Centre for
Homelessness Impact

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

Sabina Singh, Binita Sharma, Monisha Lakshminarayanan, Swati Mantri, Howard White

5th Edition (2025 Update)

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Foreword

Every day, across the United Kingdom, countless people and families face the stark reality of homelessness. It's a challenge that demands not only our compassion but also our most effective solutions. At the Centre for Homelessness Impact we've made it our business to focus the conversation on 'what works' — identifying interventions that show promise on the back of gold standard evaluations and synthesis. But we also recognise the importance of studies that seek to answer through more qualitative and non-experimental methods a more elusive question: why do these interventions truly succeed, or, heartbreakingly, sometimes fall short, even when they seem perfectly designed on paper?

This question led us to create our Implementation Evidence and Gap Map (EGM). Unlike our 'what works' map that captures causal evidence, this living, evolving resource acts as a compass, guiding us through the intricate landscape of what is needed to successfully implement homelessness interventions. It's a painstaking, yet vital, process of sifting through hundreds of process evaluations, studies that involve listening to the voices of those on the frontline – from service users to case workers, programme managers to policymakers – to understand the 'how' behind the 'what'.

With this 5th edition, our map has grown significantly, now charting the insights from a remarkable 840 English language studies from across the globe. For our UK audience, this update is particularly poignant: we've integrated 62 new evaluations from across England, Scotland, Northern Ireland and Wales, bringing our total UK-specific evidence to 213 vital pieces of the puzzle. This deep dive into our national context allows us to see patterns and nuances that might otherwise be missed. However, the lessons and insights contained within these pages resonate far beyond our borders, offering crucial guidance for a global readership grappling with similar challenges.

What has this meticulous exploration uncovered? It reveals the unseen forces that can make or break an intervention. For instance, our data shows a fascinating, yet stark, contrast: contextual factors (like the availability of affordable housing or welfare support) are twice as likely to act as barriers than facilitators. Imagine a family ready to make a fresh start, only to find a critical shortage of three-bedroom flats in their area, or facing discrimination from service providers who carry an 'aura of homelessness' prejudice. These are not mere logistical hurdles; they are deep system challenges.

Yet, there is immense hope. Insights from the map also highlight that dedicated staff and case workers are twice as likely to be facilitators than barriers. This underscores the profound impact of human connection. We've heard stories of teenagers in programmes like STRIVE+ feeling 'heard and not judged', or people in supported housing gaining 'informal emotional support' that becomes their rock. These are the emotional skills – the empathy, trust-building, and personalised approaches – that turn a service into a lifeline.

While we celebrate progress in areas like addiction support and the growing adoption of social impact bonds, our map also shines a light on persistent gaps. There's still a critical need for more qualitative evidence on the implementation of interventions related to legislation, employment, communications, and financing.

Finally, this report is also a call to action for the research community. Our critical appraisal reveals that a significant portion of studies currently offer 'low confidence' findings, often due to insufficient reporting on the relationship between researchers and participants, and ethical considerations. To truly build an impenetrable evidence base, we must collectively commit to greater transparency and rigour in our research practices.

This Implementation Evidence and Gap Map is a powerful systems thinking tool, empowering us to learn from every intervention, adapt our approaches, and work together with precision and empathy. At CHI, we will continue to strategically harness the power of this interactive map, using its insights to complement our understanding of 'what works' and collectively strengthen the evidence infrastructure. We encourage all practitioners, policymakers, and the public, both in the UK and globally, to explore the map and discover a clearer path towards ending homelessness.

Dr Ligia Teixeira,
Chief Executive, Centre for Homelessness Impact

Summary

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

This report discusses the salient features of the fifth edition of CHI's Implementation Issues EGM. The Implementation Issues EGM contains all qualitative evaluations of homelessness interventions. It organises studies according to (a) the type of intervention they evaluate and (b) issues mentioned as barriers or facilitators to successful implementation of that intervention. The fourth (2023) edition of this map contained 596[1] studies, and the fifth edition (2025) covers 840 studies (244 of which were published since the last edition). New studies were identified using updated searches conducted in September 2023.

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

More than half (approximately 57%) of the EGM's evidence is from North America, and approximately one-third (32%) is from Western Europe. The remaining evidence is from the Australasia region. This edition contains 62 newly included studies from the UK, bringing the total number of UK studies to 213 (25% of the total).

The evidence regarding implementation issues for homelessness interventions is most heavily concentrated in (a) accommodation and accommodation-based interventions (357 studies); (b) services and outreach interventions (259 studies); and (c) health and social care interventions (247 studies). The distribution of evidence within each category is also uneven. Certain subcategories are highly populated, while others have very few studies.

For example, while there are many studies on Housing First (135 studies), there are only ten studies in which hostels appeared as an intervention subcategory. There are visible gaps in the evidence base for interventions related to legislation (40 studies), employment (38 studies), communications (31 studies) and financing (19 studies). These gap areas indicate a need for qualitative evaluations in the identified areas. There are other areas in which there were gaps previously which are now better populated: substantial increase of studies in areas of the map that were not populated including addiction support (+30), discharge (+10), social impact bonds (+10) and mentoring and coaching (+7).

The highly populated areas of evidence constitute opportunities for conducting systematic reviews. CHI has commissioned systematic reviews in areas with concentrations of evidence around interventions for people experiencing, or likely to experience, homelessness. These include published reviews on accommodation-based interventions (Keenan et al., 2021), health and social care interventions (Miller et al., 2020), discharge interventions (Hanratty et al., 2020), case management interventions (Weightman et al., 2023), and abstinence-based and harm-reduction based interventions (O'Leary et al., 2024). There are also a few ongoing reviews on psychosocial interventions (O'Leary et al., 2022a and O'Leary et al., 2022b). These systematic reviews are critical for ensuring evidence-based decision making in the field of homelessness.

In addition to those mentioned above, plausible areas in which to conduct systematic reviews include those that focus on enhancing the capabilities of people experiencing homelessness, such as education and skills interventions and employment interventions.

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

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

The critical appraisal suggests that we can place medium confidence in the findings of less than one-fifth of the studies (17%). As many as 79% of the studies were assessed to be of low confidence. Only 4% of studies were assessed to be of high confidence. Though most included studies describe the research questions, methods, and analysis sufficiently, details about the relationship between researchers and participants are largely missing. Therefore, the two main reasons identified for low confidence in findings were a lack of disclosure of the relationship between researchers and participants and insufficient reporting of ethical considerations.

1. Methodology

The scope of the fifth update of the implementation issues map remains the same as the previous edition. The fourth edition of the EGM included a change in the studied population. In that update, studies of people who work with people experiencing or at risk of homelessness, such as landlords, healthcare professionals, and teachers, were also included. Up to the fourth edition, only studies of individuals who were experiencing or at risk of homelessness were eligible for the EGM. The published protocol of the map may be accessed here.

We endeavour to use and test innovative and advanced methods to update evidence in every edition of the map. For instance, in addition to the database searches, intervention-specific search terms were used in the fourth edition of the map, accompanied by title and abstract screening conducted via Cochrane Crowd. A comprehensive grey literature search was also conducted, in addition to a search based on machine learning.

The studies in the present edition of the map were identified using machine learning via OpenAlex in EPPI Reviewer. The supplementary searches were conducted using intervention-specific search terms. Additionally, selected websites for various countries eligible for the map were searched. Hand searches/ screening of selected journals was done for the past year. Backward citation tracking was conducted for selected eligible studies. Additionally, a list of studies identified by CHI was included for screening. Details of various search strategy components are discussed below.

Automated Searches Using Machine Learning Features of EPPI Reviewer

Searches for the current update were conducted by using the automated search feature within the EPPI-Reviewer software. The software identifies studies from the OpenAlex database using an inbuilt automated (machine learning) search feature.[2]

The automated search feature of EPPI Reviewer is based on machine learning, whereby the software helps in identifying records related to an existing set of eligible studies. Included studies from the previous edition of a review are provided to the machine as a training dataset. The machine then fetches a list of records that may all be imported to the EGM database in EPPI Reviewer. Alternatively, the user can import only selected records from the list. We chose the former option, whereby the entire list of records was imported to the EPPI reviewer for screening.

We ran automated searches to capture studies for both the effectiveness and implementation maps, providing studies from previous editions of both as a training dataset. The details of other search strategy components are given below.

Grey Literature Searches

A comprehensive manual search of websites and other grey literature was carried out using a systematic combination of search terms. Intervention-specific search terms combined with population and study design search terms provided additional studies.

We used Google as the starting point to identify eligible records using the intervention-specific search strings (**Appendix 1**). Boolean operators AND and OR were used in the search strings. These search strings included synonyms of intervention categories combined with population and study design using the Boolean operator AND.

Google Scholar was also used with relatively simple search terms such as 'Homeless', 'Critical Time Intervention', 'Evaluation', etc. to identify eligible studies. The research team in India conducted the searches in Google, and all the searches were conducted in 'incognito mode' or a private window depending on the browser used. The search dates and search engine page numbers on which the potentially eligible studies appeared were recorded.[3]

For the website searches, we searched various institutional and organisational websites dedicated to homelessness in various countries, as in the previous updates of the map. The list of websites searched is given in **Appendix 2**. The details about potentially eligible records for both the maps were noted and the records were manually created in EPPI Reviewer for screening.

Before importing, all potentially eligible records from searches were checked for duplicates within the list and in EPPI Reviewer. The potentially eligible and non-duplicate studies were imported into the EPPI Reviewer for screening.

We conducted hand searches (online screening) of all issues of journals selected in previous updates that were published in the past year . The list of journals and dates of searches are given in **Appendix 3**. References mentioned at the end of selected eligible records were also screened to identify further eligible studies.

A list of potentially eligible studies identified by CHI was also included for screening. The list was checked for duplicates, and new records from this list were created in the EPPI reviewer.

Deduplication in EPPI Reviewer

All searches, including machine learning and grey literature searches, were imported into the EPPI Reviewer to remove all duplicate studies identified through different sources. Deduplication in EPPI Reviewer can be done by using the automated 'Duplicate' function, whereby the records identified on a similarity index score are identified as duplicates. The user can then select one of the records as a master record. Replicas may be marked as duplicates. However, it can often be the case that certain records are not identified as duplicates automatically by the machine due to limitations related to the similarity index score. These records must be manually identified.

We sometimes came across duplicates while conducting screening and coding and addressed these issues at these stages. However, to effectively identify duplicates manually, we screened all the records towards the last stages of map generation, when the number of records to be checked manually was not very high, and there was a very low probability of missing any duplicates. This was done by adjusting the number of records appearing on the EPPI Reviewer screen to accommodate all eligible records, arranging them alphabetically by study titles in an ascending or descending order, and screening the records for duplicates. When arranged in this manner, the duplicate records appeared one after the other, rendering their identification relatively simple.

All the records were then cross-checked a second time, arranging the authors' names alphabetically. Any duplicate records missed due to slight dissimilarities in their titles were captured at this point. At this stage, we also ensured that the seemingly duplicate records were indeed duplicates by checking the uploaded PDFs.

Title and Abstract Screening

Two independent reviewers screened all the studies based on their titles and abstracts using the inclusion and exclusion criteria of this EGM. Disagreements between the two reviewers were resolved through discussion. If there were still disagreements regarding including or excluding a study, a third reviewer was consulted.

A total of 1,862 records were identified from machine learning (ML) searches, of which 159 were automatically marked as duplicates in EPPI Reviewer. A comprehensive grey literature (GL) search led to the identification of 357 records, of which 10 were duplicates. After deduplication from both the ML and GL searches, there were a total of 2,050 records in EPPI Reviewer for title and abstract-level screening. A total of 1,134 ineligible records were excluded during title and abstract screening, leaving 916 studies to be screened based on the full text.

Full-text Screening

A total of 916 studies were to be assessed for inclusion at the full-text stage. The full texts of 17 records could not be retrieved. Six duplicates were also identified at this stage, thereby reducing the number of records to be screened at full-text to 893. The full-text screening is different from the title and abstract screening as the entire PDF of a specific record is scanned for inclusion. In addition, the reasons for exclusion are given for every excluded record.

As with the title and abstract screening, full-text screening was also performed independently by two reviewers. Disagreements between two reviewers were resolved through discussion or by involving a third reviewer. As we ran the searches to cover studies for both the effectiveness and implementation maps, studies were included in either or both maps upon the assessment of the full text.

A total of 441 records were included: 128 were included for the effectiveness map, and 347 were included for the implementation issues map. A total of 34 records from the included studies were included for both maps. The remaining

452 records were excluded at the full-text stage. The reasons for the exclusion of the records at the full-text screening stage are listed in the PRISMA flowchart (Figure 1). When the 347 studies included in the implementation issues map were imported via EPPI Reviewer, another 21 records were identified as duplicates. Furthermore, the full texts of 18 records could not be retrieved. These exclusions left 308 records for data extraction in the implementation issues map.

