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RESEARCH-ARTICLE

Growth Through Participation: A Longitudinal Study of a Participation-Based Intervention for (Formerly) Homeless People

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ABSTRACT

The current longitudinal study examined a participation-based intervention for homeless and formerly homeless clients, growth through participation (GTP), developed by a Dutch organization providing shelter services and ambulatory care. GTP is based on a combination of group and individual approaches, whereby clients are enabled to learn to identify their strengths and talents, to develop social skills through interaction with each other, and to learn to once more lead a structured life. The study was conducted among 172 (formerly) homeless clients and comprised three measurement time points. It examined whether (1) quality of life increased during the GTP intervention; (2) social participation (e.g., labor/recreation), self-esteem, clients' experiences with care (i.e., satisfaction with the services received and with the client–worker relationship), and psychological distress improved during GTP; (3) clients exhibiting psychological distress benefit more from GTP than others. Results from latent growth modeling showed that quality of life and the amount of time clients spent on labor activities increased significantly, but the amount of time clients spent on recreational activities decreased over time. Clients with psychological distress experienced increased quality of life and self-esteem, and reduced psychological distress. Other variables did not significantly change during GTP. Although not all hypotheses were (fully) confirmed, it can be concluded that GTP seems to be a potentially promising intervention. It is recommendable to conduct a multisite RCT to determine the efficacy of GTP.

KEYWORDS

Homelessness; intervention; psychological distress; enabling niche; social participation

Introduction

In the Netherlands, the number of homeless people has almost doubled from 17,800 in 2009 to 30,500 in 2016 (Statistics Netherlands, 2016). Homelessness is a serious problem, because it is often associated with multiple issues, such as substance addiction (Dietz, 2010), mental disorders (Belcher, 1991; Creech et al., 2015; Fazel, Khosla, Doll, & Geddes, 2008), physical health problems (Creech et al., 2015), unemployment (Burke, Johnson, Bourgault, Borgia, & O'Toole, 2013), and social isolation (Van Straaten et al., 2018). Moreover, homeless people occasionally cause public nuisances in cities and neighborhoods in the form of criminal activity and violent behavior, such as aggression (Coston & Friday, 2016; Roy, Crocker, Nicholls, Latimer, & Ayllon, 2014). Consequently, it is important both for homeless people themselves and for their surroundings that they receive proper care and support.

Organizations providing shelter services and ambulatory care (i.e., shelter facilities) aim to deliver optimum homeless support services while observing the requirements of the government. The Dutch government has been transforming the traditional welfare state into a "participation society" (Rijksoverheid, 2013). Under this policy, citizens are expected to support each other, and appealing for aid from the government is only an option when the person in question has no resources, such as a social network or money, of their own (Van Houten, Tuynman, & Gilsing, 2008). Since most of homeless people do not have such resources, they need to seek support

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from organizations such as shelter facilities, which in turn attempt to adjust their policies and methods in order to facilitate social participation by the homeless. Consequently, shelter facilities have been developing various participation-based programs (Davelaar & Hermens, 2014).

An example of a participation-based intervention developed for residential and ambulatory clients of a shelter facility in the Netherlands is growth through participation (GTP). This program is based on a combination of group and individual approaches. In the group approach (consisting of educational, recreational, and labor activities), clients are enabled to learn to identify their strengths and talents, to develop social skills through interaction with each other, and to learn to once more lead a structured life. As such, they practice skills needed for social participation, first in the safe environment of the shelter facility, and subsequently in society. In addition to the group approach, clients are supported on an individual basis by a case manager with the aim to facilitate social participation through goal setting, monitoring, and evaluation (SMO Breda, 2014a).

An innovative aspect of GTP is the minimization of individual contacts in favor of group activities. For example, most clients need to work on their social skills, to cope with their addiction, or to handle their financial situation, and clients can therefore work on these goals together in groups. Next to these educative group meetings, learning, and developing skills can also be facilitated in recreation group activities. For instance, when clients practice sports together, they also develop social skills, discover their talents, and experience how it feels to participate in activities of daily living. One of the advantages of learning in groups is that it enables clients to learn from each other (i.e., peer support) and they get to know new people. Additionally, by participating in labor activities clients are stimulated to develop their labor skills and may even have the opportunity to earn an officially recognized diploma, which improves their chances on the labor market (SMO Breda, 2014a). GTP is in line with Dutch government policy, as the majority of the support provided to (formerly) homeless clients under this method is offered in group form, allowing for cost reductions. However, the most important goal is the enhancement of social participation, because this improves clients' physical, social and mental well-being (Rutenfrans-Stupar, Van Der Plas, Den Haan, Van Regenmortel, & Schalk, in press).

The shelter facility that developed GTP (i.e., SMO Breda e.o.) is aiming to create an "enabling niche" (i.e., an environment in which personal growth is stimulated) by offering a safe environment in which homeless people are enabled to learn and to develop their strengths and skills (Driessens & Van Regenmortel, 2006; Taylor, 1997). However, previous research involving this shelter facility revealed a risk that the environment could become too safe and too comfortable, because of which clients may restrict their participation to the shelter facility, instead of proceeding to participate in society (Rutenfrans-Stupar et al., in press). In other words, the enabling niche may become an entrapping niche, an environment in which people's self-development is restricted (Taylor, 1997). To ensure the creation an enabling niche instead of an entrapping niche, the shelter facility applies the following principles: (1) most activities are organized outside the residence in which the client lives, (2) a variety of people (i.e., not only homeless) participate in the offered activities, (3) the main objective is the development of skills through the improvement of strengths with the aim of social participation, and (4) people are treated with respect and viewed as persons who have talents, strengths, and capabilities for self-mastery (SMO Breda, 2014a).

GTP is intended to result, firstly, in an enhanced quality of life, which is defined as "individuals' perceptions of their position in life in the context of the culture and value system in which they live in relation to their goals, expectations, standards, and concerns" (WHO, 1998, p.11). Quality of life can be divided into physical and psychological health, social relationships, and salient features of the environment (WHO, 1998). Secondly, GTP aims to increase social participation and self-esteem, improve clients' experiences with care, and reduce psychological distress.

