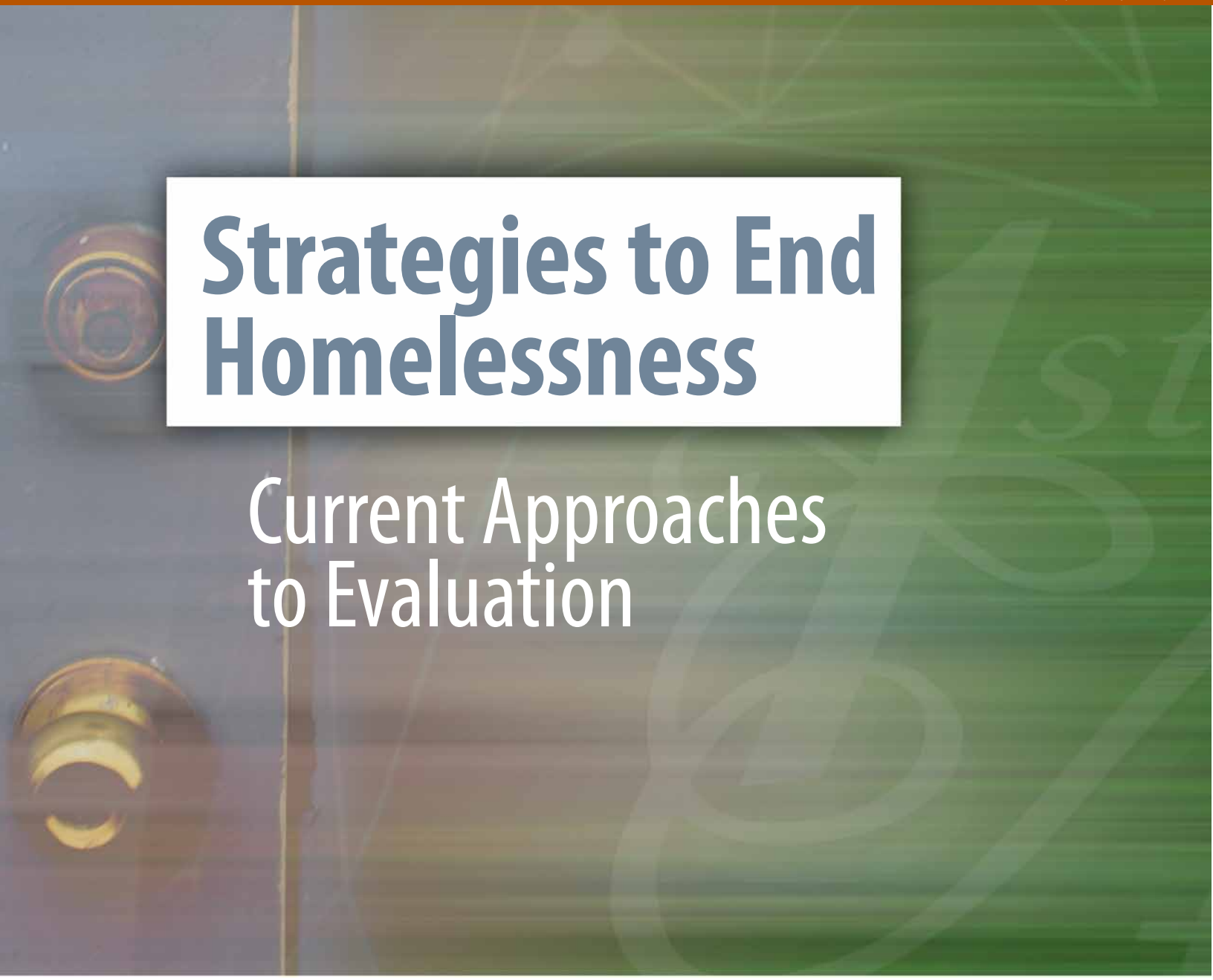

Strategies to End Homelessness

Current Approaches to Evaluation

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University of Victoria, Centre for Addictions Research of BC

the homeless hub

PAPER #2

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Strategies to End Homelessness: Current Approaches to Evaluation

Homelessness is a concern throughout Canada in rural, urban, southern and northern areas (Wellesley Institute, 2010). One estimate of homelessness in Canada indicates that there are about 150,000 people who seek refuge in emergency shelters nightly (Human Resources and Skills Development Canada, 2009). Being homeless is associated with poor physical and mental health (Frankish, Hwang, & Quantz, 2005; Hwang et al., 2008; Research Alliance for Canadian Homelessness Housing and Health, 2010; Wright & Tompkins, 2005), early death (Cheung & Hwang, 2004; Hwang, 2000; Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009; Spittal et al., 2006), lack of access to health care services (Ensign & Planke, 2002; Pauly, in press; Wen, Hudak, & Hwang, 2007), increased risk of depression and suicide (Buhrich, Hodder, & Teesson, 2006; Menzies, 2006) and victimization (Khandor & Mason, 2007). Homelessness impacts a diverse group of men, women, youth, and families, including Aboriginal peoples, military veterans, immigrants and refugees.

In the last decade, there have been calls for a shift away from managing homelessness to ending homelessness (National Alliance to End Homelessness, 2000; The Alberta Secretariat for Action on Homelessness, 2008). Managing homelessness focuses mainly on providing emergency shelter and charitable meal programs as temporary assistance for those in need of food and shelter. An over-emphasis on emergency responses is more expensive than placing individuals directly into housing (Larimer et al., 2009; National Alliance to End Homelessness; Patterson, Somers, MacIntosh, Shiell, & Frankish, 2007) and has negative impacts on the health, safety, and wellbeing of people experiencing homelessness and the communities they live in.