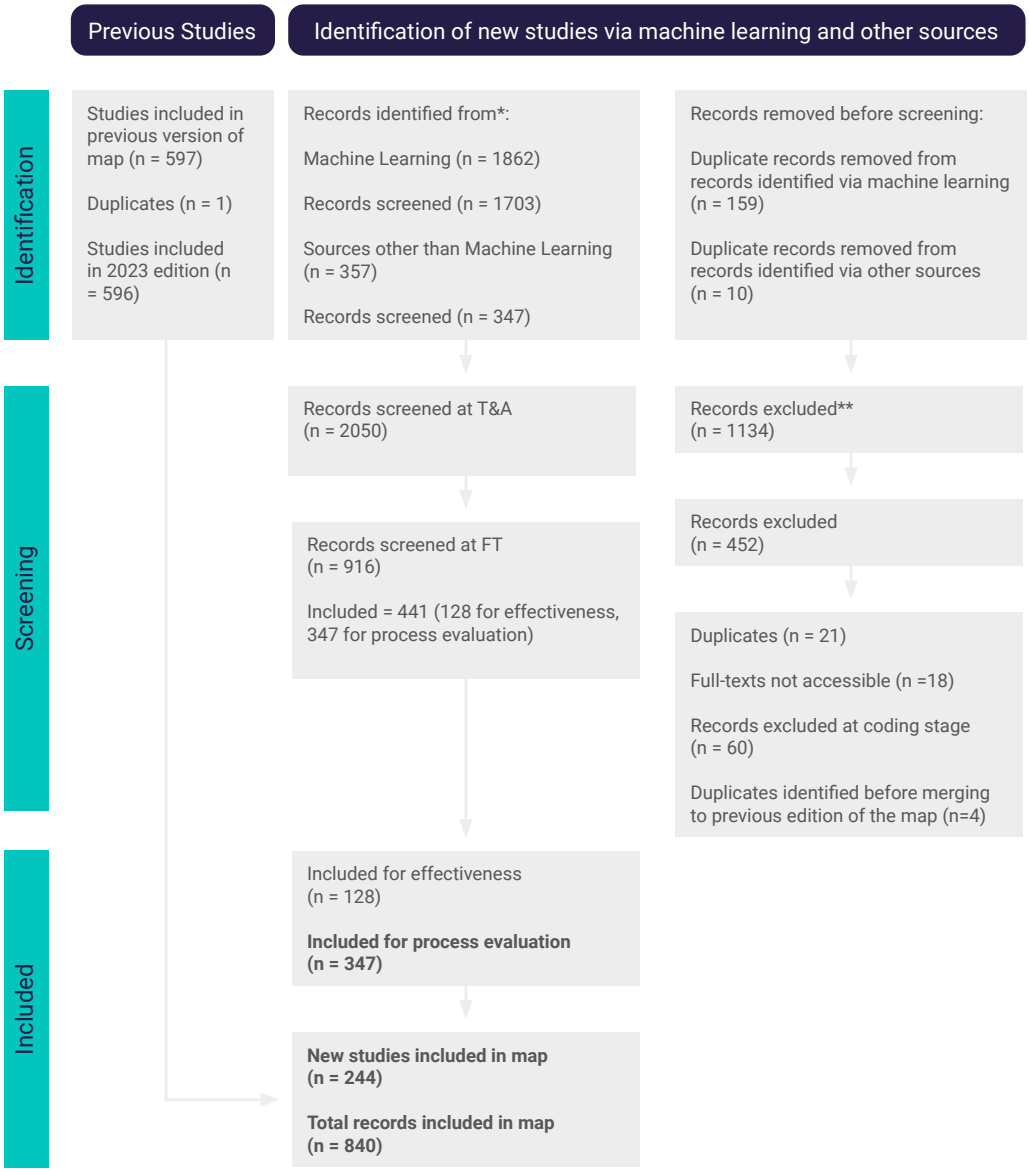
Data extraction and critical appraisal of included studies

Two independent researchers for this EGM completed data extraction for the 308 records selected at the full-text stage. Line-by-line coding and the 'comparison report' feature of EPPI Reviewer were used in this process. The results of the two researchers' data extraction were compared for differences, and disagreements were resolved by an arbitrator.

Of the 308 records considered, 60 were excluded during the coding stage. Most of these records were excluded based on study design criteria. In addition, a few records were excluded because they constituted ineligible evidence, such as letters to editors. After these exclusions, the number of records ultimately coded for this edition of the implementation issues map was 248.

Data extraction was completed for all 248 records, while critical appraisal was conducted only for the 233 studies which were completed. CASP checklist for primary studies and AMSTAR 2 checklist for systematic reviews were used to assess the confidence in the findings of the studies.

Figure 1: PRISMA Flowchart



Source: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Before merging the newly identified 248 records to the existing map (n=596), a duplicate check was conducted. Four duplicate records were identified at this stage. After deduplication and the addition of newly identified records (n=244), there are a total of 840 records in the updated EGM. The PRISMA flowchart (**Figure 1**) depicts the studies included in the previous version of the map and those added in the current update.

2. An overview of the Implementation EGM

There is a substantial body of evidence regarding implementation issues among interventions for people experiencing, or at risk of experiencing, homelessness. The latest version of the map contains 840 studies – 244 more than the fourth (2023) edition, which included 596 studies.[4]

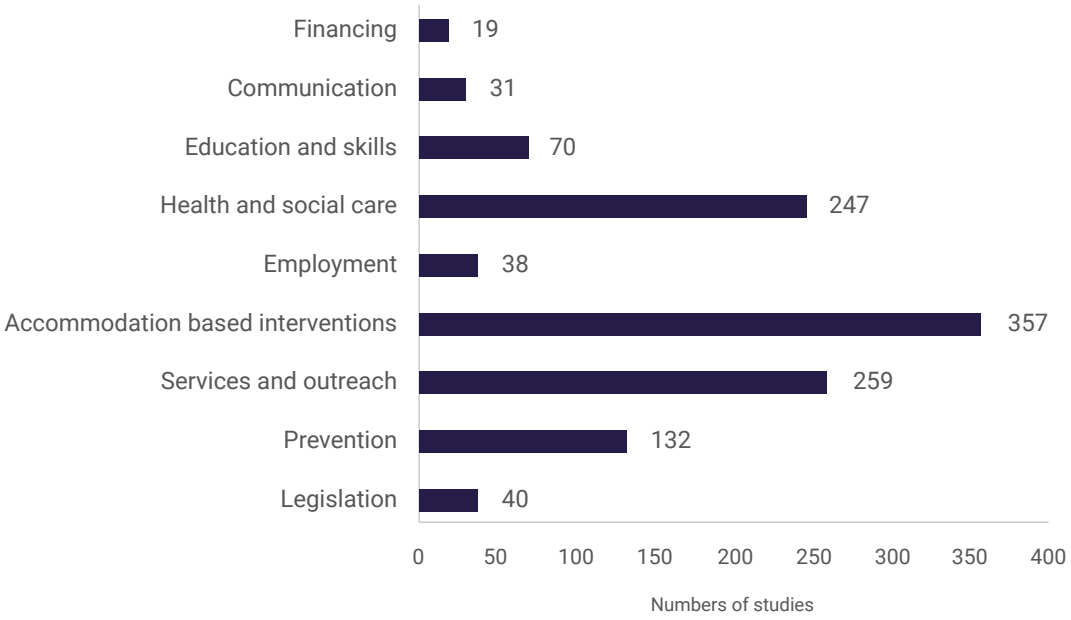
This section gives a broad overview of the map, highlighting the number of included studies by intervention categories, the regional distribution of studies, and the publication years of studies. A comparison is drawn between studies included in this edition of the map and those included in the previous edition to identify trends or patterns.

2.1 Included studies by intervention

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

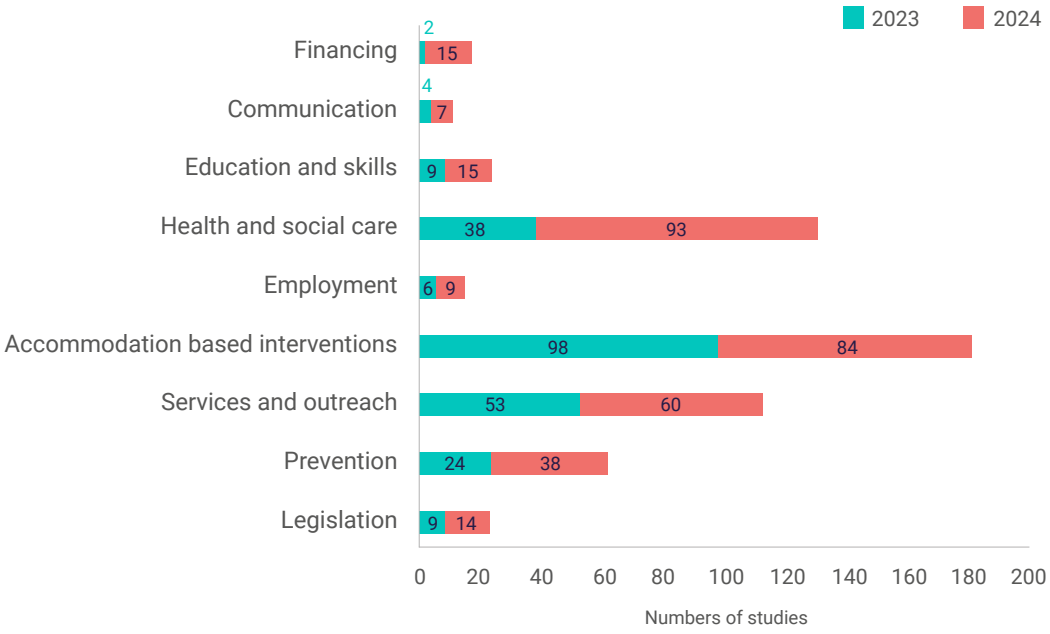
As we see in Figure 2, the evidence for implementation issues in homelessness interventions is heavily concentrated in (a) accommodation and accommodation-based interventions (357 studies); followed by (b) services and outreach interventions (259 studies); and (c) health and social care interventions (247 studies). The number of included studies for prevention, education, and skills and legislation interventions are 132, 70, and 40, respectively. There are visible gaps in the evidence on interventions related to employment (38 studies), communication (31 studies), and financing (19 studies). The EGM gap areas indicate that there is a need for primary studies on these topics.

Figure 2: Included studies by intervention categories (overall)



The number of studies evaluating the implementation of health and social care interventions increased the most in this edition of the map, with the addition of 93 new studies, followed by accommodation-based interventions (83 new studies). This could be due to increased evaluation of these types of interventions following the COVID-19 pandemic. There are 60 more studies evaluating services and outreach interventions in the present edition of the map. In addition, compared to the previous map, there is a greater number of studies evaluating evidence on interventions related to financing (15 new studies) and legislation (14 new studies). Fifteen new studies related to education and skills interventions were also added to the map in the latest update (**Figure 3**).

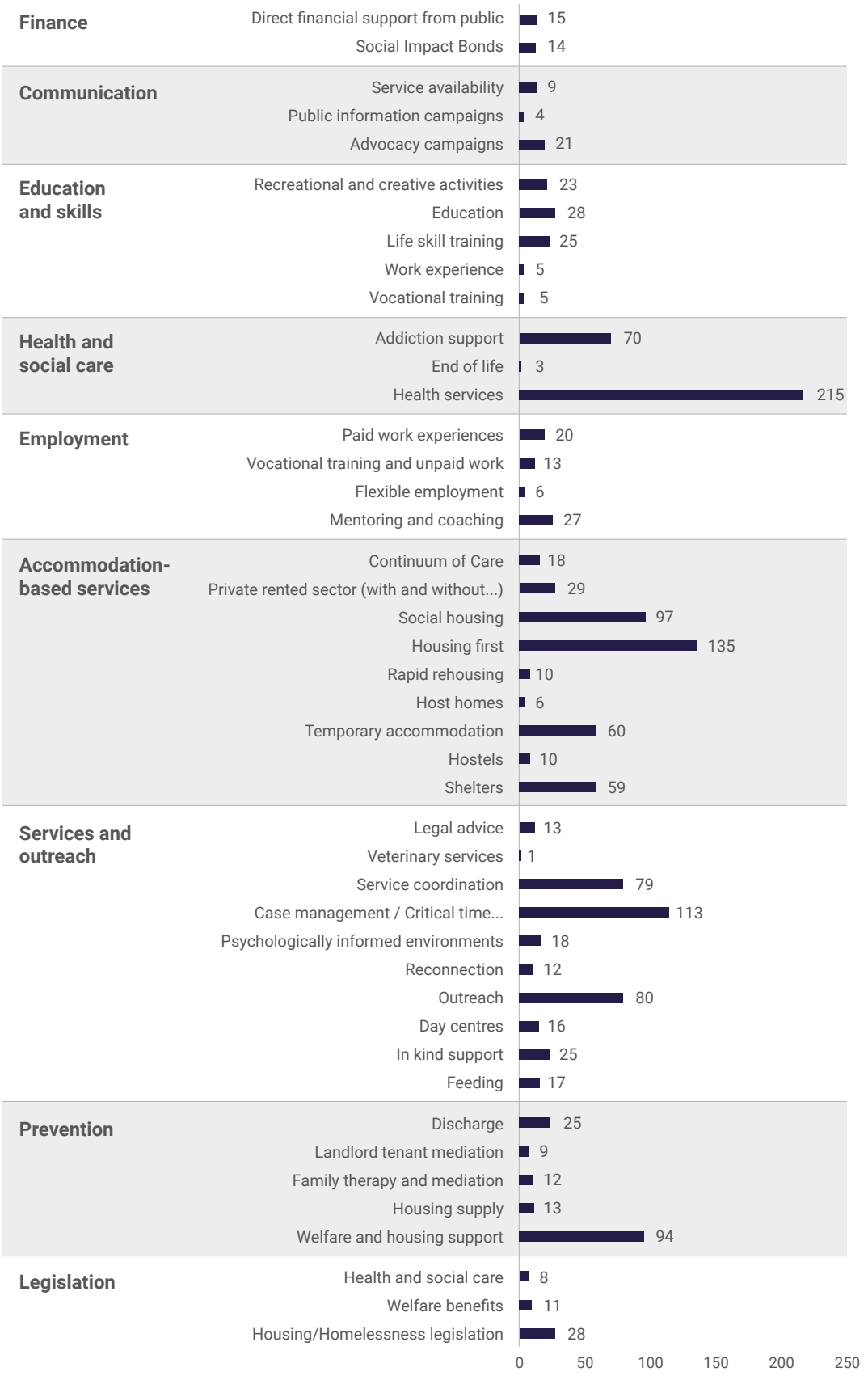
Figure 3: Distribution of newly included studies by intervention categories in the fourth (2023) and fifth (2024) editions of the Implementation EGM



As seen in Figure 4, the distribution of evidence within each intervention category is also uneven, whereby certain subcategories are highly populated while others appear in very few studies. For instance, while there are many studies addressing Housing First (135 studies), there are only ten studies in which hostels and rapid rehousing appeared as an intervention subcategory under the accommodation-based interventions.