It was expected that (formerly) homeless clients with above-average psychological distress to benefit more from GTP than others, as GTP more accurately addresses the needs of this target

group. In general, homeless mentally ill people often have negative experiences with moving from one entrapping niche to another, because they are often hospitalized for longer periods, which may result in institutionalization (Rapp & Goscha, 2012). GTP represents a very different working method than the usual care this target group receives, because the traditional method used to focus on clients' problems instead of talents, strengths, and self-development (SMO Breda, 2014b). To the extent that activity-based programs existed, these were mostly organized within residences, with participants consisting only of clients from the relevant residence. However, (formerly) homeless clients without or with less psychological distress are generally not particularly socially excluded, as compared with mentally ill homeless people, which implies that for these people the point at which the safe environment of the shelter facility becomes too safe and too comfortable occurs earlier. Commonly, these people still have more "natural" resources for participation than (formerly) homeless clients with severe psychological distress. Although the homeless with below-average psychological distress also benefit from practicing their skills in a safe environment, it is possible that for them the enabling niche will more rapidly turn into an entrapping niche.

The Current Study

The current study is the first to examine the quantitative outcomes of GTP. GTP has only been evaluated through internal evaluations by the management of the shelter facility; some aspects have been evaluated by a consultancy agency, primarily with regard to process measures (Dimensus, 2017); and one part of GTP (participation in activities) has been evaluated in depth through qualitative research (Rutenfrans-Stupar et al., in press). Additionally, a cross-sectional study about predictors of well-being among (formerly) homeless clients was conducted by using the baseline data of the current study (Rutenfrans-Stupar, Van Regenmortel, & Schalk, 2018). However, no quantitative studies have been conducted in which the outcomes of GTP were examined. Demonstrating these outcomes of the GTP would not be only of importance for the current shelter facility but can also provide information that may be useful for other organizations that would like to implement GTP. Additionally, the current study contributes to the literature on the effectiveness of interventions. Only a small number of longitudinal studies have been conducted that help to create an evidence base in Europe for effective interventions (De Vet et al., 2017; Rensen, Van Arum, & Engbersen, 2008).

The hypotheses of the current study are:

1. Quality of life among (formerly) homeless clients will increase during the GTP intervention (primary outcome);
2. GTP enhances social participation, self-esteem, clients' experiences with care, and reduces psychological distress (secondary outcomes); and
3. Clients with above-average psychological distress will benefit more from GTP than clients with below-average psychological distress.

Method

Design and Participants

In the current study the term "(formerly) homeless clients" was used, because it includes both residential and ambulatory clients of the shelter facility. In the Netherlands, commonly "all people who receive support from the shelter facility" are defined as "homeless" or "houseless" persons (e.g., Kruize & Bieleman, 2014). This includes people who have their own dwelling, because these people are still at risk of becoming homeless mostly due to their financial situation or their (mental) health status. Internationally a smaller definition of homelessness is mostly used: Only people who are roofless, houseless (e.g., residential clients of a shelter facility), or living in insecure or inadequate housing are defined as "homeless" (Springer, 2000). Hence, the term "(formerly) homeless clients" that was used in the current study includes residential and ambulatory client of the shelter facility.

The GTP intervention was evaluated by a longitudinal single group study. It was not possible to use a control group, because the organization implemented the intervention for all clients at the same moment (April to May 2015), which was necessary because the intervention was also

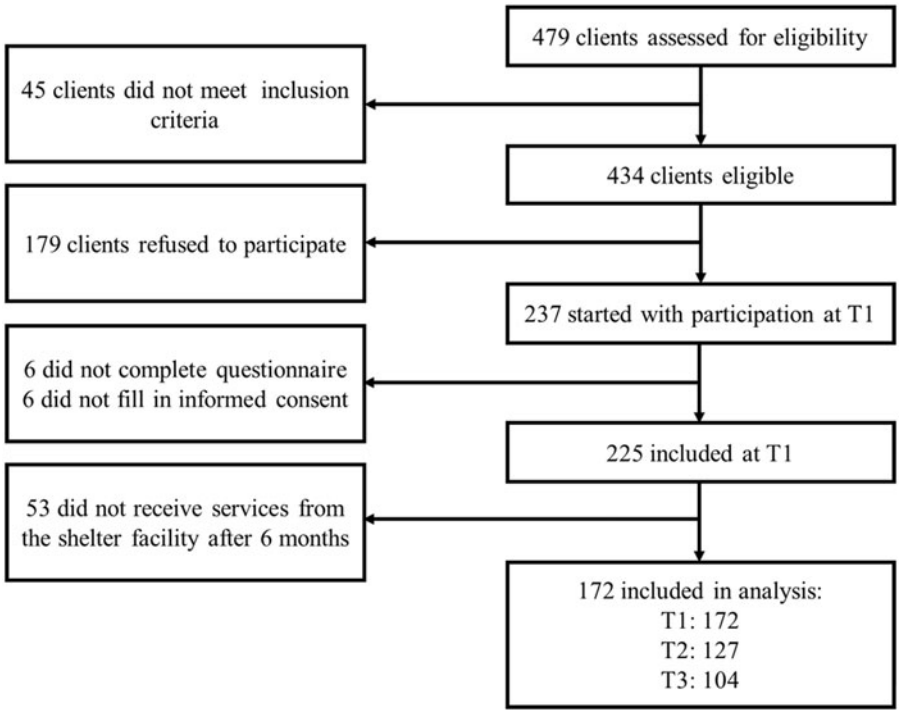

Figure 1. Participant flowchart.

subject to organizational changes (e.g., positions of management and other employees) and potential cost-saving procedures. Moreover, it was not advisable to use clients of another shelter facility as a control group, because those organizations are currently also improving their working methods by implementing similar interventions.