In response to calls to end homelessness, community coalitions have been established in several Canadian cities (Victoria, Vancouver, Calgary, Edmonton, and Toronto). Several of these cities have developed blueprints and ten year plans to end homelessness (Greater Victoria Coalition to End Homelessness, 2008; The Alberta Secretariat for Action on Homelessness, 2008; Wellesley Institute, 2006). The call to end homelessness puts the focus on the development of longer term interventions or solutions rather than emergency short term responses. However, homeless people are not a uniform group. As such, solutions must account for differences in gender, ethnicity, sexuality, geography, and age (Aratani, 2009; Bridgman, 2002; Burt, 2010; Klodawsky, 2010; Klodawsky, Aubry, & Farrell, 2006; Lehmann, Drake, Kass, & Nichols, 2007; Menzies, 2006; Native Women's Association of Canada, 2007; Robinson, 2002).

People who are homeless may experience further disadvantage and discrimination associated with age, gender, sexual orientation, or ethnicity (Hankivsky & Cormier, 2009). In this way, different kinds of disadvantage may combine to produce even worse health and social outcomes for some sub-groups than others. For example, colonization and discrimination have overwhelmingly impacted Aboriginal people's access to wealth and resources, with poor health and lack of access to housing as a consequence (Loppie Reading & Wein, 2009). Women and youth are also often extremely vulnerable to the harms of homelessness. Thus, in seeking to develop solutions to end homelessness, we asked, 'what works for whom?'

The purpose of this paper is to provide a summary of research on interventions that aim to end or reduce homelessness. Our specific goals were to gain an understanding of the different populations for whom interventions have been tested and the type of interventions evaluated, as well as to create an inventory of the indicators used to assess the effectiveness of interventions. We provide an overview of the methodology used to gather research on strategies to end homelessness. In the findings, we review the types of interventions evaluated, highlight the populations studied, and summarize the indicators of effectiveness used in the evaluations. Finally, we discuss the findings of this review in relation to current and future research on homeless interventions.

Methods

Included in our review are peer reviewed, published studies that evaluated an initiative, intervention, or program to end, reduce, or prevent homelessness. We did not embrace a particular definition of homelessness but rather sought research on interventions that described their goal as ending or reducing homelessness. Articles were identified based on a search of computer databases accessible through the University of Victoria's online library services. The search was restricted to English language papers published from January 2000 to February 2011. The following databases were reviewed: Google Scholar, JSTOR, PubMed, Medline, Summon, CBCA, Sociological Abstracts, Worldwide Political Science Abstracts, and PAIS-Public Affairs. The articles were in English, and were written about programs in Canada, the United States, and the United Kingdom.

Initially, the search was conducted using broad terms such as *homelessness* and *evaluation* and then moved to include more specific terms related to programs that emerged from the initial general search. Search terms included, sometimes in combination, or with slight variations in wording, the following: *homeless, critical time intervention, action research, participatory research, transitional housing, supported housing, supportive housing, rental supplements, income supplements, critical discourse, social determinants of health, critical social theory, housing readiness program, rapid re-housing, resettlement, and housing first*. Two of the three authors assessed the article abstracts using the eligibility criteria. Articles were excluded if they reviewed or described a type of strategy, model, or philosophy, rather than research or evaluation that focused on a specific program, or if the authors focused solely on care or treatment of homeless persons without explicit attention to ending or reducing homelessness.

In total, 66 papers fit the inclusion criteria. Articles that met the inclusion criteria were then reviewed and examined for key information relating to: 1) the population at which the program was directed, 2) the strategy that was being evaluated, 3) the indicators used in evaluation, 4) research design and data collection methods, and 5) the results of the research. This information was organized into an excel spreadsheet, and identified papers were grouped according to the kind of strategy they used in seeking to end, reduce or, prevent homelessness (See Table 1). Eight strategies were identified: 1) permanent independent housing (including Housing First); 2) transitional supports; 3) institutional discharge planning; 4) modified therapeutic communities; 5) monetary assistance; 6) housing mediation; 7) supportive housing; and 8) policy initiatives.

TABLE 1

Ending homelessness strategies		
Ending homelessness strategy	**Number of papers** (N=66)	**Percentage of papers**[1]
Permanent independent housing	20	30%
Transitional shelters and housing	13	20%
Policy initiatives	9	14%
Institutional discharge planning	6	9%
Monetary assistance	5	8%
Housing mediation	5	8%
Modified therapeutic communities	4	6%
Supportive housing	4	6%

1. The percentages were rounded up if >.5 or down if < .5 so total may not equal 100%

For seven of the eight strategies, one paper was selected and highlighted as a case study to illustrate the type of intervention and approach to evaluation. We did not include a case study of policy initiatives due to the diversity and lack of methodological detail in these studies. This category, although including 14% of the papers, will be discussed last.

For each of the papers included, we reviewed the outcomes, goals, or measures used to assess the effectiveness of the interventions. The specific outcomes or goals, according to which initiatives were evaluated, were coded and categorized according to similarities and differences. We refer to these as "indicators" to reflect the kind of outcomes assessed. Thirteen indicators emerged:

1. **HOUSING STATUS:** Client's housing status (housed or homeless) and/or housing type before, during, and/or after the program; days spent homeless.
2. **PSYCHOLOGICAL FUNCTIONING:** Assessments of psychological wellbeing (e.g. self-esteem) and/or changes in psychiatric symptoms (assessment of psychiatric symptoms before, during or after the program).
3. **SUBSTANCE USE:** Client's use or non-use of alcohol and/or drugs before, during, and/or after the program (e.g. Addiction Severity Index).
4. **SELF-SUFFICIENCY:** Achievement and/or improvement related to employment, education, and life skills before, during, and/or after the program; ability to pay rent independently.
5. **USE OF HEALTH, SOCIAL AND JUSTICE SERVICES:** Client's use of services other than those provided by a specific housing strategy, for instance, emergency medical services, detoxification services, hospital stays, criminal justice system involvement, among others, before, during, and/or after the program.
6. **COST OF PROGRAMS/SERVICES:** The financial cost of the program; costs of health, social and justice service use.
7. **CLIENT'S PERCEPTIONS OF PROGRAMS:** Client's self-reported views on the program or elements of the program, for instance satisfaction with the residential environment, general satisfaction with the program or attitudes towards participation in the program.
8. **STAFF PERCEPTIONS:** Staff perspectives on programs including program descriptions (perceptions of the goals of the program, whether the program is meeting its goals, staff descriptions of the program).
9. **QUALITY OF LIFE:** Different measures of quality of life (for example, asking program participants to rate their quality of life using a scale, or asking open-ended questions about quality of life).
10. **GENERAL HEALTH:** General health and wellbeing as measured by, for example, standardized measures such as the Short Form 12 (a 12 question standardized survey for collecting information about health) or asking participants to rate their health using a scale.
11. **CRIMINALIZATION/VICTIMIZATION:** Incidents of illegal activity or as a victim of crime.
12. **HIV STATUS:** Medical measures of the severity of the HIV infection, or HIV risk behaviours.
13. **SYSTEMIC FACTORS:** Indicators of change or progress in ending homelessness, such as changes in the number of people who are homeless, levels of need for housing, or improvement in integration of services across different areas (e.g., housing, health care, justice system).