As is evident in Figure 4, the least-populated sub-intervention areas in the map are work experience, end-of-life, flexible employment, public information campaigns, vocational training and social impact bonds. The least-represented sub-intervention categories fall within broader intervention categories that otherwise represent highly populated areas – but for other interventions.

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



Some differences are also observed in the 2023 and 2024 editions of the map for various sub-intervention categories. Appendix 6 provides a breakdown of the total number of studies per sub-intervention category, as well as the number of new studies included in this edition of the map per category.

There are several areas where no new studies were found for sub-intervention categories such as day centres, host homes, vocational training, and public information campaigns. Conversely, the 2025 update has added a substantial number of studies to already well-populated sub-intervention categories such as health services (+75), Housing First (+27 studies) and case management/critical time intervention (+24 studies)

Importantly, the 2024 edition included a substantial group of studies to areas that had a moderate or small number of studies in previous versions including addiction support (+30), discharge (+10), social impact bonds (+10) and mentoring and coaching (+7).

A detailed description of some of the sub-intervention categories is provided in section 3.

2.2 Included studies by region and country

As seen in Figure 5, the regional distribution of studies suggests that the highest number of studies added in this edition of the map is from North America (n = 144), followed by Western Europe (n = 83), and Australasia (n = 36). The individual editions of the map (2021, 2022, and 2023) reflect the same trend, with the highest number of studies from North America (480 in total), followed by Western Europe (270) and Australasia (119). However, in the present edition, the number of studies across various regions has substantially increased compared to the 2023 edition.

In terms of the geographical distribution of the included studies, Table 1 shows the five countries with the highest number of studies in the map, along with their relevant figures for the latest and previous editions of the map. The highest number of studies in the latest edition of the map is from the US, constituting approximately 43% of newly added studies (i.e. 104 of 244). The number of studies from the UK accounts for approximately 25%. The number of studies included from Australia and Canada comprise 13% and 19% respectively.

Table 1 shows the number of studies for selected countries added to the EGM in the 2023 and 2024 editions of the map. The number of newly added studies from Canada in the 2024 edition is lower than the 2023 edition. The representation of remaining selected countries in the map in the 2024 edition is higher than in the 2023 edition. Though the number of studies from Australia is only marginally higher than in the 2023 edition, the number of studies from the UK have almost doubled in the 2024 edition.

Figure 5: Regional distribution of included studies by report edition

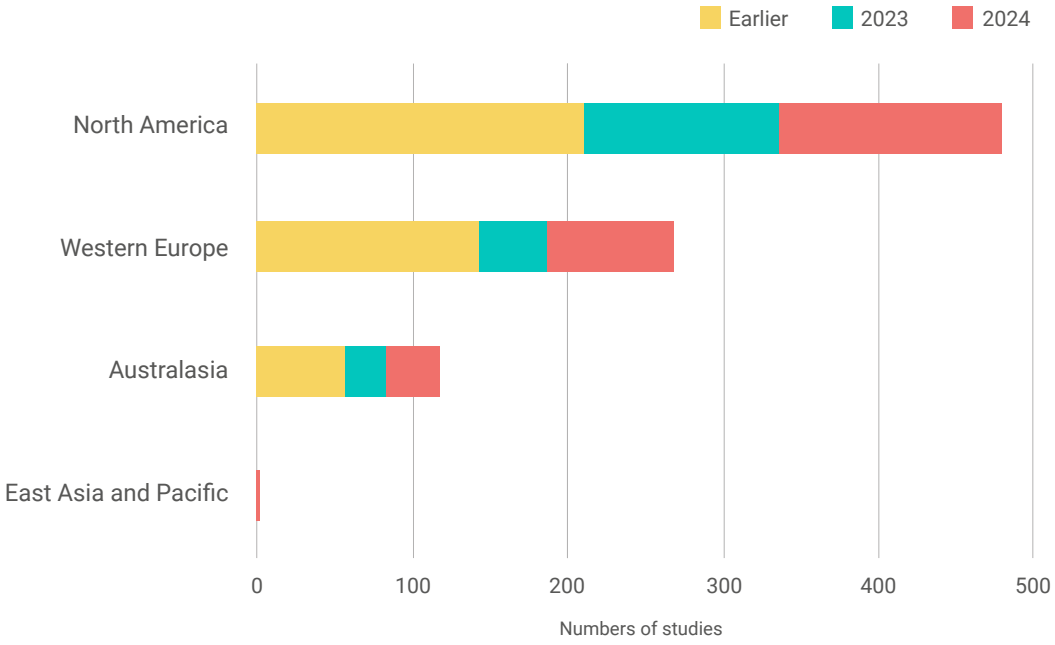


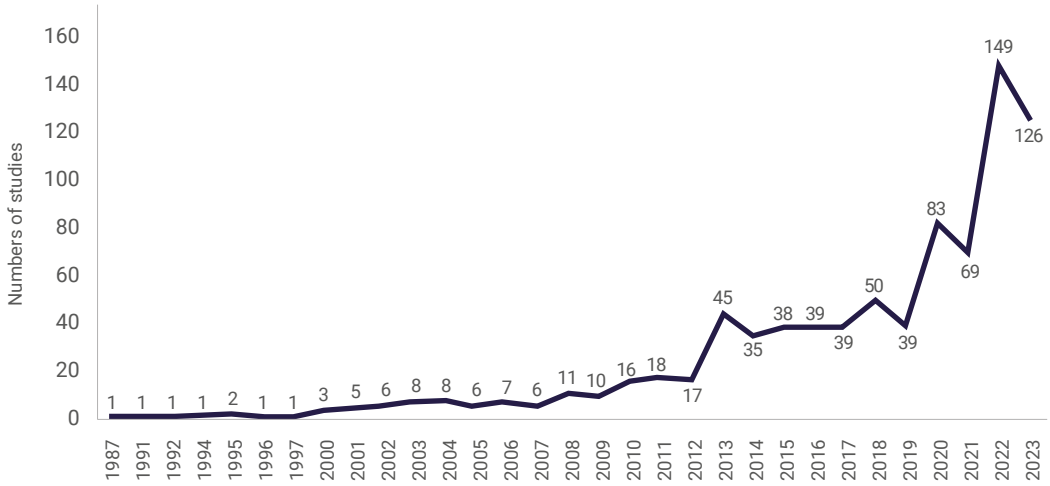
Table 1: Number of studies by countries (current, previous edition and overall)

Country	Number of additional studies in the 2023 edition	Number of additional studies in the 2024 edition	Total number of studies in EGM
US	74	104	327
UK	33	62	213
Canada	52	46	164
Australia	24	32	112
Ireland	3	13	30

2.3 Included studies by year of publication

The number of studies published each year is increasing rapidly overall, with occasional dips in certain years. Figure 6 shows the distribution of studies in the map by year of publication. Only three studies were published in the year 2000 while 83 studies were published in 2020. There has, however, been a sudden rise in the number of studies published since 2020. Before 2020, the number of published studies never exceeded 50 per year (the highest was 50 in 2018). The year in which the highest number of studies was published was 2022 (n = 149), followed by the first three quarters of 2023 (n = 126) and 2020 (n = 83).[5] A dip in the most recent year is common as papers are not yet published or indexed.

Figure 6: Studies by Year of Publication (overall)



3. Included studies by sub-intervention categories

The evidence on implementation issues for homelessness interventions is most heavily concentrated in the sub-intervention category of health services (215 studies), followed by Housing First (135 studies), and case management/critical time intervention (113 studies).

3.1 Interventions related to health services

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

Primary Healthcare for people experiencing homelessness

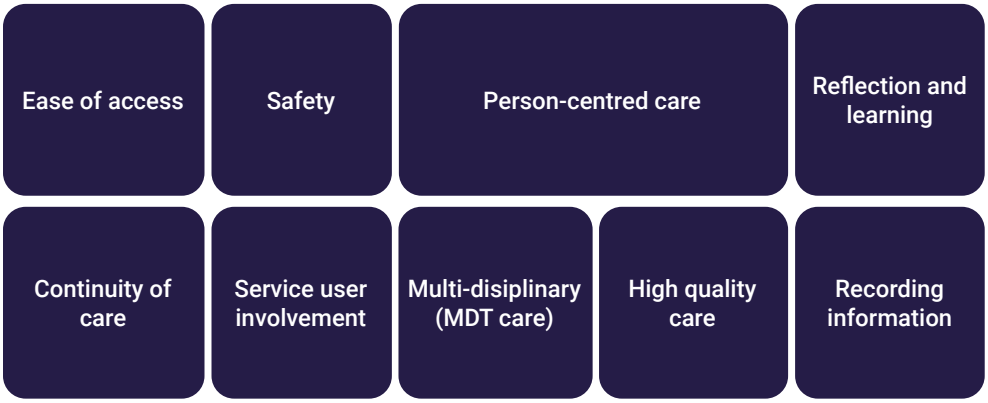
An intervention delivering bespoke, city-centre primary healthcare services for patients experiencing homelessness – meaning those living in temporary accommodation and hostels, as well as rough sleepers and 'sofa-surfers' – was based on the Faculty for Homeless and Inclusion Health framework (Clarke et al., 2020). This service offered additional support, such as visiting in-reach drug and alcohol support workers, a Hepatitis C clinic, a needle exchange, a shower, and some necessities, including donated clothes.

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

The clinic was created as a unique initiative to act as a point of entry to services for a population known to face numerous obstacles to receiving care. Building healthy relationships with the young people served by the clinic was considered

crucial to achieving this aim. Instead of expecting the young people to adapt to the intervention, the goal was to integrate the programme's services into their daily lives. Housed in a former fire station that had also been converted into a public library, the 45th Street Clinic did not look like a traditional treatment centre. The programme attempted to integrate itself into a network of youth services, while simultaneously being promoted in the neighbourhood as a unique youth programme. The clinic operated in the evenings when young people were more likely to be available (Clarke et al.,2020).

Figure 7: Faculty for Homeless and Inclusion Health Framework



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

Medical Respite Programs (MRP) provide acute and post-acute medical care for people experiencing homelessness who are not sick enough to be hospitalised but who are too sick or frail to recover from physical illness or injury on the streets. An MRP in Alberta, Canada was situated on one floor of a drop-in centre with a capacity to accommodate 16 patients at once. Five of the 16 beds were designated for patients who required temporary care, while 11 beds were dedicated to patients who required full-time care. Referrals to the MRP came via AHS Home Care, from acute care hospitals, and from the community (i.e. via clinics and/or organisations that assist people experiencing homelessness).

A full-time nursing coordinator conducted an initial assessment upon admission to ascertain each patient's medical needs and care plan. Based on this information, multidisciplinary staffing and nursing support, including the frequency of support visits, were planned for each patient. Personnel also 'checked in' on each client in the programme daily to make sure the care plan was still suitable, that no new requirements were discovered, and that handover information was received from the overnight shelter personnel every morning. An on-site healthcare assistant was accessible for 16 hours every day to help with everyday life tasks, such as administering medicine (Hoang et al., 2023).

Mindfulness and mental health

The SHINE ('Support, Honour, Inspire, Nurture, Evolve') intervention for mother-child dyads taught mindfulness awareness techniques to those facing issues with their physical and mental health, as well as poverty, homelessness, addiction, or abuse (Alhusen et al., 2017). This intervention was used at the PACT Therapeutic Nursery in conjunction with the parent-child play activity known as 'mindful awareness play', in order to encourage mutual regulation, to strengthen family ties, and to lessen stress and anxiety. The meticulously planned weekly exercises were founded on convincing scientific proof that meditation can have a clear favourable impact on immunological and brain function. To provide a predictable structure to the group meeting, specific features were repeated each week (e.g. reviewing group agreements, passing a 'talking stick' for individual comments, and sharing mindful 'victories' that parents experienced in the previous week). Each programme included three formally guided meditations. An informal 'key to mindfulness' practice was also taught every week through interactive exercises, peer teachings, and demonstrations. Each 'key' provided a straightforward technique that parents might use to intentionally pause and engage in self-reflection. Each parent received a 'key' tag at the end of the session that matched the day's mindful instruction, which they could keep in their pocket as a reminder to practise mindfulness (Alhusen et al., 2017).