The study initially consisted of four measurement time points. However, the first measurement point (i.e., pretest) was excluded because this was the only measurement point for which the original scales of all of the questionnaires used were not applied and using that measurement point would create a very high level of participant drop-out, namely 73%. Consequently, three time points were distinguished: T1, T2, and T3. T1 was conducted in the period of March to May 2015, T2 in the period of October to December 2015, and T3 in the period of May to the start of August 2016. Clients were eligible if they: (1) were at least 18 years old, (2) understood Dutch, (3) were able to give informed consent, and (4) were able to participate in an interview. This last criterion was only applicable for residential clients. In total, 479 clients were assessed for eligibility, because this was the total number of clients receiving support at the first measurement time point. Forty-five clients did not meet the inclusion criteria (Figure 1), 179 clients refused to participate in the current study, and 6 participated but refused to fill in the informed consent form; these clients were therefore excluded. Furthermore, 6 other clients were excluded because they did not fully complete the questionnaire (i.e., less than 75% of the questionnaire completed). In total, 225 clients participated at the first measurement time point, of which 53 no longer received services from the shelter

Table 1. Demographic variables of participants at the baseline measure ($n = 172$).

Demographics	*n* (%)
Gender	
Male	129 (75)
Female	43 (25)
Age	Mean 49.04, SD 12.48 (range 21–87)
Education level	
No education or primary education	37 (22)
Lower education	45 (26)
Intermediate education	60 (35)
Higher education	25 (15)
Missing	5 (3)
Residential situation	
Own dwelling with ambulatory care	92 (53)
Residential shelter (long-term stay)	70 (41)
Shelter facility (short-term stay)	10 (6)
Duration of support	
< 1 year	31 (18)
1–2 years	34 (20)
2–5 years	66 (38)
≥ 5 years	41 (24)

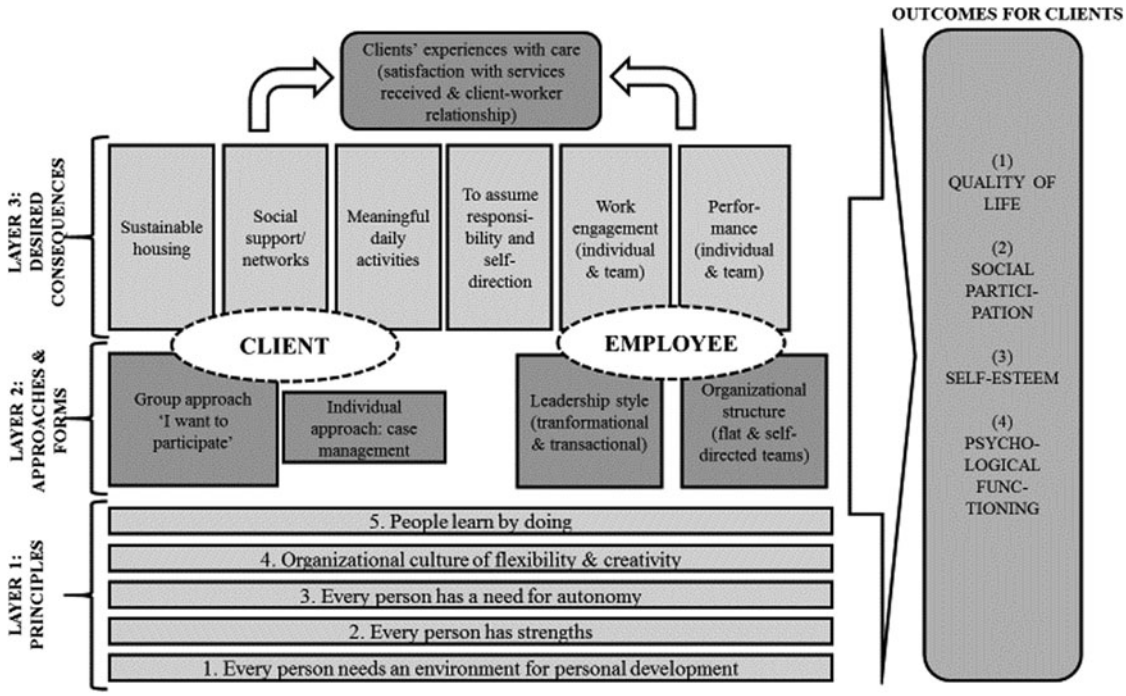

Figure 2. Visualization of key components of GTP.

facility after six months. These clients were excluded because they were barely exposed to the intervention.

Table 1 provides the descriptive statistics (Demographic variables) of the participants that were included in the analysis ($n = 172$): 75% was male, the average age was 49 years, 35% had an intermediate education level, 48% had lower education or less, slightly more than half of the participants (53%) resided in their own homes, and 58% had been supported by the shelter facility for 1–5 years.

Procedures

Separate data collection procedures were used for residential clients (i.e., clients living in a residential shelter facility) and ambulatory clients (i.e., clients living in their own home with support from social workers from the shelter facility). Residential clients were interviewed by an interviewer at the facility where they lived. The interviewers were trained in conducting interviews and in interviewing (formerly) homeless clients. They had a university degree, were specially hired as research assistants, and were not involved in activities related to the primary process of the shelter facility. All interviews for the three measurement time points that were used in the current study were conducted by the same two interviewers. The average duration of the interviews was 45 minutes. Ambulatory clients received a written questionnaire, sent to their home address, to complete. Written informed consent was obtained from all residential and ambulatory clients who were included in the analysis of the data of the current research.

Before the start of the data collection, the research was approved by the management board of SMO Breda, in which decision the official client board was involved. Human participants (i.e., clients of the shelter facility) were protected in accordance with Dutch law, and all customary requirements of due care in scientific research were observed.

Description of the GTP Intervention

Figure 2 provides a visualization of the main components of the intervention. GTP is divided into three layers: (1) principles, (2) approaches and forms, and (3) desired consequences. In addition to these layers, the behavior of clients and employees (including managers) plays a central

role in the intervention. The efforts of clients and employees are intended to result in positive experiences with care, such as satisfaction with the services received and with the client-worker relationship. All these components (three layers and clients' experiences with care) should contribute positively to quality of life, social participation, self-esteem, and psychological functioning.