Review of Findings

1) Permanent independent living including 'Housing First'

"Permanent independent housing" refers to permanent, scattered site housing (not a single, dedicated building or housing project) as an intervention to end homelessness. Individuals are provided with opportunities for independent living and services are not linked to the housing setting. In other words, services are not provided at a single housing location; rather, they follow the individual wherever that person may live. In total, 20 papers (including those on Housing First) evaluated programs that fit the description of permanent independent housing. While fifteen of the twenty papers focused on evaluation of a single program, five papers compared permanent independent housing to treatment first, communal housing, or usual care (Gulcur, Stefanic, Shinn, Tsemberis, & Fischer, 2003; McHugo et al., 2004; Padgett, Gulcur, & Tsemberis, 2006; Siegel et al., 2006; Tsai, Mares, & Rosenheck, 2010).

Twelve of the twenty papers focused on the effectiveness of permanent independent housing for people with severe mental illness, with or without problematic substance use (Gulcur et al., 2003; Lee, Wong, & Rothbard, 2009; Mares, Kasprow, & Rosenheck, 2004; McHugo et al., 2004; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005; Padgett, 2007; Padgett et al., 2006; Pearson, Montgomery, & Locke, 2009; Siegel et al., 2006; Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004). Mares et al. (2004) specifically focused on veterans with mental illness and substance use problems. Three papers focused on housing interventions for people with problematic substance use (Edens, Mares, Tsai, & Rosenheck, 2011; Gilmer, Manning, & Ettner, 2009; Larimer et al., 2009). Two papers focused on people who were chronically homeless, that is, continuously homeless for one year or more, or having experienced four periods of homelessness in three years (DeSilva, Manworren, & Targonski, 2011; Tsai et al., 2010). Two other papers focused on people who were homeless with chronic health conditions (George, Chernega, Stawiski, Figert, & Valdivia, 2008; Sadowski, Kee, VanderWeele, & Buchanan, 2009). Thus, the focus of most of the research on permanent independent housing has been on single adults with mental illness with or without problematic substance use. None of the studies focused specifically on women, youth, or specific ethnic groups, and only one study was oriented towards homeless individuals identified as over 50 or elderly (Crane & Warnes, 2007).

Housing status was the most commonly used indicator for evaluation and was a key outcome assessed in 12 of the papers in this category (See Table 2). Other indicators included changes in use of health, social and justice services, clients' self-reported substance use, costs of programs/services, psychiatric symptoms, quality of life, staff perceptions of success, and self-sufficiency. Nine of the papers compared outcomes between groups of participants distinguished by either different personal characteristics or different program conditions. For instance, one study of supported housing compared outcomes for clients with high levels of substance use to outcomes for clients with no substance use (Edens et al., 2011). Evaluations generally focused on measures of individual level change including increased self-sufficiency.

TABLE 2

Independent living indicators	
Indicators used in more than one paper	**Number of papers**
Housing Status	12
Use of Health, Police, and Social Services	10
Client Perceptions	7
Costs of Programs/Services	5
Psychological Functioning	5
Quality of Life	4
Substance Use	4

Independent living | CASE STUDY

Sadowski, L. et al. (2009). Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations among Chronically Ill Homeless Adults: A Randomized Trial. *Journal of the American Medical Association*, 301(17): 1771-1778.

PROGRAM: A case management and housing program for homeless individuals leaving a hospital setting.

POPULATION: Homeless adults with chronic medical illnesses

TYPE OF EVALUATION: Outcome evaluation[2].

EVALUATION OBJECTIVE: To measure the effect of the program on the use of emergency medical services

RESEARCH DESIGN: Participants (N= 407) were randomly assigned to either an intervention group or a usual care group. The intervention group received case management services (support from a social worker), was discharged from hospital to transitional housing in the form of respite care, and placed in stable housing using a Housing First model. Case management services were provided on-site at each of the hospital, transitional housing, and stable housing locations. The treatment-as-usual group received usual hospital discharge services, including interaction with hospital social workers only while in the hospital, and if no accommodations had been arranged before discharge, transportation to an overnight shelter.

METHOD OF DATA COLLECTION: Participants were interviewed at 1, 2, 6, 9, 12, and 18 months after leaving the hospital. At each interview, housing status, quality of life, and service use were assessed.

FINDINGS: Compared to the usual care group, the intervention group spent fewer days in hospital and had fewer emergency department visits, demonstrating that a stable housing and case management program can reduce the use of emergency medical services among homeless adults with chronic medical conditions.