Likewise, a strengths-based dyadic intervention called Support to Reunite, Involve, and Value Each Other (STRIVE) is found to be effective in lowering drug use, criminality, and high-risk sexual behaviour among marginalised adolescents facing homelessness (Bounds et al., 2023). An adapted version of STRIVE, the STRIVE+ intervention, was used among young people experiencing homelessness to address commercial sexual exploitation in an urban setting in the US. STRIVE is a strengths-based, dyadic, manualized intervention that includes five 90-to-120-minute psychoeducational sessions. A trained facilitator delivers the sessions weekly. The main goals of each session are to strengthen family bonds, enhance communication abilities, and solve problems by applying the principles of cognitive behavioural therapy.

3.2 Interventions related to accommodation provision

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

Permanent housing and care

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

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

Young people participating in a Housing First plus preventive/support services intervention in a large Mid-Western city in the US were interviewed to better understand the implementation of the intervention.

Independent housing, HIV prevention, Strengths-Based Outreach and Advocacy (SBOA), and Motivational Interviewing (MI) were all integrated into Housing + Opioid and Related Risk Prevention Services. The young people participating received six months of utility and rent support, up to $600 a month, and were placed in an apartment of their choosing. Participation in preventive services or substance use treatment was not a requirement for independent residence. With this method, SBOA, MI, and HIV risk reduction happened all at once. To connect participants to further support if they needed it after the intervention session ended, advocates facilitated connection with community resources (Brakenhoff et al., 2022).

Housing and individualised services

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

A study conducted in Canada explored case managers' perspectives of a short-term case management (STCM) model. Similar to intensive case management (ICM), STCM is a community-based intervention in which a client collaborates with a case manager to address unmet needs and customised goals. Case managers normally meet with clients once a week for about an hour in both intervention approaches; however, the unique aspect of STCM is that services are limited in time, with a maximum duration of three months. ICM services, on the other hand, might last for several years.

Critical Time Intervention (CTI) served as an inspiration for the development of STCM. CTI is an evidence-based intervention designed to assist people going through a crisis or making the move from an institution to a community environment. CTI is well-established in the literature and has demonstrated efficacy in treating a variety of populations facing mental health issues and illnesses, including women with a history of domestic abuse, children in high-risk households, and men experiencing homelessness (Duncan et al., 2023).

Housing and care for young people

The delivery of electronic case management services for homeless youth was offered through four sessions every 2–3 weeks over three months (Bender et al., 2015). A case manager contacted participants three times – first via mobile phone and then, in cases of no response, via text and another mobile phone call. If there was no response again, the participant was called, texted, and reached through email or Facebook.

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

Transitional care

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

Social housing

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

3.3 Interventions related to prevention, services and outreach

Preventive interventions include welfare and housing support, housing supply, and discharge-based services. Welfare and housing support interventions, and outreach interventions, appear in 94 and 80 studies in this map, respectively.

Welfare and housing support and service coordination

A programme titled 'Eviction Prevention in the Community' provided services to tenants facing imminent risk of eviction in Toronto, Canada, using a blended model of direct and contracted community agency service delivery. The programme's specialised services included comprehensive case management

assistance, assistance securing income supports, money management programmes, system navigation and referral to other services and support, rehousing support and shelter diversion, referrals to community legal support, and navigation/accompaniment to the landlord-tenant board (Ecker, Holden and Schwan, 2018).

Outreach

The Downtown Street Outreach Initiative involved outreach workers identifying and engaging with people experiencing homelessness on the street. These workers attempted to understand the issues experienced by participants and connect them with appropriate services and support. In addition, outreach workers established connections with other service providers and downtown stakeholders, engaging them in discussions about the best methods to satisfy the needs of the local population experiencing homelessness (Alana LaPerle Project Services, 2012).

The Los Angeles City Attorney's Office (LACA) designed the Los Angeles Diversion, Outreach, and Opportunities for Recovery (LA DOOR) programme, funded by Proposition 47. The programme offered a comprehensive, health-focused, preventive approach that proactively engaged individuals at an increased risk of returning to LACA for a new misdemeanour offence related to substance use, mental illness, or homelessness. In this programme, a multidisciplinary social service team from LA DOOR proactively engaged people in five hotspot areas with a range of social services. Those who signed up for LA DOOR could receive a range of services, such as mental health services, health and wellness checks, SUD treatment, housing services, legal services, and peer case management services (Labriola et al., 2023).

4. Analysis of implementation issues (barriers and facilitators)

4.1 Overview of barriers and facilitators

Everything that is a barrier is also a facilitator. For example, management buy in is a facilitator if present but a barrier if absent. Another example is that, lack of skills or poor performance of case workers discouraged recipients to effectively participate or engage in the programme. But good case workers can have positive motivational effects.

Overall, there are rather more facilitators reported than there are barriers: 4,291 facilitators are identified across the 840 studies compared to 3,698 barriers (Table 2).[6] The most common facilitators are from recipients (30 per cent of all facilitators) and staff and case workers (27 per cent). But recipients are also the second most common barrier (30 per cent), with "Program administrator/ manager/ implementing agency" being the most common barrier (35 per cent), followed by recipient (28 per cent).

As shown in Table 2, the distribution of barriers and facilitators across types is not the same. Contextual factors are twice as likely to be identified as a barrier as a facilitator, and the category "Program administrator/ manager/ implementing agency" is also more commonly identified as a barrier than a facilitator. In contrast, staff and case workers are twice as likely to be a recognized facilitator than barrier, and programme recipients are nearly 30% more likely to be facilitators than they are barriers.

Table 2 Barriers and facilitators by type

	Number		Share		Ratio
	Facilitators	**Barriers**	**Facilitators**	**Barriers**	**F/B**
Contextual factors	210	428	4.9	11.6	0.49
Policy maker/ funders	332	345	7.7	9.3	0.96
Program administrator/manager/ implementing agency	1154	1275	26.9	34.5	0.91
Staff/ case worker	1,291	632	30.1	17.1	2.04
Recipient of program	1304	1018	30.4	27.5	1.28
Total	4291	3698	100.0	100.0	1.16

Table 3 Facilitators and barriers by intervention category

	Number		Share		Ratio
	Facilitators	**Barriers**	**Facilitators**	**Barriers**	**F/B**
Legislation	91	111	3.1	3.9	0.82
Prevention	319	324	10.9	11.4	0.98
Services and outreach	731	657	25.1	23.1	1.11
Accommodation based interventions	909	932	31.2	32.8	0.98
Employment	92	85	3.2	3.0	1.08
Health and social care	506	489	17.4	17.2	1.03
Education and skills	147	128	5.0	4.5	1.15
Communication	83	68	2.8	2.4	1.22
Financing	38	50	1.3	1.8	0.76
Total / overall	2916	2844	100.0	100.0	1.03

The distribution of barriers and facilitators across intervention categories is very similar (Table 3, columns 3 and 4). The final column of Table 3 shows the ratio of facilitators to barriers by intervention. There are notably fewer facilitators than there are barriers for financing (ratio 0.76) and legislation (ratio 0.82), whilst the reverse is the case for communication (1.22), education and skills (1.15) and services and outreach (1.11).

4.2 Barriers

The aggregate map for the intervention categories and barriers is presented in Table 4. The intervention-barrier matrix in this aggregate map indicates the number of studies which evaluate a given intervention and mention an implementation issue as a barrier to successful implementation. These numbers represent instances of a particular barrier appearing in a particular study. Examples of the barriers mentioned in a study are below.

In Table 4 there are three rows for each intervention. The first shows the number of studies coded as reporting a barrier of that type for that intervention category (a list of these studies is obtained by clicking the cell in the interactive online map). The second row shows the share of that type of barrier in the total number of barriers faced by that intervention category. And the third row shows the ratio of that share to the share of the barrier across all interventions. Hence a ratio of

greater than 1 shows that that barrier is more prevalent for that intervention than is generally the case.

Many of the ratios are close to one, suggesting that the same sorts of barriers are common across intervention categories. But there are exceptions. Legislation is far more likely than the norm to face barriers related to policy makers (ratio 1.64) and somewhat more likely from contextual factors (1.15). But there are relatively far fewer barriers on account of staff and case workers (0.54). Communication interventions are also less likely to have problems related to staff and case workers (0.89), but have a substantially greater share of problems from policy makers or funders (1.59). In contrast, both education and skills and health and social care are more likely to have barriers related to staff and case workers (both have a ratio of 1,21), whilst being less likely to face barriers from contextual factors (0.79 and 0.75 respectively) or policy makers and funders (0.88 and 0.82).

As an example of issues related to staff, an early implementation evaluation of a Canadian multi-site Housing First intervention, it was noted that the programme recipients experienced challenges in accessing non-housing support due to a lack of staff competency. The authors identified unique challenges in hiring and training culturally competent staff to accommodate the needs of Aboriginal participants. Participants in Toronto suggested that the programme had difficulty meeting the cultural and linguistic requirements of their diverse population (Nelson, 2013, p. 23). To this end, a significant number of recipients reported an inability to completely buy into the programme and showed distrust for authorities (Cox, 2021; Choi, 2022; Harris, 2022; Milburn, 2023; Oudshoorn et al., 2018; Thomas et al., 2023).

Studies assessing health and social care interventions mostly captured barriers from the perspective of the programme administrator, manager, implementing agency, and the programme recipients.

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

> *'The doctors are only here once a week for a couple of hours. If I need to talk to one and like and it's Tuesday, what …have I got to do, wait till Friday at one o'clock? No. Sorry. That's not going to cut it…I think they should have a nurse 24 hours a day. It would be better for us because a lot of people have seizures and overdoses here' (MacKinnon, 2022: 24).*

Table 4: Aggregate Implementation EGM of included studies for intervention and barriers

	Contextual factors	Policy makers/ funders	Program administrator/ manager/ implementing agency	Staff/ case worker	Recipient of program	Total	Memo: As percent of column total
Legislation	**17**	**20**	**25**	**10**	**27**	**99**	**3.8**
	17.2	20.2	25.3	10.1	27.3	100.0	3.4
	1.15	1.64	0.91	0.54	1.04	1.00	1.12
Prevention	**46**	**35**	**90**	**53**	**77**	**301**	**11.4**
	15.3	11.6	29.9	17.6	25.6	100.0	11.1
	1.03	0.94	1.08	0.94	0.97	1.00	1.03
Services and outreach	**93**	**73**	**178**	**110**	**150**	**604**	**23.0**
	15	12	29	18	25	100	22
	1.03	0.98	1.06	0.97	0.95	1.00	1.06
Accommodation based interventions	**140**	**105**	**229**	**151**	**226**	**851**	**32.3**
	16.5	12.3	26.9	17.7	26.6	100.0	29.9
	1.10	1.00	0.97	0.95	1.01	1.00	1.08
Employment	**15**	**10**	**21**	**16**	**23**	**85**	**3.2**
	17.6	11.8	24.7	18.8	27.1	100.0	3.2
	1.18	0.95	0.89	1.01	1.03	1.00	1.01
Health and social care	**51**	**46**	**127**	**103**	**129**	**456**	**17.3**
	11.2	10.1	27.9	22.6	28.3	100.0	20.7
	0.75	0.82	1.00	1.21	1.08	1.00	0.84
Education and skills	**14**	**13**	**32**	**27**	**33**	**119**	**4.5**
	11.8	10.9	26.9	22.7	27.7	100.0	5.9
	0.79	0.88	0.97	1.21	1.06	1.00	0.77
Communication	**9**	**13**	**17**	**11**	**16**	**66**	**2.5**
	13.6	19.7	25.8	16.7	24.2	100.0	2.6
	0.92	1.59	0.93	0.89	0.92	1.00	0.97
Financing	**7**	**10**	**12**	**11**	**10**	**50**	**1.9**
	14.0	20.0	24.0	22.0	20.0	100.0	1.6
	0.94	1.62	0.86	1.18	0.76	1.00	1.19
Total / overall	**392**	**325**	**731**	**492**	**691**	**2631**	**100.0**
	14.9	12.4	27.8	18.7	26.3	100.0	

Note: First row: number of studies coded as reporting a barrier of that type for that intervention category. Second row: share of that type of barrier in the total number of barriers faced by that intervention category (i.e. a % of the total in that row). Third row: ratio of that share to the share of the barrier across all interventions. Those in red show that this is a particular barrier.

In another study in Australia, many women recipients of antenatal care (ANC) reported a lack of emotional support from the staff. Participants reported a lack of personal connection, respect, compassion, and encouragement to express their emotions. Some even reported feeling rushed by practitioners who lacked the time or energy to provide care. One of the recipients reported:

'It was like they hated being there and they hated you for being there. And it was very rushed, nothing was explained, and I guess again they wanted to tick boxes and get you out of there as fast as possible' (Penman et al., 2023: 4679).