Layer 1: Principles. The first principle, "Every person needs an environment for personal development," is related to the concept of the enabling niche (Taylor, 1997). As previously mentioned (see Introduction Section), the shelter facility aims to provide a safe environment, also called an enabling niche, for clients (Driessens & Van Regenmortel, 2006; Taylor, 1997). Notably, learning and the development of skills are not only important goals for clients, but also for employees, as they too must to some extent work on personal development.

The second principle, "Every person has strengths," concerns the assumption that every person (i.e., clients and employees) has several strengths, talents, skills, but that these may be hidden due to the central position occupied by problems and negative life experiences (Wolf, 2016). Hence, in such cases, strengths can be rediscovered by reflection on life, for example by performing an assessment of strengths (Rapp & Goscha, 2012; Wolf, 2016), and by creating new, positive experiences. In GTP, the strengths of employees are as important as those of the clients, because talent management improves organizational client-related outcomes (Michaels, Handfield-Jones, & Axelrod, 2001). An example within GTP is that employees with a specific hobby are encouraged to investigate whether they can practice their hobby as a means of supporting clients in groups.

The third principle, "Every person has a need for autonomy," refers to a basic need that relates to self-determination, that is, that people have a choice. In organizations, relationships might be based on power, such as worker-client or manager-subordinate, in which autonomy is not encouraged, which creates a potential risk that the client or subordinate is being controlled (Deci & Ryan, 1987). A principle of GTP is that autonomy must always be respected and that relationships are based on equality.

The fourth principle is that the members of the organization should have the intention to facilitate or create an organizational culture of flexibility and creativity in which people can be autonomous and allowed to make mistakes if they learn from them. This type of culture is consistent with the structural dimension of "flexibility and discretion" of the "Competing Values Framework" described by Cameron and Quinn (1999).

The final principle, "people learn by doing," means that people "learn from experiences resulting directly from one's own actions, as contrasted with learning from watching others perform, reading others' instructions or descriptions, or listening to others' instructions or lectures" (Reese, 2011, p. 1). The essence of GTP is that clients discover talents, develop strengths, and practice skills, all by doing, for example through participation in group activities. It is not the care worker who gives clients instructions about what they must do, but the clients themselves learn through a process of trial and error. Employees also learn by doing. Social workers seek to adopt an accommodating learning style as described by Kolb (2015; Wolf, 2016).

Layer 2: Approaches and forms. Layer 2 forms the core of GTP and includes working methods to support clients and organizational forms and aspects. The first component of this layer, the group approach (which is called "I want to participate"), consists of participation in educational, recreational, and labor activities. Clients can choose several activities based on their preferences, talents, and needs. They formulate a goal regarding what they want to learn through their participation in the chosen activities. The main objectives of "I want to participate" are to develop strengths and obtain skills that are useful for social participation. Most activities are supervised by a social or community worker (with an intermediate education level or Bachelor degree) with experience in the relevant activity (e.g., a sports activity is supervised by a social worker who is familiar with the principles and possibilities of sports). The average number of clients in a group per social worker is six.

Some activities are organized by (former) clients and based on principles of peer support. Clients are expected to participate in the "I want to participate" program for 8–20 hours per week, depending on their needs, housing situation, and the hours they already devote to social participation. Efforts are aimed at the best achievable result: If someone can participate in society, that type of participation takes priority and will be encouraged. If necessary, the social worker can contact external organizations to facilitate social participation. Clients are expected to participate in group meetings on a weekly basis. These meetings are organized around several themes but can also consist of relaxing activities (SMO Breda, 2014a).

The second component is the individual approach, which among others entails the individual support of clients by a case manager (i.e., a social worker with a Bachelor degree) for approximately 1 hour per week, depending on the clients' needs. Clients in crisis situations receive more hours of support; clients who reside in their own homes and who are stable require less support. These ambulatory clients are expected to participate in group meetings, where they can also meet with their case manager. Key components of case management are the building of a client–worker relationship which is based on respect and trust, but also allows for confrontation. The case manager is responsible for the creation of a personal recovery plan together with the client; if possible, a strengths assessment and ecogram (in which social relations are explored) are also made. Where applicable, the recovery plan describes at least three goals: (1) to find sustainable housing, (2) to build social contacts, either through reestablishment of contacts from the past or the creation of new ones, and (3) to find a meaningful activity program (in or outside the shelter facility; efforts are aimed at the best achievable result). Ideally, the same case manager follows the client throughout the care trajectory (SMO Breda, 2014a). However, within the shelter facility in which the current study was conducted, this was not always possible for organizational reasons.

The third component, leadership style, consists of a combination of transactional and transformational leadership. Research shows that a transactional and especially a transformational leadership style can enhance team performance and organizational outcomes (Cummings et al., 2010). Transformational leadership is a person-focused style in which the leader provides (1) inspirational motivation by having a vision, (2) individualized attention by building relationships, (3) intellectual stimulation by encouraging followers to learn, and (4) idealized influence by being a role model (Bass, 1985). Transactional leadership is a task-focused leadership style centered around the exchange process between leaders and followers (e.g., the leader gets things done by rewarding employees; Bass, 1985). Within GTP, these two leadership styles are considered complementary. Managers are coached and supported by team coaches. Special attention is given to leadership style, but team coaches also provide advice and support on a various range of topics, such as team building, team performance, and working methods (SMO Breda, 2014a).

The fourth component, organizational structure, is characterized by a flat organizational structure and a working method involving autonomous teams following the principles of self-directed work teams such as self-management, the assignment of jobs to team members by team members, planning and scheduling of work, making service-related decisions, and taking action to solve problems (Wellins et al., 1990). Self-directed teams have a collective responsibility, are encouraged to achieve autonomy (i.e., self-determination), and receive feedback on their team performance (Wall, Kemp, Jackson, & Clegg, 1986). In GTP, teams are supervised by a manager who is not part of the team. Managers have a span of control of approximately 70–80 employees in the primary process, who are divided into about 7–8 teams. There are no coordinators or team leaders, but support is provided by the team coaches. Every team coach supports approximately 80–90 employees (SMO Breda, 2014a).