2) Transitional housing and supports

The category of "transitional housing and supports" was used to describe programs that provided temporary housing and/or supports with an expectation that clients gradually move to greater self-sufficiency and permanent housing. In total, 13 papers evaluated programs that fit this description. Of the 13 papers, 4 of the programs were oriented towards youth under 25 and in one case LGBT (lesbian, gay, bisexual or transgendered) youth (Bridgman, 2001; Kisely et al., 2008; Nolan, 2006; Senteio, Marshall, Ritzen, & Grant, 2009), four focused on low-income families who were homeless or at risk of homelessness (Camasso, 2003; Camasso, Jagannathan, & Walker, 2004; Kleit & Rohe, 2005; Washington, 2002), and three were oriented towards homeless individuals with a mental or medical illness and/or substance use issues (Dordick, 2002), including veterans (Schutt, Rosenheck, Penk, Drebing, & Seibyl, 2005), and women (Bridgman, 2002). One paper focused on female survivors of domestic violence (Baker, Niolon, & Oliphant, 2009) and another considered differences in outcomes for men and women receiving services from a program (Rich & Clark, 2005). The literature on transitional supports does consider the different needs of several sub-groups beyond those with mental illness including women, youth, families and veterans.

The indicators used to evaluate transitional supports included housing status, use of health, social and justice services, psychiatric symptoms, general health, substance use, client perceptions of success, staff perceptions of success, quality of life, and self-sufficiency (See Table 3). One study was a survey of the characteristics of 236 transitional housing programs and another was a process evaluation.[3] Again, the focus of these evaluations was on individual level changes.

2. An outcome evaluation is a way of evaluating a program based on what happened as a result of the program, rather than the process of creating and running the program.
3. A process evaluation focuses on the way the program was set up and run, rather than the end results of the program.

TABLE 3

Transitional housing and supports indicators	
Indicators used in more than one paper	**Number of papers**
Clients' Perceptions of the Program	7
Housing Status	6
Self-Sufficiency	3
Psychological Functioning	3
Substance Use	3
Use of Health, Social, and Justice Services	2
General Health	2
Staff Perceptions	2
Quality of Life	2

3) Institutional discharge planning

The category of "institutional discharge planning" (IDP) was used to describe intervention programs that helped individuals transition from an institutional setting (such as a shelter or hospital) to a community setting (such as independent housing). The programs consisted of placing individuals in housing following discharge, and in some cases helping participants to strengthen the long-term ties to clinical services, families, and friends as part of the transition. In total six papers evaluated a program that fit this description.

The institutional discharge programs included in the review were directed towards individuals with no fixed address leaving either a shelter's onsite psychiatric program (Lennon, McAllister, Kuang, & Herman, 2005), general emergency shelter (Herman, Conover, Felix, Nakagawa, & Mills, 2007), or a psychiatric hospital program (Forchuk et al., 2008). All six papers focused on people with mental illness. Five of the programs specifically focused on a Critical Time Intervention (CTI) model (Herman et al., 2007; Jones et al., 2003; Kasprow & Rosenheck, 2007; Lennon et al., 2005; Susser et al., 1997).

Transitional Housing | CASE STUDY and supports

Bridgman, R. (2001). I Helped Build That: A Demonstration Employment Training Program for Homeless Youth in Toronto. *American Anthropologist*, 103(3): 779-795.

PROGRAM: Eva's Phoenix - A temporary housing and employment training program.

POPULATION: Homeless youth, under 25

TYPE OF EVALUATION: Participatory evaluation[4]

EVALUATION OBJECTIVE: Evaluate the degree to which youth's perspectives, values, expectations and participation were integrated into the project.

RESEARCH DESIGN: Ethnographic study[5] of participants and program in general

METHOD OF DATA COLLECTION: Participant observation and interviews with youth and project employees were conducted throughout the design and construction of the program.

FINDINGS: Despite a few conflicts, youth praised the project. The authors stressed the value of program flexibility and cooperation with other partners, such as employers.

4. Youth participants are involved in all aspects of planning and carrying out the program evaluation
5. Ethnography is a way of collecting information about cultural aspects of a group or organization that often involves, among other things, joining that group to see what it is like to be a member. This is called "participant observation". Ethnography may also include activities like open-ended interviews and surveys.

Critical Time Intervention is a model of short term case management (usually social work support) for people who are homeless or at risk of homelessness when they leave an institution like a hospital or shelter. In the sixth paper, the authors piloted an intervention to prevent homelessness among people discharged from psychiatric care (Forchuk, Ward-Griffin, Csiernik, & Turner, 2006).

Outcomes for individuals receiving an IDP program were contrasted with those receiving treatment as usual. Treatment as usual ranged from discharge planning with social workers, consultation on request with a case manager, community based mental health and rehabilitation services, and limited assistance with finding housing. In two of the papers, the treatment as usual participants also received direct housing placements, while the other group received CTI (Herman et al., 2007; Lennon et al., 2005). Indicators used for evaluation included housing status, psychiatric symptoms, costs of program/services, and substance use (see Table 4).

TABLE 4

Institutional discharge planning indicators	
Indicators used in more than one paper	**Number of papers**
Housing Status	6
Costs of Program/Services	2
Psychological Functioning	2

Institutional discharge planning | CASE STUDY

PROGRAM: A Critical Time Intervention program providing continuing care in the community, strengthening relationships with families and friends, and offering emotional and practical support during an individual's transition from an institutional to a community setting.

POPULATION: Homeless adults with mental illness leaving a shelter

TYPE OF EVALUATION: Outcome evaluation

EVALUATION OBJECTIVE: Evaluate the effectiveness of a CTI program on number of nights spent homeless, psychiatric symptoms, and cost effectiveness (use of emergency services, outpatient health services, housing and shelter services, and criminal justice services).

RESEARCH DESIGN: Randomized control trial[6] involving a comparison of two groups (N = 96): an experimental group receiving CTI and a comparison group receiving treatment as usual. Both groups received housing, however the treatment as usual group received discharge planning and limited consultation on request with an on-site psychiatric team about the transition to a community setting . The experimental group received CTI, an important feature of which is continuing care in the community by workers who get to know the client when they are in the hospital. Both groups had access to community rehabilitation programs, treatment, and case coordination services if they were available in their community.

METHOD OF DATA COLLECTION: Participants were interviewed when they entered the program and 6 months later for psychiatric symptoms. Information on cost effectiveness and nights spent homeless was collected over an 18-month follow up period.