4.3 Facilitators

As with the analysis of barriers presented above, Table 6 shows the aggregate map of the intervention-facilitator matrix. The same analysis is shown, with three rows for intervention reporting absolute numbers, share of facilitators for that intervention, and the relative share of that facilitator for that intervention compared to the average across all interventions.

The factors that were disproportionately barriers for legislation – contextual factors and policy makers /funders – act even more disproportionately as facilitators with ratios of 2.85 and 1.74 respectively. As will be seen below, there are differences between which contextual factors are likely to be barriers and which are more likely to be facilitators. There are less likely to be contextual factor facilitators related to recipients (0.54) and staff /case workers (0.63).

Health and social care are more likely to have facilitators from staff / care workers (1.23) and recipients (1.15). For education and skills this is only so for recipients (1.21). All of the contextual factors, policy makers / funders, and programme administration are less likely to be facilitators (0.56, 0.68 and 0.85). The same is true for contextual factors, and policy makers / funders with respect to financing (0.62 and 0.92).

For communication, policy makers / funders are more likely to be a facilitator (1.48), and staff / care workers and recipients less so (0.87 and 0.80).

Table 5: Aggregate Implementation EGM of included studies for intervention and facilitators

	Contextual factors	Policy makers/ funders	Program administrator/ manager/ implementing agency	Staff/ case worker	Recipient of program	Total	Memo: As percent of column total
Legislation	**22**	**18**	**20**	**16**	**15**	**91**	**3.1**
	24.2	19.8	22.0	17.6	16.5	100.0	3.4
	2.85	1.74	0.99	0.63	0.54	1.00	0.93
Prevention	**31**	**32**	**76**	**87**	**93**	**319**	**10.9**
	9.7	10.0	23.8	27.3	29.2	100.0	11.1
	1.15	0.88	1.08	0.98	0.96	1.00	0.99
Services and outreach	**56**	**92**	**177**	**201**	**205**	**731**	**25.1**
	8	13	24	27	28	100	22
	0.90	1.11	1.09	0.99	0.93	1.00	1.15
Accommodation based interventions	**86**	**110**	**193**	**240**	**280**	**909**	**31.2**
	9.5	12.1	21.2	26.4	30.8	100.0	29.9
	1.12	1.06	0.96	0.95	1.02	1.00	1.04
Employment	**8**	**9**	**24**	**24**	**27**	**92**	**3.2**
	8.7	9.8	26.1	26.1	29.3	100.0	3.2
	1.03	0.86	1.18	0.94	0.97	1.00	0.99
Health and social care	**24**	**39**	**95**	**172**	**176**	**506**	**17.4**
	4.7	7.7	18.8	34.0	34.8	100.0	20.7
	0.56	0.68	0.85	1.23	1.15	1.00	0.84
Education and skills	**11**	**14**	**29**	**39**	**54**	**147**	**5.0**
	7.5	9.5	19.7	26.5	36.7	100.0	5.9
	0.88	0.84	0.89	0.96	1.21	1.00	0.86
Communication	**7**	**14**	**22**	**20**	**20**	**83**	**2.8**
	8.4	16.9	26.5	24.1	24.1	100.0	2.6
	1.00	1.48	1.20	0.87	0.80	1.00	1.10
Financing	**2**	**4**	**10**	**10**	**12**	**38**	**1.3**
	5.3	10.5	26.3	26.3	31.6	100.0	1.6
	0.62	0.92	1.19	0.95	1.04	1.00	0.82
Total / overall	**247**	**332**	**646**	**809**	**882**	**2916**	**100.0**
	8.5	11.4	22.2	27.7	30.2	100.0	

Note: First row: number of studies coded as reporting a facilitator of that type for that intervention category.
Second row: share of that type of facilitator in the total number of barriers faced by that intervention category (i.e. a % of the total in that row).Note. Third row: ratio of that share to the share of the facilitator across all interventions. Those in green show that this is a particular facilitator.

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

Similarly, residents in supported housing with mental health challenges and those who might have gone through significant trauma gained informal emotional support from the support workers. One of the supported housing residents described:

> *'The staff….. just listened to my problems – I think that was half the battle, just telling people your problems and someone not being judgemental, just listening and understanding how you really feel…… knowing I could go and talk to someone, with any issue I had' (Blood et al., 2023: 37).*

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

Barriers to implementation

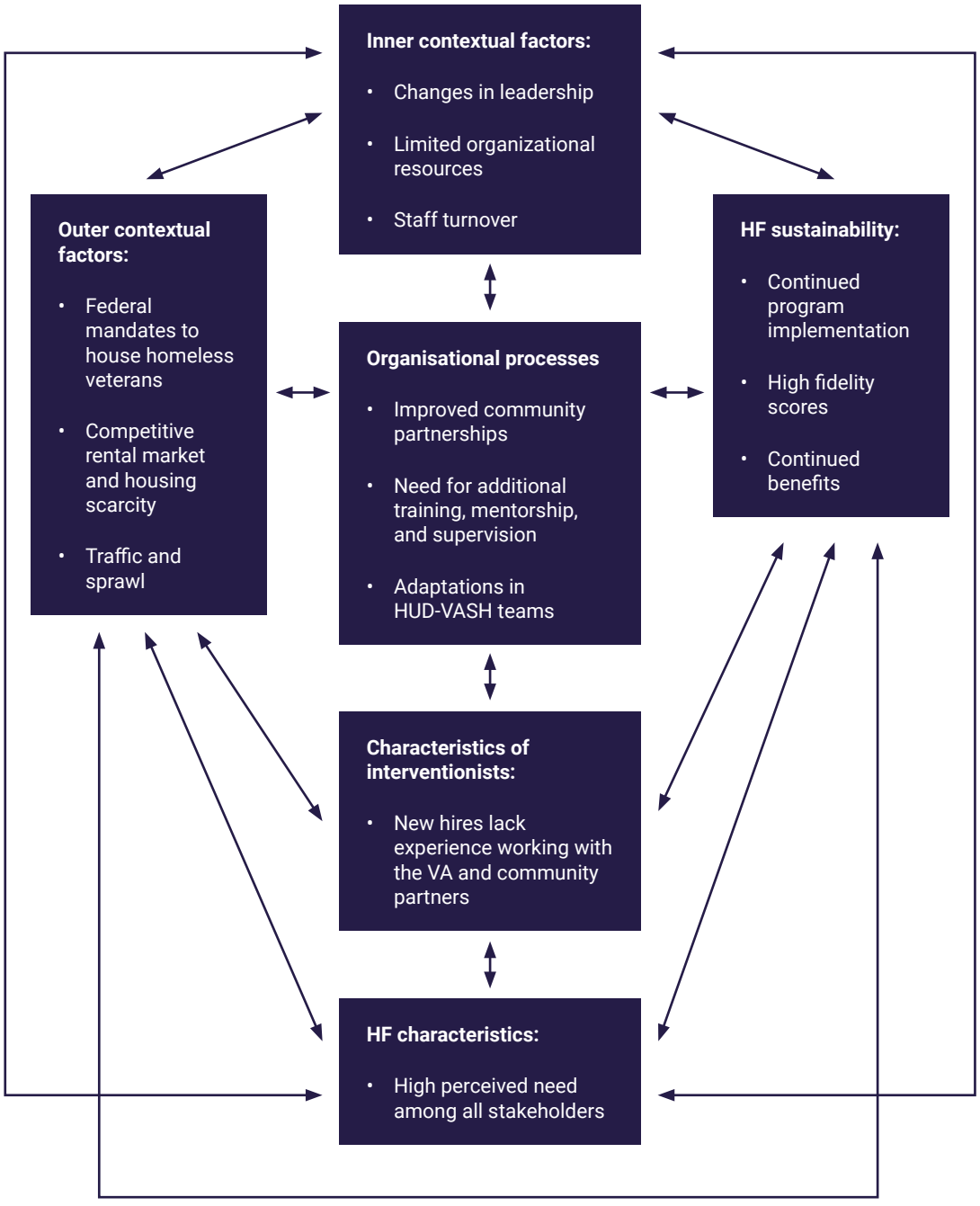
This section conducts an in-depth examination to provide specific examples from the five barrier categories. The examples reported here encompass the perspectives of clients, service providers and implementing agencies.

1) Contextual factors: housing market and welfare support

Both housing and welfare support were oft-cited contextual barriers, accounting for 47 and 35% of all reported contextual barriers respectively (see Appendix 5). Housing in particular is a factor which is a commonly reported barrier and rarely a facilitator (facilitator/barrier ratio = 0.21).

For example, in an evaluation of sustaining Housing First as a permanent supportive housing programme for veterans with experience of homelessness, it was reported that contextual factors such as a paucity of suitable apartments in the housing market negatively affected the permanent housing programme (Fletcher et al., 2022).The challenges related to housing markets and the scarcity of appropriate rental units is also featured in the integrated sustainability framework adapted for Housing First by the author, in which they differentiate between inner and outer contextual factors.

Figure 8: Integrated sustainability framework adapted for Housing First



Source: Fletcher et al. 2022, p.379

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

The challenges posed by the housing market were also observed in a Housing First implementation evaluation from Ireland. The housing units in most regions were sourced from local authorities, non-governmental organisations, and other approved housing bodies. Availability of one-bedroom units varied across rural and urban regions, with rural regions reporting more challenges in sourcing one-bedroom flats compared to programmes in Dublin or other urban areas. An NGO manager described the challenge:

> *Our biggest problem at the moment is housing. Getting one-beds. We basically ground to a halt…we've only just hit our one-year target, our one year would have been February, we just hit eight. And […] we're going to struggle (Greenwood et al., 2022: 20).*

Another NGO manager stated:

> *'There [are] one-bedroom units and, you know, that's a recognition of the serious lack in the, even on the private, you know, the private rented market or buying. People did not build one-bedroom units [here]. I mean, it's just, I'm told it costs almost no difference to make a two-bedroom unit in terms of the development of it than a one-bedroom unit. One-bedroom units are selling here for €80,000 or €85,000, two-bedroom units are selling for €120,000. You know, who builds one-bedrooms, privately, I mean developers? So, through the boom, there was no council housing built, no local authority units. So, it was all private, and there's very little one-bedroom units. (NGO manager)' (Greenwood et al., 2022: 20).*

Along with inadequate availability of certain housing units, studies on the implementation of programmes related to COVID-19 also suggest that certain policy and organisation-level decisions regarding vaccination posed challenges such as a lack of access to vaccination or delayed vaccination among persons experiencing homelessness. For example, in a study examining challenges experienced during COVID-19 vaccination efforts in the United States, healthcare providers and housing programme staff who delivered healthcare and other services to veterans experiencing homelessness cited insufficient policy and organisational efforts to improve uptake and vaccine acceptance among the target population (Balut et al., 2022). As is discussed later in the report, this was also due to mistrust of authorities and low buy-in among recipients in the programme.

While access to and the absence of welfare support was identified as a barrier, it is also important to highlight the discrimination from service providers faced by potential participants. For instance, Gorton and colleagues (2004) stated that people experiencing homelessness face discrimination from general physicians and their practices, which limits the healthcare they receive. In their study of the experiences of people experiencing homelessness seeking treatment and

services from the National Health Service in London, participants reported that the welfare context did not make a difference when they felt labelled and stereotyped by healthcare professionals who grouped them under the 'aura of homelessness', irrespective of their health conditions. One participant stated that 'The stigma sticks to you – no matter how long it is. "He's only a dosser." This is what you hear. How many times have we heard that?' (Ibid., p. 7).

Similar experiences of prejudice and labelling were observed among those experiencing alcoholism and substance abuse, as well as among sexual and gender minority groups. In a study exploring how supportive housing is experienced by sexual and gender minority groups in the US, cycles of marginalisation experienced by the client could be reinforced by service providers, if practitioners were not adequately trained. A provider in one of the studies stated:

> *"Incarceration is kind of just, I guess, a by-product of their life circumstances. It's just what they do for survival, being sex workers, or stealing, or drug addiction because of inability to deal with life situations… Any time you don't have a source of income to be able to take care of yourself, you gonna survive by any means necessary…For those that are sex workers, they have to look a certain way, they have to be appealing. So of course they gonna go to a store and they gonna shoplift, they gonna do stuff to keep up their appearance' (Dopp, 2022, p. 13).*

The limited experience and training of healthcare support staff also affected the provision of care for mental health and addiction. In a medical respite program (MRP) developed in Alberta, Canada, through a partnership between the provincial health authority and the province's largest homeless shelter, one of the personnel engaged in operations and frontlines reflected on the challenges presented by a lack of training and specialised care:

> *'This population has addictions and mental health, so the home care model was challenged. We couldn't keep [up with] some of the requests from the Drop-In Centre to support detox. Our staff are not trained. We have them do trauma-informed care; however their specialty is not in addictions and mental health, and really that's where one of the gaps was, we really needed someone from addictions and mental health to help deal with some of the behaviours' (Hoang et al., 2023:6).*

2) Policy makers/funders: collaboration, inadequacy of resources and framework provisions

Collaboration with external agencies emerged as a strong limiting factor in studies across different settings. The lack or inadequacy of a framework for provision of services for participants in an intervention accounted for half of reported barriers in this category.