Layer 3: Desired consequences. The third layer is divided into desired consequences for clients and desired consequences for employees; these two meet in the middle at the concept of "taking responsibility and direction." For both

clients and workers, it is necessary to assume responsibility and self-direction to achieve goals. Among clients, this concept is practiced at two levels. First, at the personal level, every client has a personal recovery plan with goals that are based on the client's strengths and talents. In this context, it is important for the client to be the director of his own trajectory (Rapp & Goscha, 2012; Wolf, 2016). Second, at the level of the living situation, clients reside in an intramural setting are encouraged to seize as much autonomy as possible in their living situation, and clients who live in their own homes are encouraged to take control of their living situation with the goal to remain housed. Employees are also expected to take responsibility and apply direction in their work because this can result in positive organizational outcomes (e.g., Hackman & Oldham, 1980).

For clients, the desired consequences are the three goals: Sustainable housing, building social contacts, and a meaningful daily activity program. For employees, the desired outcomes are to perform well and to be engaged in their work, meaning that they have "a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption" (Schaufeli, Salanova, González-Romá, & Bakker, 2002, p. 74). Work engagement can appear at both individual and team levels (Tims, Bakker, Derks, & Van Rhenen, 2013) and can be encouraged through a transformational leadership style (Tims, Bakker, & Xanthopoulou, 2011), which is part of the second layer of GTP. Team members themselves also play an important role in the level of individual work engagement, as the team members are responsible for performance interviews with each other, team meetings, the recruitment and the filling of positions in the team and the training of their own skills. Work engagement leads to improved team performance (Christian, Garza, & Slaughter, 2011). As mentioned above, self-directed teams require feedback on their work (Wall et al., 1986). Results are therefore measured via a digital dashboard accessible by employees and managers, which provides information about results at individual and team levels.

Outcomes for clients. The layers and components of GTP are intended to result in positive experiences with care on the part of clients, which includes satisfaction with the services received and a positive working relationship between employee and client. Previous research showed that there exists a positive relationship between experiences with care and outcomes for (formerly) homeless clients. Specifically, experiences with care are a predictor of social participation and well-being, defined as the combination of quality of life, self-esteem, and the absence of psychological distress (Rutenfrans-Stupar et al., 2018). Additionally, the other components of GTP are also intended to result in these outcomes for clients.

Measures

Demographic variables were assessed as shown in Table 1. The primary outcome, quality of life, was assessed by the World Health Organization Quality of Life Brief version (WHOQOL-BREF) (Skevington, Lotfy, & O'Connell, 2004; WHO, 1998). This questionnaire consists of 26 items, divided into four subscales: Physical health, psychological health, social relationships, and environment. Each item was rated on a 5-point Likert scale, ranging from 1 (*very poor* or *very dissatisfied*) to 5 (*very good* or *very satisfied*). Because quality of life is the primary outcome, the total score and the scores on all subscales were used. The scores were transformed to a 100 point scale in conformance with the instructions of the SHOQOL-BREF manual (WHO, 1998).

Secondary outcomes included social participation, self-esteem, clients' experiences with care, and reduction of psychological distress. Social participation was assessed using various instruments. First, the Participation Ladder was used (Van Gent, Van Horssen, Mallee, & Slotboom, 2008), which consists of six phases, namely (1) isolated, (2) social contacts outside of the home, (3) participation in organized activities, (4) unpaid work, (5) paid work with additional support, and (6) paid work (Van Gent et al., 2008). Participants were asked which of these phases applied to them. Second, five items derived from scales used in the Medical Outcome Study

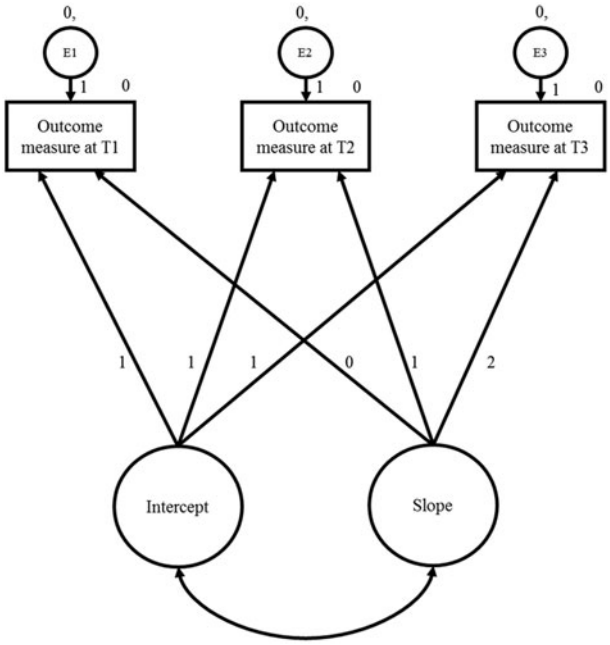

Figure 3. Latent growth model used to explore rate of change in primary and secondary outcome variables.

(MOS) Social Support Survey (Sherbourne & Stewart, 1991) were used, which consisted of five items respectively for family for friends or other acquaintances. Each item was rated on a five-point Likert scale, ranging from 1 (*none of the time*) to 5 (*all of the time*). In the current study, calculations were based on the total score based on all 10 items. Third, participants were asked how many hours they participated in activities, in which they had contact with other people, in the last week. The questionnaire explicitly stated that this question concerned activities outside the shelter facility. The answers (number of hours) were divided into labor, recreational, and educational activities. Because clients barely participated in educational activities outside the shelter facility (M(T1) = .50 hours a week, SD = 2.48), this item was eliminated from the analysis.

