FACS New South Wales  <a href="https://facs.nsw.gov.au/providers/homelessness-services/resources/research-and-evaluation/chapters/reports">facs.nsw.gov.au/providers/homelessness-services/resources/research-and-evaluation/chapters/reports</a></p> <p>Mission Australia  <a href="http://www.missionaustralia.com.au">www.missionaustralia.com.au</a></p> <p>The Deck  <a href="http://thedeck.org.au">thedeck.org.au</a></p> <p>FACS Victoria  <a href="https://www.google.de/search?q=facs+victoria+homelessness+evaluation&amp;sxsrf=ALeKk01pUglVgnjqxSUZHltQ-rWpwhf-cg%3A1628277144999&amp;source=hp&amp;ei=mlkNYb7P0tqi1fAphpSQyA4&amp;ifls">https://www.google.de/search?q=facs+victoria+homelessness+evaluation&amp;sxsrf=ALeKk01pUglVgnjqxSUZHltQ-rWpwhf-cg%3A1628277144999&amp;source=hp&amp;ei=mlkNYb7P0tqi1fAphpSQyA4&amp;ifls</a></p> <p>FACS Western Australia  <a href="https://www.google.de/search?q=facs+western+australia+homelessness+evaluation&amp;sxsrf=ALeKk00V6ki-Px50eC9otQL6N06-I0Rdsw%3A1628277216586&amp;ei=4IkNYZidI4mnUq-spqAL&amp;oq=facs+">https://www.google.de/search?q=facs+western+australia+homelessness+evaluation&amp;sxsrf=ALeKk00V6ki-Px50eC9otQL6N06-I0Rdsw%3A1628277216586&amp;ei=4IkNYZidI4mnUq-spqAL&amp;oq=facs+</a></p> <p>Queensland  <a href="https://cabinet.qld.gov.au/documents/2009/jul/implementation%20plan%202009-13%20for%20homelessness/Attachments/Homelessness%20Strategic%20Impact%20Evaluation%20Final%20Report">https://cabinet.qld.gov.au/documents/2009/jul/implementation%20plan%202009-13%20for%20homelessness/Attachments/Homelessness%20Strategic%20Impact%20Evaluation%20Final%20Report</a>.</p> <p>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></p> <p>APO  <a href="http://apo.org.au">apo.org.au</a></p>

Country/Region (with dates searched in parentheses)	Websites searched (Organisation/ Institution name and URL)
Canada (15th & 16th August 2022)	<p>Homeless Hub (Journal articles)  <a href="https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;f%5B0%5D=field_resource_type%3A253">https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;f%5B0%5D=field_resource_type%3A253</a></p> <p>Homeless Hub (Reports)  <a href="https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;f%5B0%5D=field_resource_type%3A259">https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;f%5B0%5D=field_resource_type%3A259</a></p> <p>Homeless Hub (Dissertations)  <a href="https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;f%5B0%5D=field_resource_type%3A262">https://www.homelesshub.ca/search-library?keywords=evaluation&amp;publication_date=1970-01-01%2000%3A00%3A00&amp;f%5B0%5D=field_resource_type%3A262</a></p> <p>Inn from the cold  <a href="https://innfromthecold.org/">https://innfromthecold.org/</a></p> <p>University of Ottawa  <a href="https://uniweb.uottawa.ca/#!psychology/themes/999:246/publications">https://uniweb.uottawa.ca/#!psychology/themes/999:246/publications</a></p>
Europe (15th August, 2022)	<p>FEANTSA  <a href="https://www.feantsa.org/en">https://www.feantsa.org/en</a></p>