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

In another study exploring how providers apply a harm-reduction practice in a Norwegian Housing First project, harm reduction was found to comprise most of the follow-up work for service providers, pointing to a lack of collaboration and adequate resources (Andvig et al., 2018). The authors undertook a thematic analysis, in which policy guidelines were observed as a barrier to implementation of the practice. 'We don't follow service provision contracts, we do everything… Doing "everything" could include actions ranging from carrying out garbage and shopping for food with service users to conversations about existential topics' (Ibid, p. 8).

Hennepin County's Homeless to Housing Program in the US provides housing-focused case management services to vulnerable adults experiencing homelessness. An evaluation suggested the program's novelty also posed some challenges, as supervisors cited ambiguities or a lack of clarity. They also expressed that a manual or the creation of more recorded policies would aid in the program's ongoing development. One supervisor, for instance, also mentioned that they would want to see their data procedures streamlined because some of the components felt redundant (Carlson, Rohrer and Steiner 2022).

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

A lack of adequate resources was understood to be a prevalent barrier across different settings, experienced by both participants and service providers – accounting for one third of reported barriers in this category. In Gorton and colleagues' study on the experience of homeless populations receiving healthcare support from the National Health Service in London, recipients reported that they routinely came across staff who were 'frustrated with the limitations of the system and wanted to be able to provide a better service than they had the resources to provide' (Gorton et al., 2004, p. 9).

Referrals and identification of recipients were identified as important aspects of delivering any intervention. A study among service providers in Australia's New South Wales (NSW) region suggested that referral networks may also be 'person-based rather than service-based, [though] this may be expected to change over time as awareness of the service grows'. Emphasising the role of a person-based approach, one of the service providers shared:

> *"We did have an Aboriginal admin person working here who used to make a lot of referrals but she is no longer here' (Robyn Kennedy Consultants, 2013, p. 25).*

Service providers also shared the relevance of an Aboriginal-specific service that could respond to tenancy issues of indigenous populations in a culturally appropriate way:

> *'What works are [Aboriginal] men... having blokes that just get on with it and can deal with some of the difficult clients ... E.g. a male client with mental health issues came into the office... using offensive language ... When this man deals with the guys at CSATSS he can just be himself and express himself the way he wants to and the matter does not get out of hand' (Robyn Kennedy Consultants, 2013, p.39).*

The challenge associated with the complexity of referrals was also observed in an evaluation of the integrated social prescribing model in Redbridge, UK. The Council for Voluntary Service (CVS) respondents shared that there were significant regional differences in the amount of primary care network (PCN) referrals to CVS. They also noted that referrals had recently grown incredibly complex–– especially related to housing concerns that were entrenched in broader structural problems with Redbridge's and other areas' housing shortages –– and were therefore difficult to resolve. Due to the programme's inability to handle the intricacy of the referrals they received, Redbridge CVS was forced to reduce the volume of accepted referrals. One of the CVS respondents shared:

> *'So, some of our limitations can come from the type of work that we're getting, referrals that we're getting sent through, because the referrals are so complex now. The complexity has grown massively you know, I was only just speaking to one of my team and I was saying to them, 'I need to give you some more referrals.' And she said, 'My referrals are so complex at the moment, that I cannot say to you at the moment give me more referrals because of the complexity of the work that they're doing.' So as long as they're trying to meet their goal and make sure the clients are getting what they need, you know we're getting a lot of refugees, a lot of people with housing issues, and there aren't the organisations out there, you know we can signpost, but we can't actually do anything*

> *about housing. So that's what stops us from meeting their need sometimes' (Bertotti, Hanafiah and Canitrot, 2022: 14).*

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

Staff and case workers that are most likely to be a facilitator rather than a barrier (Appendix 5). Nonetheless, there are still a large number of reported barriers, notably for engagement with recipients (29% of reported barriers in this category), and technical skills (27%).

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

Inadequate staff training was widely reported in included studies, particularly in interventions targeting minority groups and marginalised homeless populations. In a study of supportive housing for sexual- and gender-minority individuals with criminal justice histories, a primary challenge identified by the provider was staff capabilities in treating sensitive cases:

> *'We've created a small network of culturally competent LGBT substance use and co-occurring providers. That network is about three providers right now. There are lots of agencies out there that say "Oh yeah, we treat 'em!," you know, like that's something significant, but they have little or no competency… and we had to go through our own personal journey to get there [with our competency]' (Dopp, 2022: 10).*

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

> *'It would be help[ful] to know of companies and people who understand and accept [transgender people]. It's like [the case manager] might say "I'm going to send you over to this company"… but the company has no familiarity with LGBTQ' (Dopp, 2022: 10)*

Similarly, one client using mental health facilities mentioned that the staff providing services are required to have knowledge, interest and recognition of the sexuality of the recipient for effective psychological care and prevention of homelessness:

> *'It was my counsellor's supervisor that picked it up, that I needed support and getting involved in activities more for LGBT…the person I had the initial assessment and counselling with, if they picked up, I might not have been in the position of being homeless, and sorting myself out' (Milburn, 2022: 88).*

A lack of relevant staff skills was also reflected in a lack of communication and engagement with other agencies. This further impeded the implementation of housing support for homeless populations. A study identifying the challenges experienced by homeless individuals with a traumatic brain injury and mental health and/or substance use found that systems of care were siloed and organised around clinical diagnoses, which made service delivery challenging (Estrella et al., 2021).

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

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

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

> *'The situation about the sexual harassment … how many of those women are living on VA benefits that have to do with military sexual trauma … they bring in an extra security guard so the women [on] staff feel safe, but he leaves at 5' (Jacobs et al., 2022, p.3).*
>
> *'For a long time I didn't feel safe living there. . .between the people who are doing drugs and the people who are acting crazy when they came*

> *out of their unit trying to talk to me. And in the beginning, there was more than a few instances of men saying inappropriate things to me, sexual remarks or questions or offerings' (Ibid).*

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

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

Another participant stated:

> *'I thought, 'Oh this [is] definitely a government initiative. They're going to run a test on the homeless…maybe they've got a dodgy batch of [e-liquid] and they just want to see if it takes anyone out before they put them up for sale' (Ibid., p. 23).*

There was also concern around anonymity and private details being shared with authorities: '…if I thought my information was being shared, then I wouldn't take part' (Ibid.). Such emotions from service users in any programme resulted in limited client self-disclosure to providers (Dopp, 2022; End Homelessness Winnipeg, 2022; Cox, 2021; Estrella et al., 2021).

Similarly, some veterans cited their mistrust of the government or the military as their justification for declining the vaccination. The majority of veterans who mentioned that regular vaccinations were part of their military training stated that they felt accustomed to receiving recommended vaccinations as a result. One of the veterans expressed how he felt being tested on during his tenure in the army:

> *'I'm used to being a guinea pig . . . I was in the Army active for three and a half years, and then I did nine and a half years total, the reserve and active. So, you know people sticking needles in me, telling me, "all right you need to take this"' (Gin, Balut and Dobalian, 2022: 5).*

Another veteran noted that he preferred not to receive any more vaccines, now that he was not obligated to:

> *'Going into the military, I had tons of vaccines, and putting one more in my body is something I try not to do if I don't have to' (Gin, Balut and Dobalian, 2022: 6).*

Facilitators of implementation

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

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

The only contextual factor which is more likely to be a facilitator rather than a barrier is the legal framework. For example, a study of the Rough Sleepers Initiative in Scotland mentions various legislation which helped protect and underpin the initiative (Anderson, 2007).

While housing markets and welfare support comprised the bulk of identified barriers, they were also identified as enabling factors in many studies. For instance, in an NSW Homelessness Action Plan intervention providing long-term accommodation and support for women and children experiencing domestic and family violence, the service user's entry into the housing market acted as a facilitator. The intervention acted as a bridge, facilitating women's access to markets, which in turn enabled sustained tenancies (Gomez-Bonnet et al., 2013).

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

Participants also discussed how having insurance made them feel more at ease about getting treatment and following doctors' recommendations. On the other hand, many participants talked about never having had insurance before. They believed that they were not entitled to treatment in places other than emergency departments, where they would always be seen by a provider, regardless of their financial situation. Some participants refrained from pursuing recommended treatment due to uncertainty about the financial consequences of seeking care. Moreover, participants talked about how gaining insurance affected how they perceived being able to seek healthcare without worrying about the expense of unpaid care (Dickins et al., 2019: 7).

2) Policy makers and funders: framework provisions, and leadership, culture and commitment

The most frequently mentioned facilitators in the policymakers and funders category are buy-in (leadership, culture, and commitment – 42% of reported facilitators in this category) and framework provisions (33%).

In a Housing First Pathfinder evaluation, a strong political commitment to Housing First at national and local levels, as well as a high level of buy-in from many important housing providers in the Pathfinder area, was cited as a facilitator.

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

> *'There's been a real commitment from [the] Scottish Government… There's been a real commitment that this is what we're going to be doing…I think that seems to have filtered down. Not necessarily all the way down, but far enough down for the wheels to start to change. I think because of that coming down from the top there has been local buy-in' (Stakeholder, Dundee) (Johnsen et al., 2021, p. 41).*

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

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

> *'We have social workers in each building. They're all paid through [special education] and general dollar funds for the district, so it's a commitment from the superintendent to have them in the buildings' (Robson, 2016: 94).*
>
> *'We have a superintendent who truly is a student first. She will not make a decision that will make an adult happy simply to avoid a union issue. She sees the need in our community for a community resource, a wraparound care team. She just sees the need and is willing to find the resources to meet that need' (Robson, 2016: 94).*

An example of a framework provision acting as a facilitator is the approval for off-label use of buprenorphine using micro-induction in which minute doses are administered for prolonged release. This approach can overcome the problems that marginal populations – such as sex workers – can have with regular treatment compliance over a sustained period. Specifically, a health-at-the-margins approach for transactional sex workers, was adopted using a weekly or monthly buprenorphine prolonged-release injection (BPRI) as a treatment option for opioid use disorder (Gittins et al., 2023: 6).

The flexible and joined-up approach in housing allocation in an evaluation of a social impact bond in the Greater Manchester area of the UK was also discussed as an implementation facilitator. With the offer of wrap-around support for individuals, housing providers adopted a progressive stance and felt at ease to overlook past evictions or a history of unpaid rent, which would have typically disqualified a large number of applicants. As the initiative progressed, housing providers shared that they were able to pick up new skills along the way and that policies and procedures were frequently modified. One of the housing providers shared:

'Yeah we have an allocations panel in place now for that, so it's kind of myself,support teams sit on that, place managers, community safety teams sit on that, the rents team sit on that, and it's all to make sure really we're not setting people up to fail from the beginning, that we're putting them in the right place with the right surroundings, and the right amenities as well, and services that are local that meet their needs' (GMCA, 2021: 21).

3) Programme administrators/ managers/ implementing agencies

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

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

In another evaluation, members of the advisory board were committed to making a meaningful difference in the lives of disadvantaged and marginalised people, a group often described as being difficult to access and as having complex needs. Members of the executive and day centre staff noted the generosity, passion and dedication of designers, donors, and volunteers involved in the programme's implementation.

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

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

The cooperation with volunteer organisations and other community services was shown to facilitate fidelity in the implementation of European and North American Housing First Programmes. Several programmes discussed how having access to a wide range of community-based services that offer supplementary support to those experiencing homelessness enabled them to carry out their programmes effectively and, as a result, maintain high levels of model fidelity across the board. A social worker from a Housing First programme in Belgium emphasised the importance of partnerships and collaboration among different stakeholders:

> *'We have different partners, each one is a piece of the puzzle in the fight against homelessness, but nobody is going alone. If we combine our means, work together and are responsible together, we can have something to offer to people with complex problems who have nowhere else to turn. I think it's really important that a project starts from a field network' (Greenwood et al., 2018: 11).*

4) Referral route for identification of stakeholders

Early identification and adapting the target route to locate stakeholders both help to facilitate smoother implementation. In a care transfer intervention for people experiencing homelessness after hospital discharge, a key mechanism to achieve patient in-reach was the 'homeless ward round', in which clinicians from the homelessness team identified and supported homeless patients located across the hospital site (Cornes et al., 2021).

In a study assessing an intervention targeting homeless persons with HIV, the centralised intake system was one of the programme's major strengths. Across the interviews, key informants agreed that having a centralised intake system was more effective. In particular, all informants saw the state-wide intake system as a means of integrating services and screening clients for eligibility for various programmes.

> *'We go through a process, the…process of centralised intake…they kind of categorise you in terms of intensity or the seriousness of your homelessness and they put you in a category. They make a call to agencies accordingly' (Courternay-Quirk et al., 2022:6).*

5) Use of robust data and monitoring mechanisms

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

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

In an evaluation of the Youth Homelessness Demonstration Program in the US, high levels of coordination between YHDP sites and the child welfare system were observed as factors facilitating implementation, as all parties regularly took part in planning, data sharing, preventive and diversion activities, and the process of providing housing to participants (Henderson et al., 2022).