Self-esteem was assessed using the Rosenberg Self-Esteem Scale (RSES), which consists of 10 items (this instrument has no subscales). These items were scored on a four-point Likert scale ranging from 1 (*strongly agree*) to 4 (*strongly disagree*) (Rosenberg, 1965; Van Der Linden, Dijkman, & Roeders, 1983). Clients' experiences with care were assessed using two subscales from the Consumer Quality Index for Shelter and Community Care Services (CQI-SCCS) (Asmoredjo, Beijersbergen, & Wolf, 2017; Beijersbergen, Christians, Asmoredjo, & Wolf, 2010), namely services received and client-worker relationship. Response categories ranged from 1 (*never*) to 4 (*always*). In the current study, the total score based on 13 items (nine items from the subscale Services Received and four items from the subscale Client–Worker Relationship) was calculated. Psychological distress was measured using the Brief Symptom Inventory (BSI-53) (De Beurs & Zitman, 2005; Derogatis, 1975). The 53 items of this scale assess nine patterns of psychological symptoms: Somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Items were scored on a five-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*) (De Beurs & Zitman, 2005; Derogatis, 1975). In the current study, the total sore of the BSI-53 was used.

All scales used in the current study had moderate to high internal consistencies across measurement points (range at T1 = .67–.95, T2 = .70–.97, T3 = .73–.96). Additionally, all instruments, except the Participation Ladder and the questions about the hours spent on activities outside the shelter facility, have been used in studies among homeless people before (e.g., De Vet et al., 2017; Lako et al., 2013; LePage & Garcia-Rea, 2008; Van Straaten et al., 2018).

Statistical Analyses

Descriptive statistics were analyzed using SPSS (version 24). To test whether the primary and secondary outcomes increased across time, Latent Growth Modeling (LGM) was used with the support of AMOS (version 22) (Arbuckle, 2013). LGM is a flexible analytic technique for modeling change over time, which takes variability in rate of change at the individual level into account and focuses on correlations over time, changes in variances and in mean values (Hess, 2000). A major advantage is that LGM can handle missing data, as it uses data from all participants, not only from those who have completed the questionnaire, and as such provides less biased information on treatment

effects (Choi, Golder, Gillmore, & Morrison, 2005; Feingold, 2009). LGM is an especially suitable technique for social and behavioral intervention studies (Curran & Muthén, 1999; Feingold, 2009; Preacher, Wichman, MacCallum, & Briggs, 2008). Figure 3 shows the path diagram that was used to test growth in every primary and secondary outcome variable (Hypotheses 1 and 2). In order to test the third hypothesis, it was needed to conduct a multigroup analysis (i.e., clients defined by the baseline characteristic, the level of psychological distress). Therefore, the grouping variable (psychological distress) was specified as a predictor of both intercepts and slopes and tested whether every primary and secondary outcome variable changed across time using a conditional growth curve (Preacher et al., 2008; Figure 4).

Additionally, to test the third hypothesis, a dummy variable of psychological distress was created. Therefore, the cutoff point for BSI was calculated using the Jacobson and Truax method of calculating clinical significance (Jacobson & Truax, 1991) with the following formula: Cutoff = $((SD_{patient} * M_{nonpatient}) + (SD_{nonpatient} * M_{patient}))/(SD_{patient} + SD_{nonpatient})$. According to De Beurs and Zitman (2005), the mean (and standard deviation) of the BSI total score for the Dutch patient population is 1.23 (.72) and for the Dutch nonpatient population is .42 (.40), which lead to a cutoff score of .71. The BSI total scores of the first measurement point were used: Participants with BSI >.71 had "above-average" psychological distress.

In the current study missing data had to be handled, as 24% of the data were missing, including missing time points (as shown in Figure 1) and unanswered questions. To investigate whether the missingness had biased the data, Little's Missing Completely At Random (MCAR) test (χ^2 = 12,408, df = 24,727, p = 1.00) was used, which showed that data were missing completely at random and therefore it can be concluded that the incomplete data sample is still representative of the hypothetically complete data (Little, 1988). Missing data was handled in two steps. First, with regard to BSI and WHOQOL, the mean scores were calculated according to the

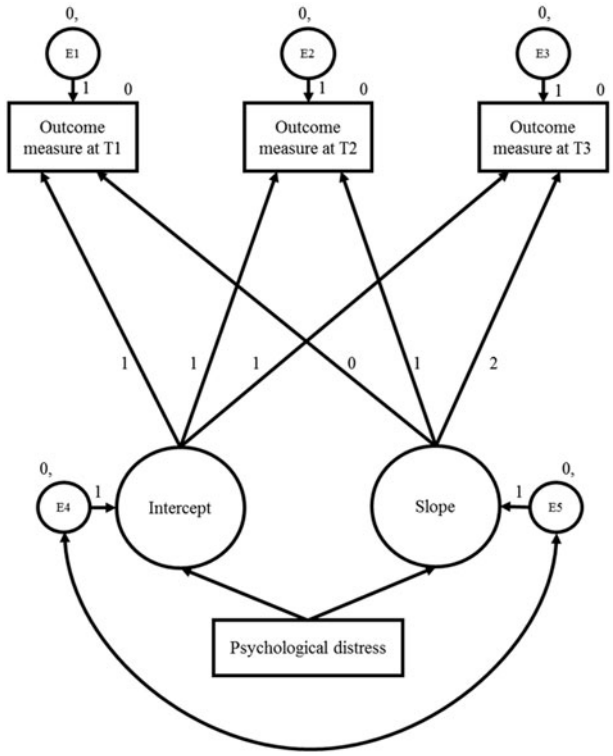

Figure 4. Conditional latent growth model with psychological distress as an exogenous predictor.

instructions for missing data (Derogatis, 1975; Skevington et al., 2004). According to the BSI manual, it is permissible to calculate the total BSI score if twelve or fewer items are missing (Derogatis, 1975). Skevington et al. (2004) indicated that the total score of WHOQOL may be calculated when 20% or less is missing, and mean scores of subscales may be calculated when two items are missing, except where it concerns the Social Relationships subscale, where only one item may be missing (WHO, 1998). Second, the Full Information Maximum Likelihood method was used, because this is considered one of the most preferred methods to handle missing data (Arbuckle, 2013; Byrne, 2016; Enders & Bandalos, 2001), especially when data are MCAR (Preacher et al., 2008).