Country/Region (with dates searched in parentheses)	Websites searched (Organisation/ Institution name and URL)
UK (15th and 16th August, 2022)	<p>Centre for Housing Policy, York <a href="https://www.york.ac.uk/chp/">https://www.york.ac.uk/chp/</a></p> <p>Crisis <a href="https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/">https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/</a></p> <p>Homeless Link <a href="https://homeless.org.uk/">https://homeless.org.uk/</a></p> <p>i-sphere <a href="https://i-sphere.site.hw.ac.uk/">https://i-sphere.site.hw.ac.uk/</a></p> <p>Joseph Rowntree Foundation <a href="http://jrf.org.uk">jrf.org.uk</a></p> <p>Shelter <a href="http://shelter.org.uk">shelter.org.uk</a></p> <p>Social Care Institute for Excellence <a href="https://www.scie-socialcareonline.org.uk/">https://www.scie-socialcareonline.org.uk/</a></p> <p>St. Mungos <a href="http://mungos.org">mungos.org</a></p> <p>The National Lottery Community Fund <a href="https://www.tnlcommunityfund.org.uk/">https://www.tnlcommunityfund.org.uk/</a></p>
USA (16th August, 2022)	<p>HUD Program Evaluation Division <a href="https://www.huduser.gov/portal/research/eval.html">https://www.huduser.gov/portal/research/eval.html</a></p> <p><a href="https://www.huduser.gov/portal/index.php?qbing=evaluation&amp;q=search.html&amp;x=0&amp;y=0">https://www.huduser.gov/portal/index.php?qbing=evaluation&amp;q=search.html&amp;x=0&amp;y=0</a></p> <p><a href="https://www.huduser.gov/portal/publications/pdr_studies.html">https://www.huduser.gov/portal/publications/pdr_studies.html</a></p> <p>Department of labour Search term: Homeless evaluation <a href="https://search.usa.gov/search?utf8=%E2%9C%93&amp;affiliate=www.dol.gov&amp;query=homeless+evaluation">https://search.usa.gov/search?utf8=%E2%9C%93&amp;affiliate=www.dol.gov&amp;query=homeless+evaluation</a></p>
USA (30th and 31st January,2023)	<p>ProQuest, Dissertation &amp;theses <a href="https://about.proquest.com/en/dissertations/">https://about.proquest.com/en/dissertations/</a></p>

## Appendix 3: List of hand searched journals

<b>Name of the Journal</b>	<b>URL</b>	<b>Dates searched</b>
Health & Social Care in the Community	<a href="https://onlinelibrary.wiley.com/loi/13652524">https://onlinelibrary.wiley.com/loi/13652524</a>	17th Jan, 2023
Housing Care and Support	<a href="https://www.emerald.com/insight/publication/issn/1460-8790">https://www.emerald.com/insight/publication/issn/1460-8790</a>	17th Jan, 2023
Housing Policy Debate	<a href="https://www.tandfonline.com/loi/rhpd20">https://www.tandfonline.com/loi/rhpd20</a>	18th Jan, 2023
Housing Studies	<a href="https://www.tandfonline.com/loi/chos20">https://www.tandfonline.com/loi/chos20</a>	18th Jan, 2023
International Journal of Housing Policy	<a href="https://www.tandfonline.com/loi/reuj20">https://www.tandfonline.com/loi/reuj20</a>	18th Jan, 2023
Journal of Social Distress and the Homeless	<a href="https://www.tandfonline.com/loi/ysdh20">https://www.tandfonline.com/loi/ysdh20</a>	18th Jan, 2023
Parity	<a href="https://search.informit.org/journal/par">https://search.informit.org/journal/par</a>	18th Jan, 2022

## Appendix 4: Defining intervention categories and implementation issues

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

Category	Sub-category	Description
Prevention	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.
Services and Outreach	Direct feeding	Provision of food in street settings to people experiencing homelessness.
	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.



Category	Sub-category	Description
Services and Outreach Services and Approaches	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. discharges) 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 Outreach 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 shortterm 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
Accommodation Based Interventions	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 inwork 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 care	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 socioemotional 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.
Communications	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.
	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.

Category	Sub-category	Description
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.
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.