6) Staff/case workers: efficient communication and engagement

Case workers' skills, and how they communicated and connected, were deeply valued by stakeholders. According to one service user of a specialist homelessness service programme:

> *'They've always been there, and I've always been able to rely on them and go back to them when I need to for that support and to help me get back on my feet. So it's definitely been a big part of my life for the last four years and the caseworkers that I've been given in the last few years they've just been wonderful' (Valentine et al., 2017: 35).*

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

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

The emotional skills of staff/ case workers were mentioned in several studies as a factor that encouraged recipients' buy-in to a specific programme or intervention (e.g. Aung 2023; Bark 2023; Bounds 2023; Carver 2022; Kennedy 2022).

A strengths-based dyadic intervention called Support To Reunite, Involve, and Value Each Other (STRIVE) was found to be effective in lowering drug use, criminality, and high-risk sexual behaviour among marginalised adolescents facing homelessness

Adolescents experiencing homelessness in a strengths-based dyadic intervention called STRIVE+ emphasised how important it was to feel heard and unjudged when in the STRIVE+ Space. One adolescent emphasised that the facilitator's nonjudgmental approach was crucial to understanding individual dyadic relationships:

> *'I liked that the people there were nonjudgmental. They really tried to help. They took time out to conduct surveys to get a better understandin' of what we feel. They were studying the relationship that me and my mom had to try to offer us better solutions to our problems each and every time. That's what I like' (Bounds et al. 2023: 5)*

Facilitators also played an important role in the Career Readiness for Young Parents Project (CRFYP) in Australia. The respondents shared that their relationship with their CRFYP facilitator was so strong that sessions felt like therapeutic counselling sessions and that the guidance or emotional support they received gave them a sense of being heard, understood, more confident in themselves, and more hopeful about the future. One of the respondents shared:

> *'The CRFYP facilitator was great. She never gave up on me. Even though I went downhill and didn't finish she is still helping me to finish. If it wasn't for the program and the CRFYP facilitator, I wouldn't have got off my ass and I wouldn't have done the TAFE course. Should have more programs to help more people get more jobs' (Atkins, Dau and Evans, 2022: 55).*

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

Access to non-housing support is reported to be the strongest facilitator of intervention success (accounting for one-third of reported facilitators for recipients), particularly when considering the challenges experienced during COVID-19. In a study of veterans experiencing homelessness related to COVID-19 in the US, providers and housing staff reported that access to vaccines in closer vicinities facilitated their use and increased participants' uptake of the programme (Balut et al., 2022).

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

> *'You know because when I went to the rehab, it was all about how to live life sober, and then so once you have, so once you're sober and everything, it's like then what? This place [Housing Facility] gave me different tools and helped me…to be able to be a good mom and you know, a productive member of society, to do what people do, or supposed to do you know' (Brott et al., 2022: 12).*

People experiencing homelessness with a history of substance use cited the effectiveness of Alcoholics Anonymous and Narcotics Anonymous (AA/NA) in California, US as key to their sobriety. One of the respondents shared:

> *'What really helps me stay sober is NA and AA, that is really my rock. I have a sponsor, I have for several years, and that's what works for me' (Beecher et al., 2023: 7).*

The respondents also shared positive experiences at mental health agencies as:

> *'This place [the Clubhouse] is the best place in the world. Seriously. For mental health, this is the best. I come here ... anything I need. I come here and they do help me. They do everything. The dual-diagnosis day treatment program was great—we did arts and crafts and socialized, and it was good to be around other people' (Ibid.)*

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

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

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

> *'Community workers really trusted me, it's very rewarding for me…it really helped me …I did not just do the tenants committee, it went much further than that. Exchanges were really fun, I found it fun that [in] my opinion is worth something, that I was not just the little young representative, but that they consider me as I am' (Bourbonnai, 2019: 40).*

Finally, access to services beyond just the housing can make the house a home, and make it feasible to accept such accommodation. This is illustrated by women benefiting from the Homelessness Action Plan project in Australia. One participant reported:

> *'Well we didn't have anything. Before I went on the programme we didn't have anything so getting a house was even harder because we had nothing to put in the house. So just getting everything set up for the house so that we could have our own house and be all set up and get on with our lives'(Breckenridge, 2013: 31).*

When analysing barriers and facilitators, it is common to find that many factors act as both. Discussion of both the obstacles and enablers from different stakeholder perspectives (e.g. managers, staff and recipients) offered an opportunity for in-depth analysis from all vantage points.

In the next section, we present the critical assessment of the included studies.

5. Critical appraisal of the included studies

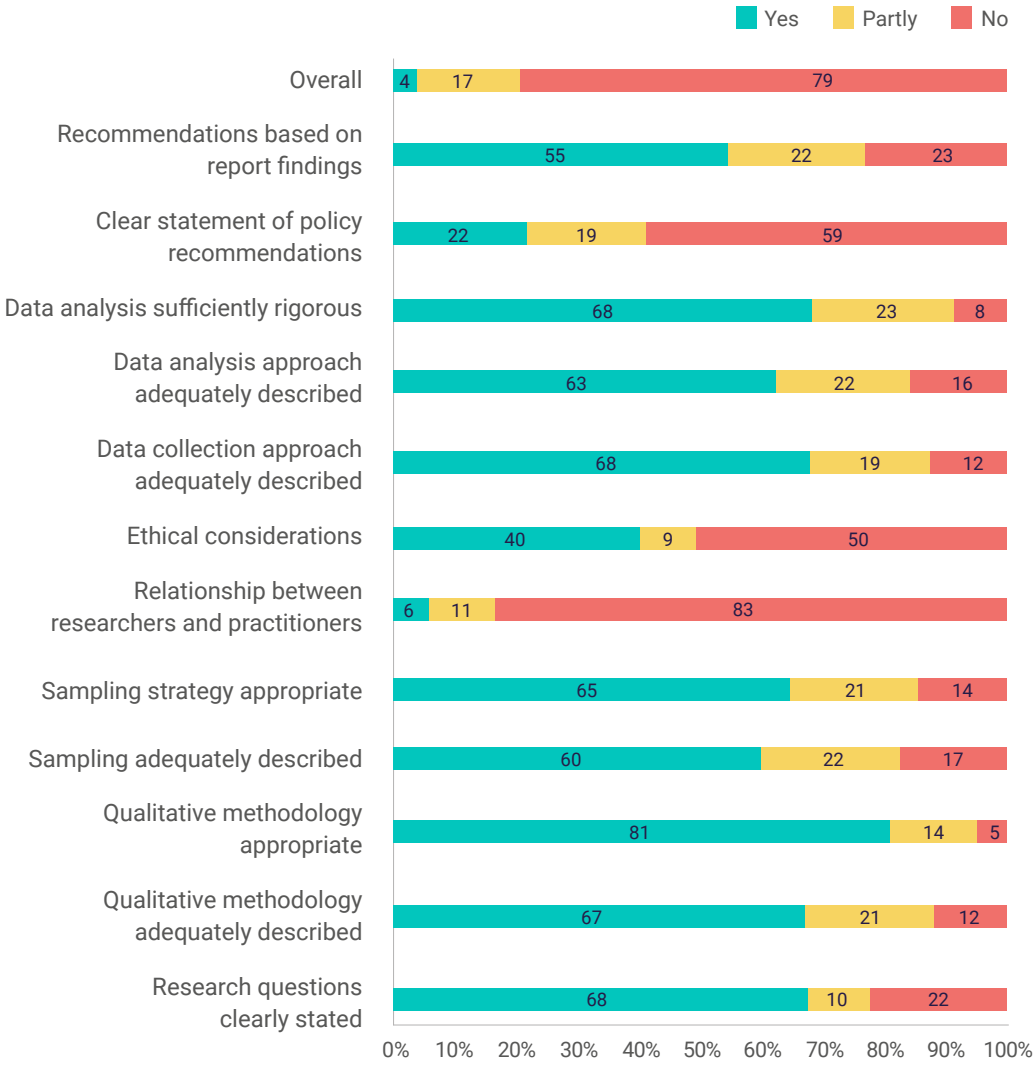
Critical appraisal of the studies was carried out using the CASP checklist for qualitative studies, which includes research questions, methods, ethics in the research process, analysis, and policy recommendations, and related questions for the reporting of study findings. Systematic reviews included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

This confidence in study findings is assessed using the CASP checklist, which has twelve questions on the clarity of reporting of research questions, methodology, sampling strategy, the relationship between researcher and participants, ethical considerations, data collection, analysis, policy recommendations and coherence between recommendations and study findings. A total of 76% of included studies were assessed as low confidence with regard to their study findings. Approximately 17% of included studies were assessed as medium confidence, while less than 4% of studies were assessed as high confidence.[7] Other studies are protocols so have not been critically appraised.

Each study is assessed for each of these indicators, and a low score on any one is enough to classify a study as low confidence in its reporting of findings. The principle of the 'weakest link in the chain' often leads to a study being classified as low confidence, even if it might have high scores in all other items.

Figure 9 shows the distribution of responses in the included studies for each item on the CASP checklist. Although most included studies describe the research questions, methods and analysis sufficiently, not many details are provided on the relationship between researchers and participants, and ethical considerations were not sufficiently reported. Many studies are assessed to be of low confidence in their findings due to these two reasons.

Figure 9: Distribution of responses for critical appraisal of included studies (percent)



6. Implementation evidence base in the UK

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

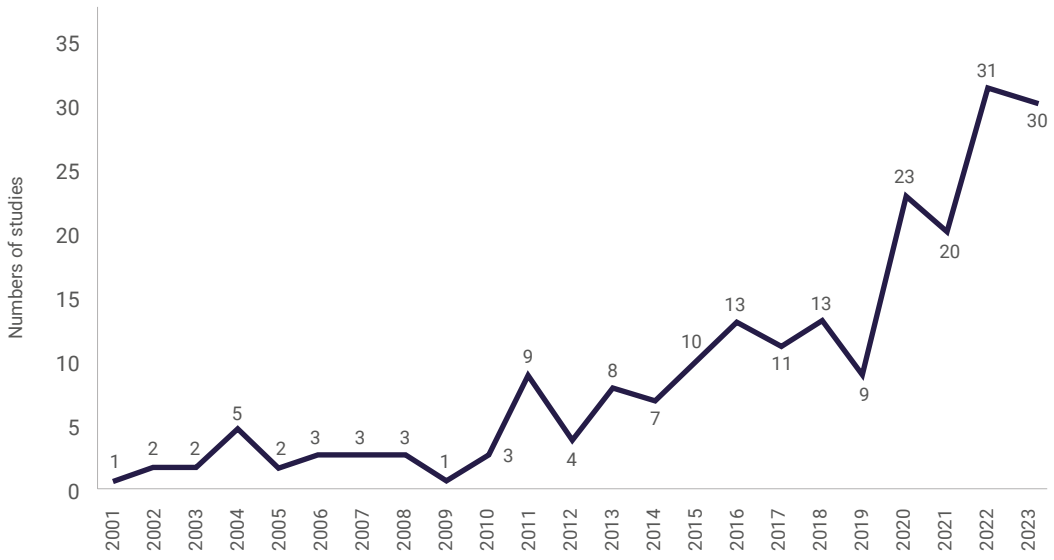
6.1 Number of studies

The total number of UK studies on this map is 213 (25%). 62 studies from the UK were added in this update of the map. The previous edition contained 151 studies from the UK.

6.2 Years of publication

As we see in Figure 10, there is an upward trend in the number of included studies in the implementation map published in the UK since 2002. However, an occasional dip in the number of studies is also observed for certain years. In 2022 and 2023, there was a sudden increase in the number of studies, with 31 and 30 studies published from the UK, respectively.

Figure 10: Included studies by the publication year (UK, overall)



6.3 Geographical distribution

Of the studies in the United Kingdom 77 are for England, 33 for Scotland, and 12 for Wales. Other studies are identified as evaluating interventions in specific cities: London (49), Birmingham (13), Edinburgh (13), Glasgow (10), Bristol (7), York (6), Greater Manchester (9), Oxford (5), Brighton (4), Liverpool (4), Leicester (3), Sheffield (3), Belfast (2), Leeds (2), Nottingham (2), Plymouth (2) and Ipswich (2). There is one study for each of Gateshead, Cambridgeshire, Cornwall, Gloucestershire, Great Yarmouth, Lancaster, Lincolnshire, Luton, Lothian, Norwich, Peterborough, Stockport, Suffolk, Sussex, Sterling, Cheshire, Glossop, Ashton, Northampton, Wolverhampton, and Aberdeenshire,

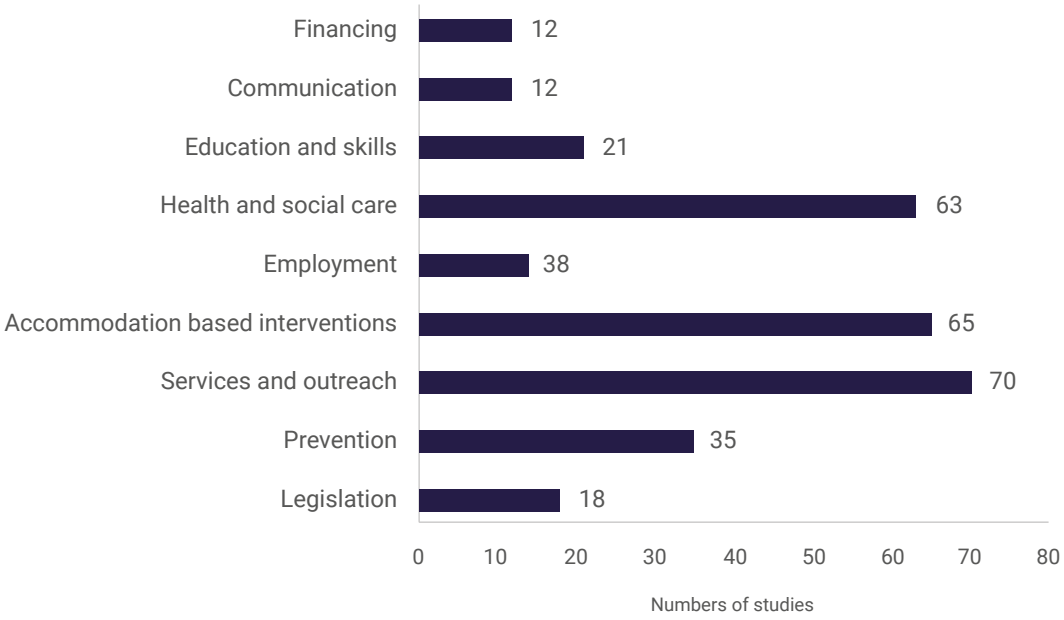
6.4 Intervention and sub-intervention categories

The distribution of included studies from the UK in this edition by intervention categories (Figure 11) suggests that services and outreach interventions constitute the highest proportion of all studies (n = 70), followed by accommodation-based interventions (n = 65) and health and social care interventions (n = 63).