FINDINGS: Individuals receiving CTI spent fewer nights homeless (30 compared to 91) over the 18-month period and had fewer psychiatric symptoms at the 6-month interview. CTI participants and the usual services group accumulated mean service costs of $52,374 and $51,649 respectively. However, due to significantly fewer nights spent homeless, the authors conclude that CTI was effective.

Herman, D. el. al. (2007). Critical Time Intervention: An Empirically Supported Model for Preventing Homelessness in High Risk Groups. *Journal of Primary Prevention*, 28:295–312.

6. A randomized control trial is a research design meant to test the effectiveness of an intervention by randomly assigning participants to either a control or experimental group. Researchers apply the intervention to the experimental group, but not the control group. They then compare the outcomes for both groups to see if the intervention made a difference.

4) Monetary Assistance

"Monetary assistance" programs provided supports such as rent subsidies for tenants, or housing subsidies directed to landlords. In total, five papers evaluated a program that fit this description. This strategy was used with several different populations. One program was oriented towards homeless and unstably housed individuals with HIV/AIDS (Wolitski, Pals, Kidder, Courtenay-Quirk, & Holtgrave, 2009), two towards homeless, or formerly homeless individuals with a history of substance use (Casper, 2004; Fisk, Sells, & Rowe, 2007), one towards low-income women (DeVerteuil, 2005), and one towards formerly homeless veterans (O'Connell, Rosenheck, & Kasprow, 2008). The most common indicator used to evaluate effectiveness of a program was housing status, used in all five papers; three papers tracked substance use, and two papers tracked self-sufficiency (see Table 5). Additional indicators included use of health, social and justice services; HIV status; psychiatric symptoms; and quality of life.

TABLE 5

Monetary assistance indicators	
Indicators used in more than one paper	**Number of papers**
Housing status	5
Substance Use	3
Self-Sufficiency	2

Monetary Assistance | CASE STUDY

Deverteuil, G. (2005) The Relationship between Government Assistance and Housing Outcomes among Extremely Low-income Individuals: A Qualitative Inquiry in Los Angeles. *Housing Studies,* 20(3): 383-399.

PROGRAM: Government assistance in the form of housing subsidies and welfare payments.

POPULATION: Low-income women staying in emergency shelters in Los Angeles, USA.

TYPE OF EVALUATION: Outcome evaluation

EVALUATION OBJECTIVE: To illustrate the relationship between government assistance and housing outcomes.

RESEARCH DESIGN: Qualitative/structured ethnographic comparison of groups of women receiving various combinations of housing subsidies and government assistance.

METHOD OF DATA COLLECTION: The author uses "structured ethnography", which includes both structured and open-ended interviews, as well as participant observation. Data collection took place in a women's shelter.

FINDINGS: The best housing outcomes were achieved by women receiving both housing subsidies and welfare. Women with one or the other kind of assistance did less well, especially if the welfare payment was unpredictable. The author describes California's General Relief program, which is conditional on participation in employment programs and time-limited, as providing only "erratic" support. Women without either kind of assistance did not always do poorly, if their lack of housing was due to temporary circumstances. Assistance in the form of housing subsidies and government programs is unevenly distributed, and welfare reform has made it more difficult for people to access government assistance. There is a lack of government-supported low-income housing policy. Overall, current welfare and housing policies make it difficult for low-income people to access support.

5) Housing mediation

"Housing mediation" programs provide skills and advice directly related to finding housing for individuals who are homeless or at risk of homelessness, as well as initial supports for tenants and landlords. In total, five papers evaluated a program that fit this description. One program was oriented towards homeless individuals with a mental or medical illness and substance abuse related issues (Bowpitt & Harding, 2008), two towards homeless youth (Hennessy, Grant, Cook, & Meadows, 2005; Slesnick, Kang, Bonomi, & Prestopnik, 2008), one towards elderly people aged 54 or older (Ploeg, Hayward, Woodward, & Johnston, 2008), and one towards families at risk of homelessness due to eviction from public housing (Mulroy & Lauber, 2004). Self-sufficiency was used as an indicator in three papers (See Table 6). Housing status, and client and staff perceptions were used in two papers. Substance use and psychiatric functioning were used in one paper.

TABLE 6

Housing mediation indicators	
Indicators used in more than one paper	**Number of papers**
Self-Sufficiency	3
Housing Status	2
Client Perceptions	2
Staff Perceptions	2

Housing mediation | CASE STUDY

Mulroy, E. and Lauber, H. (2004). A User-Friendly Approach to Program Evaluation and Effective Community Interventions for Families at Risk of Homelessness. *Social Work*, 49(4).

PROGRAM: Parents for Children and the Family Center, a USA federally funded program run by a non-profit, helps families in a public housing project avoid homelessness by providing support services.

POPULATION: Families who were previously homeless or are at risk of homelessness.

TYPE OF EVALUATION: Case Study Design[7] using a logic model[8]

EVALUATION OBJECTIVE: To assess the effectiveness of the program in preventing homelessness by promoting movement towards independent housing, employment, and civic pride within the public housing development.

RESEARCH DESIGN: The evaluation was based on findings that emerged from logic modeling.

METHOD OF DATA COLLECTION: Data for the logic model was gathered from program records, focus groups, participant observation, and interviews.

FINDINGS: Those involved in the research found the logic model was insightful. It demonstrated that the initial program goals were too ambitious and as such the model helped in streamlining program design and practice. Originally, program staff planned to provide services to all 2,500 residents of the housing development, but based on discussions with evaluators decide to focus on 93 people most at risk of homelessness. Also, program staff reduced the number of interventions they planned to provide from 72 interventions to 5 general areas of activity. Looking back, it was found that not enough data was collected about participants at the beginning of the program, as well as about the ways in which they accessed services. In general residents had successful experiences with job preparation and volunteer training programs. Of the 24 clients who contributed information to the evaluation, 67% were employed at least part time, and nearly all the others were in school or volunteering. One person had left the labour market because of a pregnancy. The authors also concluded that the evaluation helped program staff increase their organizational capacity.