To evaluate the model fit of every tested latent growth model, a combination of fitness indexes was used, namely the Comparative Fit Index (CFI) (Hu & Bentler, 1995), the Normed Fit Index (NFI) (Bentler & Bonett, 1980), and the Incremental Fit Index (IFI) (Bollen, 1989). All these fitness indexes should be close to one with a minimum of .90 (e.g., Arbuckle, 2013).

Table 2. Results from latent growth modeling ($n = 172$)[a].

Outcome measures	T1 mean (SE)[b]	Slope (SE)	*p*-value slope	χ^2	CFI	NFI	IFI
Primary outcome							
Quality of life	59.70 (1.23)	.92 (.44)	.04*	16.161	.949	.939	.950
Physical health	60.93 (1.54)	−.15 (.70)	.84	8.205	.970	.954	.970
Psychological health	60.16 (1.44)	.77 (.61)	.21	4.747	.992	.980	.993
Social relationships	58.32 (1.65)	1.94 (.85)	.02*	.067	1.000	1.000	1.021
Environment	59.50 (1.32)	1.72 (.58)	.00**	18.143	.916	.903	.918
Secondary outcomes							
Psychological distress (BSI)	.73 (.05)	−.01 (.02)	.47	1.089	1.000	.995	1.009
Self-esteem (RSES)	29.60 (.37)	.26 (.18)	.16	4.353	.987	.961	.988
Social support	46.87 (2.04)	−.04 (1.28)	.98	6.750	.959	.931	.961
Participation ladder	3.50 (.10)	.03 (.05)	.51	6.104	.979	.960	.979
Labor[c]	5.83 (.86)	.72 (.32)	.02*	1.655	1.000	.994	1.005
Recreation[c]	16.60 (2.08)	−2.53 (1.18)	.03*	.737	1.000	.969	1.108
Experiences with care (CQi)	3.26 (.04)	.03 (.03)	.25	3.239	.997	.960	.997

[a]df = 3 for all tested latent growth models.
[b]Intercept.
[c]Outside the shelter facility (hours per week).
*$p < .05$.
**$p < .01$.

Results

To test whether primary and secondary outcomes changed across time, LGM was used ($n = 172$). As shown in Table 2, the total quality of life increased significantly (M(T1) = 59.70, m = .92, p = .04), including the subscales social relationships (M(T1) = 58.32; $m = 1.94$; p = .02) and environment (M(T1) = 59.50, $m = 1.72$, $p <$ .001). As such, the first hypothesis was confirmed. Regarding the secondary outcomes, the number of hours a week clients spent on labor activities increased significantly (M(T1) = 5.83, m = .72, p = .02). However, the number of hours a week clients spent on recreational activities decreased significantly (M(T1) = 16.60, m = −2.53, p = .03). Other variables did not increase or decrease significantly. This means that the second hypothesis was mainly rejected. All fit indexes were acceptable (> .90): CFI varied from .916 to 1.000, NFI varied from .903 to 1.000, and IFI varied from .918 to 1.108.

To test whether GTP had a larger influence on (formerly) homeless clients with above-average level of psychological distress than on those with lower levels of psychological distress, conditional growth modeling (Preacher et al., 2008) was used. Table 3 shows that psychological distress was a predictor of the initial status of quality of life and all its subscales (all p values <.001), self-esteem ($p <$ .001), and social support (p = .01), and that psychological distress was a predictor of the rate of change (i.e., slope). Concerning rate of change, the total quality of life ($m = 2.56$, $p <$ .001), including the subscales physical health ($m = 3.00$, $p = .04$) and environment ($m = 3.99$, $p <$ .001), increased significantly over time. Additionally, self-esteem increased significantly ($m = 1.09$; $p <$ .001) and psychological distress decreased significantly ($m = -.15$; $p <$.001) over time. As such, the third hypothesis was partially confirmed. All fit indexes were acceptable (> .90): CFI varied from .933 to 1.000, NFI varied from .919 to .995, and IFI varied from .935 to 1.109.

Discussion

The current study evaluated whether (formerly) homeless clients from a shelter facility in the Netherlands experienced changes over time in several outcomes after implementation of the GTP intervention. As expected, the total score of quality of life (including the subscales social relationships and environment) increased over time (Hypothesis 1 was confirmed). Additionally, the amount of time clients spent on labor activities outside the shelter facility also increased over time. However, the amount of time clients spent on recreational activities outside the shelter facility decreased over time, and no changes were found in the scores of the subscales physical and psychological health, nor in the scales psychological distress, self-esteem, social support, participation ladder, and experiences with care (Hypothesis 2 was mainly rejected). (Formerly) homeless clients with above-average psychological

Table 3. Results from conditional growth modeling with psychological distress as a exogenous predictor ($n = 172$)[a].

Outcome measures	BSI=>Intercept[b] (SE)	*p*-value (BSI-Icept)	BSI=>Slope[c] (SE)	*p*-value (BSI-slope)	χ^2	CFI	NFI	IFI
Primary outcome								
Quality of life	−20.82 (2.01)	.00***	2.56 (.90)	.00**	18.198	.958	.948	.959
Physical health	−22.55 (2.72)	.00***	3.00 (1.45)	.04*	9.111	.977	.961	.978
Psychological health	−24.41 (2.33)	.00***	1.13 (1.27)	.37	12.257	.974	.963	.974
Social relationships	−16.49 (3.23)	.00***	1.07 (1.77)	.55	.866	1.000	.995	1.019
Environment	−17.58 (2.39)	.00***	3.99 (1.15)	.00***	19.237	.933	.919	.935
Secondary outcomes								
Psychological distress (BSI)	.93 (.07)	.00***	−.15 (.04)	.00***	8.147	.988	.977	.988
Self-esteem (RSES)	−4.71 (.68)	.00***	1.09 (.36)	.00**	8.779	.968	.946	.970
Social support	−11.39 (4.18)	.01**	3.91 (2.66)	.14	8.574	.953	.920	.956
Participation ladder	−.23 (.21)	.28	−.11 (.10)	.30	6.392	.984	.959	.984
Labor[d]	1.31 (1.80)	.47	.33 (.67)	.62	3.170	1.000	.988	1.003
Recreation[d]	3.00 (4.39)	.49	.76 (2.47)	.76	1.487	1.000	.945	1.109
Experiences with care (CQi)	−.06 (.09)	.48	.09 (.05)	.07	3.699	1.000	.956	1.004