Category	Sub-category	Description
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
Policy maker / funder	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	Description
Staff / case worker	Buy-in (commitment to programme)	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.
Staff / case worker	Access to nonhousing support (medical, financial, training etc.)	Access to non-housing support services necessary for programme implementation to be successful
	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 5: Distribution of included studies by sub-intervention categories

<b>Intervention category</b>	<b>Intervention sub-category</b>	<b>Number of Studies (Overall)</b>	<b>Number of Studies (Newly added to 4th edition)</b>
<b>Legislation</b>	Housing/Homelessness legislation	20	6
	Welfare benefits	10	4
	Health & social care	2	2
<b>Prevention</b>	Welfare and housing support	68	20
	Housing supply	11	3
	Family therapy and mediation	11	0
	Landlord tenant mediation	9	1
	Discharge	15	2

<b>Intervention category</b>	<b>Intervention sub-category</b>	<b>Number of Studies (Overall)</b>	<b>Number of Studies (Newly added to 4th edition)</b>
<b>Services and Outreach</b>	Feeding	9	2
	In kind support	21	19
	Day centres	16	2
	Outreach	66	26
	Reconnection	11	3
	Psychologically informed environments	14	7
	Case management/ Critical time intervention	89	20
	Service coordination	49	13
	Legal advice	12	1
	Shelters	44	14
	Hostels	6	0
<b>Accommodation Based Services</b>	Temporary accommodation	45	21
	Host homes	6	4
	Rapid rehousing	8	1
	Housing First	108	32
	Social housing	67	29
	Private rented sector (with and without support)	24	4
	Continuum of care	14	5

Intervention category	Intervention sub-category	Number of Studies (Overall)	Number of Studies (Newly added to 4th edition)
<b>Employment</b>	Mentoring and coaching	20	3
	Flexible employment	5	2
	Vocational training and unpaid	12	1
	Paid Work experiences	14	4
<b>Health and Social Care</b>	Health services	140	33
	End of life	2	0
	Addiction support	40	14
<b>Education and Skills</b>	Vocational training	5	1
	Work experience	3	1
	Life skill training	22	2
	Education	23	4
	Creative activities	16	4
<b>Communication</b>	Advocacy campaigns	17	2
	Public information campaigns	4	0
	Service availability	6	2
<b>Finance</b>	Social impact bonds	4	0
	Direct financial support from public	10	2

## Appendix 6: Distribution of included studies by sub-intervention categories in the UK

Intervention category	Intervention sub-category	Number of Studies
<b>Legislation</b>	Housing/Homelessness legislation	11
	Welfare benefits	3
<b>Prevention</b>	Welfare and housing support	18
	Housing supply	3
	Family therapy and mediation	4
	Landlord tenant mediation	3
	Discharge	5
<b>Services and Outreach</b>	Feeding	1
	In kind support	4
	Day centres	3
	Outreach	17
	Reconnection	3
	Psychologically informed environments	8
	Case management/ Critical time intervention	20
	Service coordination	11
Legal advice	4	
<b>Accommodation Based Services</b>	Shelters	10
	Hostels	3
	Temporary accommodation	1

Intervention category	Intervention sub-category	Number of Studies
<b>Accommodation Based Services</b>	Host homes	2
	Housing First	20
	Social housing	10
	Private rented sector (with and without support)	7
<b>Employment</b>	Mentoring and coaching	7
	Flexible employment	2
	Vocational training and unpaid	5
	Paid Work experiences	4
<b>Health and Social Care</b>	Health services	34
	End of life	1
	Addiction support	11
<b>Education and Skills</b>	Vocational training	2
	Work experience	1
	Life skill training	10
	Education	4
	Creative activities	4
<b>Communication</b>	Advocacy campaigns	6
	Public information campaigns	1
	Service availability	3
<b>Finance</b>	Social impact bonds	3
	Direct financial support from public	4

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