7. An evaluation using a case study design looks at the program's process and outcomes as well as the context in which the program operates. These are meant to uncover factors specific to the program being studied, as opposed to producing generalizable findings on the type of program being evaluated.
8. The authors describe a logic model as "a one-page 'graphic representation of a program that describes the program's essential components and expected accomplishments and conveys the logical relationship between these components and their outcomes'(Conrad, Randolph, Kirby, & Bebout, 1999)" (Mulroy & Lauber, 2004), see page 573.

6) Modified therapeutic communities

The category of "modified therapeutic communities" (MTC) was used to describe intervention programs that centered on developing a supportive social community through self-help, role modeling, and a structured daily routine to foster change in substance use, psychological functioning and social behaviour as a means of ending homelessness (French, McCollister, Sacks, McKendrick, & De Leon, 2002; Sacks et al., 2004). Therapeutic communities typically serve people with substance use problems, whereas the MTC discussed here are designed for people who are homeless and have co-occurring disorders, that is, people with substance use problems and mental health problems and who are also homeless (Skinner, 2005). While there is a range of literature on therapeutic communities, papers were only included if they identified an explicit goal of addressing homelessness. In total, four papers evaluated a program that fit this description.

Two papers were directed towards homeless individuals with a mental illness and substance use issues (De Leon, Sacks, Staines, & McKendrick, 2000; French et al., 2002), one program was specifically oriented towards homeless veterans with mental illness and substance use problems (Skinner, 2005), and another towards homeless mothers with substance use problems (Sacks et al., 2004). In three of the four papers, outcomes for individuals in modified therapeutic communities were compared to those from individuals receiving treatment as usual (De Leon et al., 2000; French et al., 2002; Skinner, 2005). Treatment as usual consisted of the services available in the local area of the study, and varied from one study to the next. For example, treatment-as-usual might include emergency shelter, other supported housing programs, treatment programs, or case management. Indicators included housing; health, social, and justice service use; substance use; criminalization/victimization; costs of programs/services; psychiatric symptoms; HIV status; self-sufficiency; and client perceptions of programs (See Table 7).

TABLE 7

Modified therapeutic communities indicators	
Indicators used in more than one paper	**Number of papers**
Housing	2
Health, Social, and Justice Service Use	2
Substance Use	2
Criminality/Victimization	2
Costs of Program/Services	2
Psychological Functioning	2
HIV Status	2
Self-Sufficiency	2

Modified therapeutic communities | CASE STUDY

Skinner, D. (2005). A Modified Therapeutic Community for Homeless Persons with Co-Occurring Disorders of Substance Abuse and Mental Illness in Shelter: An Outcome Study. *Substance Use & Misuse*, 40:483-497.

PROGRAM: A modified therapeutic community

POPULATION: Homeless adults with mental illness and co-occurring problematic substance use.

TYPE OF EVALUATION: Outcome evaluation

EVALUATION OBJECTIVE: To evaluate the effectiveness of the modified therapeutic community on sobriety, psychiatric hospital use, consistency in taking prescribed medication, shelter use and discharge, and housing placement.

RESEARCH DESIGN: A comparison study of two groups: an experimental group (N=70) living in a MTC and a comparison group (N=70) living in a general shelter.

METHOD OF DATA COLLECTION: Participant observation and interviews were conducted throughout the design and construction of the program. Data were collected from individual case records.

FINDINGS: Overall, this study showed some promise for the MTC approach. The MTC shelter had significantly fewer subjects who were hospitalized and/or transferred to a higher level of care upon leaving the shelter. In terms of medication compliance, the MTC shelter also had more subjects who were taking their medication compared to the general shelter. Regarding housing placement appropriate to individuals' level of functioning, the MTC shelter referred all of their clients to appropriate housing, compared to the general shelter, which referred 14.3% of their clients to inappropriate placements.

7) Supportive housing

The term "supportive housing" is used to describe any housing approach that provides support services onsite, including subsidized and non-market housing identified as an intervention to address homelessness (DeSilva et al., 2011; Lipton, Siegel, Hannigan, Samuels, & Baker, 2000). In this review, "supportive housing" describes permanent independent housing approaches where support and care services are specifically linked to the housing rather than the individual. While there is a good deal of literature on supportive housing, four papers specifically concerned evaluation of a supportive housing program to address homelessness. Two of the housing programs were directed towards homeless individuals with a mental or medical illness and/or substance abuse related issues (Lipton et al., 2000; Martinez & Burt, 2006). One program was specifically oriented towards individuals with HIV (Buchanan, Kee, Sadowski, & Garcia, 2009). The fourth paper focused on clients who had not spent long periods of time in institutions and had only recently started trying to access supportive housing (Fakhoury, Priebe, & Quraishi, 2005).

Lipton et al. (2000) followed three groups of clients over a five-year period. Martinez and Burt (2006) compared use of health services before and after clients moved into one of two supportive housing sites. Buchanan et al. (2009) randomized individuals with HIV into two groups, one group received permanent housing and intensive case management and the other received usual care. Fakhoury, Priebe, and Quraishi (2005) interviewed both clients and staff about clients' goals when entering the program. Clients provided additional ratings of psychiatric symptoms and quality of life. Housing status was used as an indicator in two of the papers. Other indicators included use of health, social, and justice services; HIV status; client perceptions of the program; staff perceptions; psychiatric symptoms; and quality of life (See Table 8).

TABLE 8

Supportive housing indicators	
Indicators used in more than one paper	**Number of papers**
Housing Status	2

Supportive housing | CASE STUDY

Lipton, F. et al., (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiatric Services*, 51(4):479-486.

PROGRAM: A range of supportive housing units, categorized into high, moderate, and low intensity of support depending on the degrees of structure and independence the housing offered to residents. Structure refers to the rules and requirements and the schedule of routines and activities. Independence refers to the tenant's level of individual choice of activities.