[a] $df = 4$ for all tested latent growth models.
[b] Group effect on intercept.
[c] Group effect on slope.
[d] Outside the shelter facility (hours per week).
*$p < .05$.
**$p < .01$.
***$p < .001$.

distress experienced more improvements over time in quality of life (subscales physical health and environment), self-esteem and psychological distress (i.e., psychological distress decreased) compared to those with lower levels of psychological distress. However, the amount of time these clients spent on labor and recreational activities outside the shelter facility neither increased nor decreased and the scores on other variables also did not change over time (Hypothesis 3 was partially confirmed). Most of these findings were in line with the results of the qualitative study that was conducted to evaluate one of the aspects of GTP, namely the influence of participation in activities on well-being. That study also showed that participants experienced increased physical, social, and mental well-being because of their participation in educational, recreational, and labor activities (Rutenfrans-Stupar et al, in press).

Regarding the second hypothesis, an unexpected outcome was found, namely a decrease in the number of hours spent on recreational activities outside the shelter facility. It is possible that clients have been spending more time on recreational activities inside the shelter facility. This finding would be contradictory to the aim of GTP (i.e., participation in society). However, if the quality of the recreational activities inside the shelter facility is higher than the quality of the recreational activities outside the shelter facility in which clients were participating, this finding can be considered as a neutral or positive outcome. Nonetheless, the number of hours spent on recreational activities inside the shelter facility was not included as a variable in the current study, or the quality of the activities, which means that a valid conclusion on this matter cannot be drawn.

With regard to the third hypothesis, among clients with above-average psychological distress, the highest change over time after implementation of GTP occurred in the scores on person-centered variables (increased psychological health and self-esteem and decreased psychological distress). This implies that persons with above average psychological distress first work on their personal recovery process in terms of improvement of their own psychological health. This is congruent with the first stages of recovery as described by Powel (2009), in which people are initially overwhelmed by the disabling power of their mental illness and are preoccupied with the illness, which implies that persons first must cope with their psychological distress and functioning. In the next phase, people are enabled to pay attention to their environment, for example, social functioning, as they begin to challenge the disabling power of the mental illness and reassume social roles (Powel, 2009; Rapp & Goscha, 2012). It can be speculated that if the duration of the current study had been longer,

positive outcomes for the other variables would have been found.

Limitations and Suggestions for Future Research

There are several limitations of the current study. First, a control group was not used, which makes it impossible to compare GTP to care as usual. Therefore, it cannot be concluded whether the significant changes that were found are related to GTP or to other factors. Second, the fidelity of GTP was not measured, because no process measures were included in the current study. However, evaluation from practice showed that important aspects of GTP were implemented (Dimensus, 2017). Nevertheless, future research should include process measures to examine whether the intervention is fully implemented. Third, the intervention was implemented in the period April and May 2015, and the first measurement point was conducted from March to May 2015, which means that there was a partly overlapping period. This implies that there is not a fully adequate baseline measurement (i.e., clients' scores before implementation of GTP), but this does not have a large impact on the results, considering that this type of intervention needs more time to cause a change in clients' scores (Bybee, Mowbray, & Cohen, 1994). Finally, the current study was conducted within one shelter facility in the Netherlands, because GTP is currently only implemented in this organization. The external validity of the present study would benefit if other shelter facilities implement GTP, accompanied with broader research into the efficacy of this intervention. In that case, it is recommended to conduct a Randomized Controlled Trial to examine the effects of GTP in which the fidelity is also assessed.

Implications

Although more research is required to examine the efficacy of GTP, we conclude that GTP seems to be a potentially promising intervention for shelter facilities. First, this participation-based intervention is in line with government policy in the Netherlands and various other Western countries. The current research showed that after implementation of GTP, significant change occurred in an important aspect of social participation, namely the number of hours clients spent on labor activities. Labor is one of the high-priority issues of the Dutch government, even for people with a disability (Rijksoverheid, 2018). Furthermore, this study showed that the scores on the primary outcome measure, quality of life, changed over time, which is also relevant for the government, as one of the government's objectives is to take care of the well-being of their citizens. Second, implementing GTP allows for cost reduction. For example, offering group-based activities is cheaper than individual support, and working with self-directed teams and fewer managers can also reduce costs. The current shelter facility calculated that a cost reduction of more than 10% could be achieved through implementation of GTP, but has chosen to invest the saved money in the intensity of care (SMO Breda, 2014a). It would be therefore recommendable to perform a cost-benefit analysis to determine whether GTP does in fact facilitate cost reduction compared to alternative approaches.

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We disclose a potential conflict of interest: the first author (MRS) of the article is employed by SMO Breda, the shelter facility where the research is conducted. Additionally, regarding funding, SMO Breda is one of the sponsors of the "Stichting Sociaal Werk" which provides funds for the Academic Workplace Social Work at Tranzo, Tilburg University. However, the employment and funder had no influence on the outcomes, because the management board of SMO Breda and the "Stichting Sociaal Werk" had no role in the study design, the collection, analysis, and interpretation of data, or in the content of the article. Furthermore, the employment conditions of the first author are fully independent of the content and publication of the current article. The second (RS) and third authors (TVR) do not have a direct relationship with SMO Breda and they supervised and monitored the accuracy of data analysis, interpretation of data, and the content of the article.

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