POPULATION: Homeless persons with serious mental illness (described by authors as: schizophrenia, bipolar or another mood disorder, other psychiatric disorders)

TYPE OF EVALUATION: Outcome evaluation

EVALUATION OBJECTIVE: To evaluate the long-term (5 year) effectiveness of different types of supportive housing settings on housing status.

RESEARCH DESIGN: A comparison study of three groups (N = 2,937), 30% placed in high-intensity settings, 18% in moderate intensity settings, and 52 % in low-intensity settings.

METHOD OF DATA COLLECTION: Information was collected through administrative databases and monthly reports submitted by housing providers.

FINDINGS: After one year, 75% of participants remained stably housed; after two years, 64%; and after five years, 50%. Various features of the housing did make a difference to whether or not people stayed housed. For high-intensity settings, low medication management predicted worse outcomes, while living in conditions similar to market housing (normalized conditions) and non-congregate living arrangements were associated with better outcomes. However, in moderate-intensity settings, normalization (such as having an occupancy agreement and being allowed overnight guests) was associated with worse outcomes. People in low-intensity settings did better if they were in a place with a studio floor plan, as opposed to a single room, suite, or shared apartment. The findings of this paper show that long-term housing stability can be promoted by providing affordable supportive housing to homeless persons with serious mental illness.

8) Policy Initiatives

The category of "policy initiatives" was used to describe papers that evaluated systemic approaches to reducing or ending homelessness. Nine papers were included within this category. Policy was understood to be formal policies that guided action and decision making at either organizational or government levels. Three papers evaluated national policy (Anderson, 2007; May, Cloke, & Johnsen, 2006; O'Sullivan, 2008). Four papers focused on evaluating the integration of different government support systems, specifically the Center for Mental Health Services' project, Access to Community Care, and Effective Services and Support (ACCESS) (Isett & Morrissey, 2006; Min, Wong, & Rothbard, 2004; Rosenheck et al., 2002) and the Collaborative Initiative to Help End Chronic Homelessness (Greenberg & Rosenheck, 2010). One paper explored a housing provider's 'no eviction policy' (Gurnstein & Small, 2005) and another focused on homelessness prevention strategies used by five communities (two cities, two counties, and one state) (Burt, Pearson, & Montgomery, 2007).

To evaluate national level policy initiatives, researchers looked at the number of homeless people in the country (Anderson, 2007; O'Sullivan, 2008), and the amount and quality of emergency housing available in the country (May et al., 2006). The four papers on systems integration focused on improvements in client housing and health situations or opinions of service providers on the success of the initiatives. One group of researchers interviewed clients and staff to evaluate the 'no eviction policy' of a housing provider (Gurnstein & Small, 2005). Thus, all nine papers focused on systemic factors. Given the range of strategies and the lack of clear methodological description, we have not included a case study example in this section.

Summary of Populations/Indicators

In an overall assessment of the papers as a group, we sought to identify what populations and groups had been the focus of homelessness initiatives as well as to summarize evaluation indicators used. In the Table 9, we highlight the populations for which homelessness interventions were evaluated. In Table 10 we provide a summary of the indicators used in the papers included in this review.

TABLE 9 - Populations studied

Defining characteristic of the housing strategy's target population		
Population	**Number of papers** (N=66)	**Percentage of papers**[9]
Homeless and Mental Illness	16	24%
Homeless, Substance Use, and Mental Illness	9	14%
Homeless and Substance Use	6	9%
Homeless Veterans	5	8%
Homeless Youth	5	8%
Homeless Families	5	8%
Homeless Women	4	6%
Chronically Homeless	4	6%
Homeless with Chronic Health Condition	4	6%
Homeless	4	6%
Homeless and HIV/AIDS	2	3%
Elderly Homeless	2	3%

9. The percentages were rounded up if >.5 or down if < .5 so total may not equal 100%

TABLE 10

Summary of evaluation indicators		
Indicator	**Number of papers** (N=66)	**Percentage of papers**[10]
Housing status	35	53%
Client Perceptions	18	27%
Use of Health, Police and Social Services	16	24%
Substance Use	14	21%
Client's Psychological Functioning	15	23%
Self-Sufficiency	11	17%
Systemic Factors (features of the local housing market or policy context such as housing prices or welfare rates)	9	14%
Quality of Life	9	14%
Program Costs/Services	9	14%
Staff Perceptions	6	9%
HIV Status	4	6%
General Health	3	5%
Criminality	3	5%

Limitations

There are a number of limitations to this review. First, the review only focused on published and peer-reviewed literature. It is often the case that program evaluations are conducted within programs or organizations and rarely published or disseminated beyond programs or organizations. We did not undertake a review of non-peer-reviewed documents and it is likely such a search would have yielded additional evidence and information. However, it is often difficult and complex to do a comprehensive search of this kind. At the same time, we recognize that the lack of program evaluations in the published literature is in part due to the lack of funding to support program evaluations.

Secondly, in this project, we did not adopt a definition of homelessness. There are varied definitions of homelessness, with consensus definitions evolving in Europe, Australia, United States and Canada (European Federation of National Association Working with the Homeless (FEANTSA), 2007; Tipple & Speak, 2005). Further, there is a huge number of papers that focus on housing strategies such as supported housing that were excluded because their focus was not homelessness specifically. For example, there is a large body of literature on supported housing for people with mental illness which was excluded because the goal of these programs was not framed as addressing homelessness (Rog, 2006). Similarly, some of the transitional housing literature which focuses on women leaving violent or abusive situations would not be included because ending homelessness is not an explicit aim.

Thirdly, in our review we did not fully assess the effectiveness of the various methodologies and strategies described in the studies. While the articles are peer reviewed and published in academic journals, an overall assessment of the strength of the evidence and findings was not conducted. Rather we wanted to highlight the types of interventions evaluated, range of populations studied, and types of indicators used in such evaluations.

10. The percentages were rounded up if >.5 or down if < .5 so total may not equal 100%

Discussion

Based on this review, we identified a number of insights relevant to future research and evaluation of interventions to end homelessness. The largest category of interventions evaluated was permanent independent housing, with 20 papers in total. This category included Housing First studies that have been primarily conducted with people who are experiencing mental illness. At least one group of authors raised concerns about the lack of interventions focusing on substance use as a primary concern in housing programs for homeless people (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). While problematic substance use and mental illness can occur together, these authors identified the need to more thoroughly consider independent living as an intervention for those whose main problems are substance use and homelessness. There was, in fact, very little research found in this review that deliberately focused on people with problematic substance use.

It should be noted that Housing First programs differ from many other housing interventions in that people are placed directly into permanent housing and principles of harm reduction are embraced; that is, residents are not required to stop substance use in order to keep their housing. Harm reduction programs, such as managed alcohol programs (where instead of having to abstain from alcohol, people with alcohol addictions are provided with safer source of alcohol), which are sometimes part of housing settings, were not included in this review as they more often have a stated goal of preventing the harms of substance use rather than preventing or reducing homelessness (Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006). In particular, there is a need to better understand the housing needs of people with substance use problems, the challenges that substance use poses in re-housing, and housing providers' substance use policies in a range of housing settings.

As described above, the populations that have received the most attention in evaluations of homelessness interventions are those with mental health problems, with or without problematic substance use. There were fewer papers that focused on youth, families, women, or veterans. In general, there is a lack of attention to the importance of sex and gender in research on homelessness interventions. Only a few studies specifically focused on women or men, and only one identified gender differences as a focus of the analysis (Rich & Clark, 2005). Based on the findings of this review, it appears that there has been limited assessment of permanent housing interventions for sub-groups within the homeless population beyond those with mental illness. Of the few papers focused on veterans, youth, women, and families, almost all of these were about transitional programs, modified therapeutic communities, and housing mediation to increase self-sufficiency.

It is worth noting that there were no papers found that evaluated programs or initiatives for Aboriginal people or immigrants and refugees. Given that Aboriginal people are overrepresented among those identified as homeless in Canada, there is a huge gap in evaluations of interventions that are culturally appropriate and that reflect Aboriginal peoples' traditions, beliefs, and practices. Similarly, immigrants and refugees are overrepresented among the homeless in some urban centres, but are not represented in research evaluating homelessness interventions. These are significant gaps and extremely important areas for future research related to homelessness interventions.

> "Given that Aboriginal people are overrepresented among those identified as homeless in Canada, there is a huge gap in evaluations of interventions that are culturally appropriate and that reflect Aboriginal peoples' traditions, beliefs, and practices."

Housing status was the most common indicator used to assess the effectiveness of interventions in the studies reviewed. The main focus was on whether or not clients remained housed or returned to emergency shelters. However, there was no attention to the availability or affordability of housing in current rental markets, which are often characterized by low vacancy rates and high rental costs. In this sense, the majority of the papers in this review centered on the individual, focusing on the ability of individuals to obtain housing as well as changes in self-sufficiency or behaviour such as substance use, rather than highlighting an environment in which housing may be more or less available. Thus, evaluations seem to judge the success or failure of the individual or the program with little attention to the broader structural context in which programs and individuals exist. Given the importance of affordable housing and adequate income as part of the

response to homelessness (Parsell, 2012; Quigley & Raphael, 2001; Quigley, Raphael, & Smolensky, 2001), there is a lack of attention to how different types of interventions work in different housing markets and the reality that having enough income to pay rent is a major factor in housing stability.

It is notable that in 18 of the papers, client views of interventions, including satisfaction and quality of life, were included. Our experience has taught us that understanding clients' perspectives is critical. However, there is little focus on clients' experiences of transitioning through a particular program or transitioning from housing to home in order to understand what works or does not work in easing transitions out of homelessness. Experiences of leaving homelessness are diverse and the transition to having a home is not necessarily straightforward, nor is success assured when housing is provided (Busch-Geertsema, 2005). Studies on experiences of leaving homelessness can shed light on the things that help people find housing and feel at home in their new place, as well as the things that hinder this transition.

Further, except for changes in substance use and psychological functioning, there has been limited evaluation of the improvements in health status that come with housing. This is of particular concern, given the poor health of homeless persons discussed at the beginning of this paper and the strong relationship between housing and health (Dunn, Hayes, Hulchanski, Hwang, & Potvin, 2006; Shaw, 2004).

Conclusion

The primary focus of this review was evaluations of strategies to end homelessness and the specific interventions, sub-populations, and assessment indicators evaluated. In total, eight strategies for ending homelessness were identified. The main focus of evaluations of permanent independent housing tends to be people with mental illness, with virtually no attention given to differences in gender, age, ethnicity, or substance use within this population. This is concerning given the increasing number of homeless women, youth, and families, including people from diverse ethnic backgrounds and those with minority sexual orientations. The gap in evaluation of housing interventions for Aboriginal peoples is particularly concerning given the over-representation of Aboriginal people in homeless populations. Future research in homelessness interventions would benefit from a focus on evaluating the effectiveness of interventions for a range of sub-groups with different needs. This is particularly relevant in examining permanent independent housing solutions, currently the most studied interventions.

The evaluation indicators most frequently used are housing status and client perceptions of interventions. While these are important outcomes, there is a lack of attention to the broader structural conditions that affect access to housing and other resources. Thus, we would revise our initial research question of 'what for whom?' to ask 'what works for who under what conditions?'(Dunn, van der Muelen, O'Campo, & Muntaner, 2012). There is a need for future research that focuses on changes in health (both physical and mental) related to housing, and a particular need to better understand what eases transitions out of homelessness for a broad range of people with distinct needs.

While there are policy level initiatives to end homelessness included in this review, it appears that more attention to systemic factors in program evaluations, and more evaluations of the systems themselves are needed. This is particularly relevant given that the main solutions to homelessness include access to affordable housing and an adequate income. Thus, we suggest that in evaluating homelessness initiatives, there be attention to broader systemic responses to end homelessness.

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