This trend is similarly observed in the global evidence on implementation issues for interventions related to homelessness; however, in the 2022 and 2023 map editions, accommodation-based interventions represented the highest number of studies, followed by services and outreach.

The number of studies from the UK under the intervention categories of legislation (n = 18), employment (n = 14), communication (n = 12) and financing (n = 12) are low compared to the overall map. However, compared to the 2023 edition, ten new studies have been added under financing interventions in the current map, which evaluate social impact bonds.

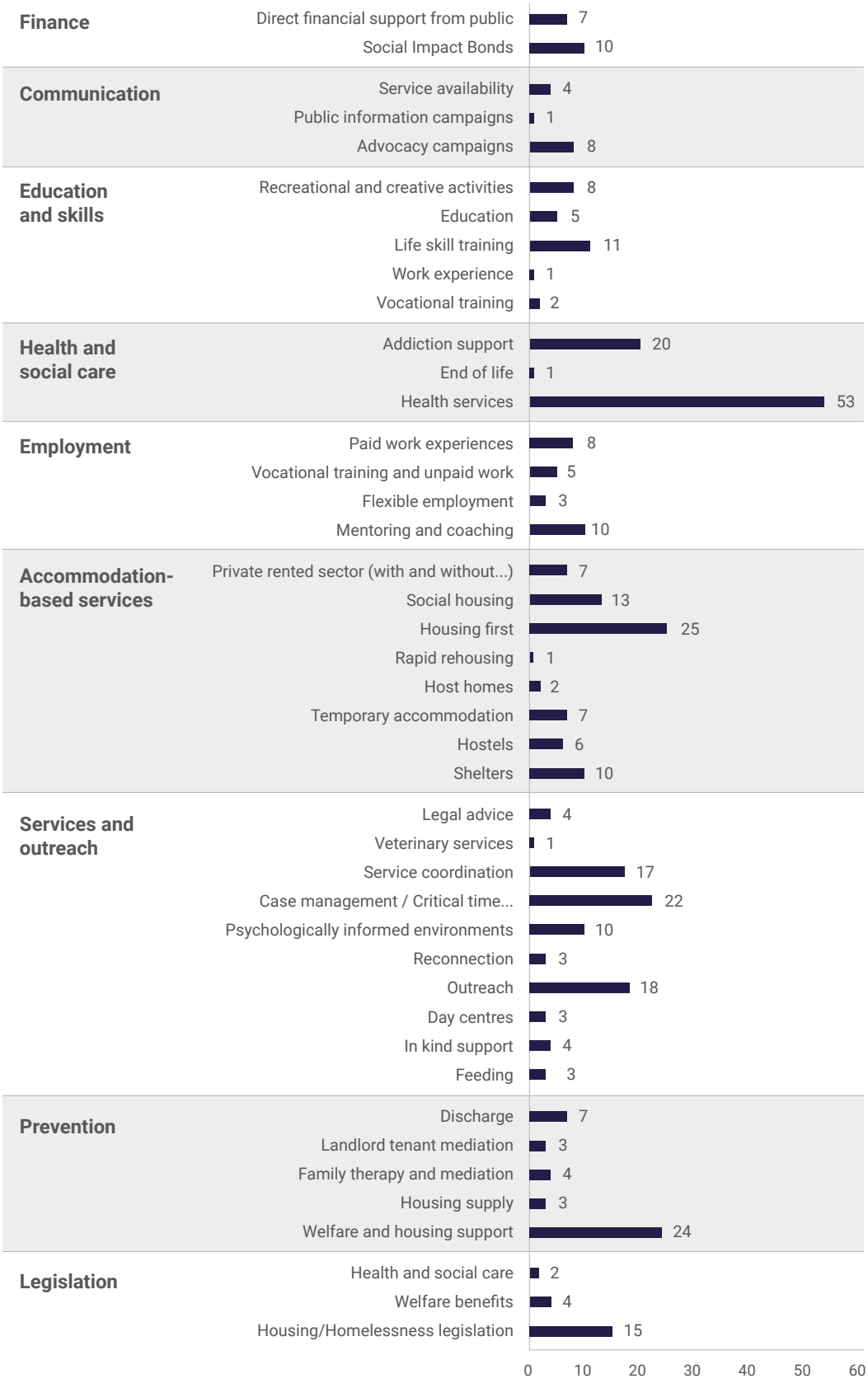
Figure 11: Included UK studies by intervention categories



When we analyse the sub-intervention categories for studies from the UK (Figure 12), we find that health services (within health and social care interventions) are highest in number (n = 53), followed by Housing First interventions (n = 25) (within accommodation-based interventions) and welfare and housing support (n = 24) (within prevention interventions). Other sub-intervention categories with a fair number of studies include case management/critical time interventions (n = 22) (within services and outreach interventions) and addiction support (n = 20) (within health and social care interventions), and outreach interventions (n = 18) (within services and outreach interventions).

Sub-intervention categories with the lowest number of studies include: public information campaigns, work experience, vocational training, rapid rehousing, host homes, end-of-life care, flexible employment, day centres and feeding, landlord-tenant mediation, and housing supply.

Figure 12: Distribution of included studies by sub-intervention categories (UK, overall)



6.5 Barriers

Table 6 shows the aggregate map the same as presented for the map overall above just for UK studies. The pattern is not very different from that seen in the map as a whole. For legislation, contextual factors are more likely to be a barrier (ratio 1.52), as are policy makers / funders (1.32), with staff / case worker and recipient are less likely to be so (0.67 and 0.84 respectively). The converse is true for health and social care, and for education and skills. Staff and case workers are disproportionately likely to be a barrier for these interventions.

6.6 Facilitators

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

Table 6: Aggregate Implementation EGM of included studies for intervention and barriers (UK only)

	Contextual factors	Policy makers/ funders	Program administrator/ manager/ implementing agency	Staff/ case worker	Recipient of program	Total	Memo: As percent of column total
Legislation	**9**	**9**	**13**	**7**	**10**	**48**	6.5
	18.8	18.8	27.1	14.6	20.8	100.0	3.4
	1.52	1.32	1.01	0.67	0.84	1.00	1.94
Prevention	**11**	**12**	**24**	**18**	**18**	**83**	11.3
	13.3	14.5	28.9	21.7	21.7	100.0	11.1
	1.07	1.01	1.08	0.99	0.88	1.00	1.02
Services and outreach	**23**	**26**	**48**	**37**	**47**	**181**	24.6
	13	14	27	20	26	100	22
	1.03	1.01	0.99	0.94	1.05	1.00	1.13
Accommodation based interventions	**26**	**25**	**43**	**30**	**45**	**169**	22.9
	15.4	14.8	25.4	17.8	26.6	100.0	29.9
	1.25	1.04	0.95	0.81	1.08	1.00	0.77
Employment	**4**	**3**	**9**	**8**	**8**	**32**	4.3
	12.5	9.4	28.1	25.0	25.0	100.0	3.2
	1.01	0.66	1.05	1.14	1.01	1.00	1.36
Health and social care	**8**	**14**	**34**	**34**	**31**	**121**	16.4
	6.6	11.6	28.1	28.1	25.6	100.0	20.7
	0.54	0.81	1.05	1.29	1.04	1.00	0.79
Education and skills	**2**	**4**	**10**	**10**	**10**	**36**	4.9
	5.6	11.1	27.8	27.8	27.8	100.0	5.9
	0.45	0.78	1.03	1.27	1.12	1.00	0.83
Communication	**4**	**4**	**7**	**8**	**6**	**29**	3.9
	13.8	13.8	24.1	27.6	20.7	100.0	2.6
	1.12	0.97	0.90	1.26	0.84	1.00	1.51
Financing	**4**	**8**	**10**	**9**	**7**	**38**	5.2
	10.5	21.1	26.3	23.7	18.4	100.0	1.6
	0.85	1.48	0.98	1.08	0.75	1.00	3.24
Total / overall	**91**	**105**	**198**	**161**	**182**	**737**	100.0
	12.3	14.2	26.9	21.8	24.7	100.0	

Note: First row: number of studies coded as reporting a barrier of that type for that intervention category. Second row: share of that type of barrier in the total number of barriers faced by that intervention category (i.e. a % of the total in that row). Third row: ratio of that share to the share of the barrier across all interventions. Those in red show that this is a particular barrier.

Table 7: Aggregate Implementation EGM of included studies for intervention and facilitators (UK only)

	Contextual factors	Policy makers/ funders	Program administrator/ manager/ implementing agency	Staff/ case worker	Recipient of program	Total	Memo: As percent of column total
Legislation	**9**	**9**	**10**	**9**	**8**	**45**	**5.7**
	20.0	20.0	22.2	20.0	17.8	100.0	3.4
	2.42	1.62	0.97	0.70	0.63	1.00	1.71
Prevention	**9**	**11**	**21**	**29**	**26**	**96**	**12.2**
	9.4	11.5	21.9	30.2	27.1	100.0	11.1
	1.13	0.93	0.95	1.06	0.97	1.00	1.11
Services and outreach	**15**	**30**	**52**	**54**	**54**	**205**	**26.1**
	7	15	25	26	26	100	21.7
	0.88	1.18	1.11	0.93	0.94	1.00	1.20
Accommodation based interventions	**14**	**24**	**41**	**47**	**48**	**174**	**22.2**
	8.0	13.8	23.6	27.0	27.6	100.0	29.9
	0.97	1.12	1.03	0.95	0.98	1.00	0.74
Employment	**4**	**1**	**10**	**8**	**9**	**32**	**4.1**
	12.5	3.1	31.3	25.0	28.1	100.0	3.2
	1.51	0.25	1.36	0.88	1.00	1.00	1.28
Health and social care	**6**	**9**	**22**	**46**	**44**	**127**	**16.2**
	4.7	7.1	17.3	36.2	34.6	100.0	20.7
	0.57	0.57	0.76	1.28	1.24	1.00	0.78
Education and skills	**2**	**4**	**7**	**13**	**18**	**44**	**5.6**
	4.5	9.1	15.9	29.5	40.9	100.0	5.9
	0.55	0.74	0.69	1.04	1.46	1.00	0.96
Communication	**5**	**5**	**8**	**9**	**6**	**33**	**4.2**
	15.2	15.2	24.2	27.3	18.2	100.0	2.6
	1.83	1.23	1.06	0.96	0.65	1.00	1.62
Financing	**1**	**4**	**9**	**8**	**7**	**29**	**3.7**
	3.4	13.8	31.0	27.6	24.1	100.0	1.6
	0.42	1.12	1.35	0.97	0.86	1.00	2.32
Total / overall	**65**	**97**	**180**	**223**	**220**	**785**	**100.0**
	8.3	12.4	22.9	28.4	28.0	100.0	

Note: First row: number of studies coded as reporting a barrier of that type for that intervention category. Second row: share of that type of barrier in the total number of barriers faced by that intervention category (i.e. a % of the total in that row). Third row: ratio of that share to the share of the barrier across all interventions. Those in red show that this is a particular barrier.

From the perspective of the staff/case worker, engaging in effective communication was the most-noted facilitator. The analysis broke this into two separate categories: communication with the programme recipient (n = 99) and emotional skills (e.g. awareness, empathy, building trust, and taking a personalised approach) (n=89). In addition, staff technical skills, capabilities and training (n = 63) helped facilitate the intervention implementation. Likewise, buy-in or commitment to the program (n=64) and communication with other agencies (n=62) were also identified as a facilitator for interventions.

Recipients, meanwhile, identified access to non-housing support (e.g. medical, financial and training) as a major contributor that facilitated the successful implementation of interventions (n = 113), followed by buy-in and emotional acceptance of the program (n = 81) and accessibility (in terms of both time and place) (n = 60).

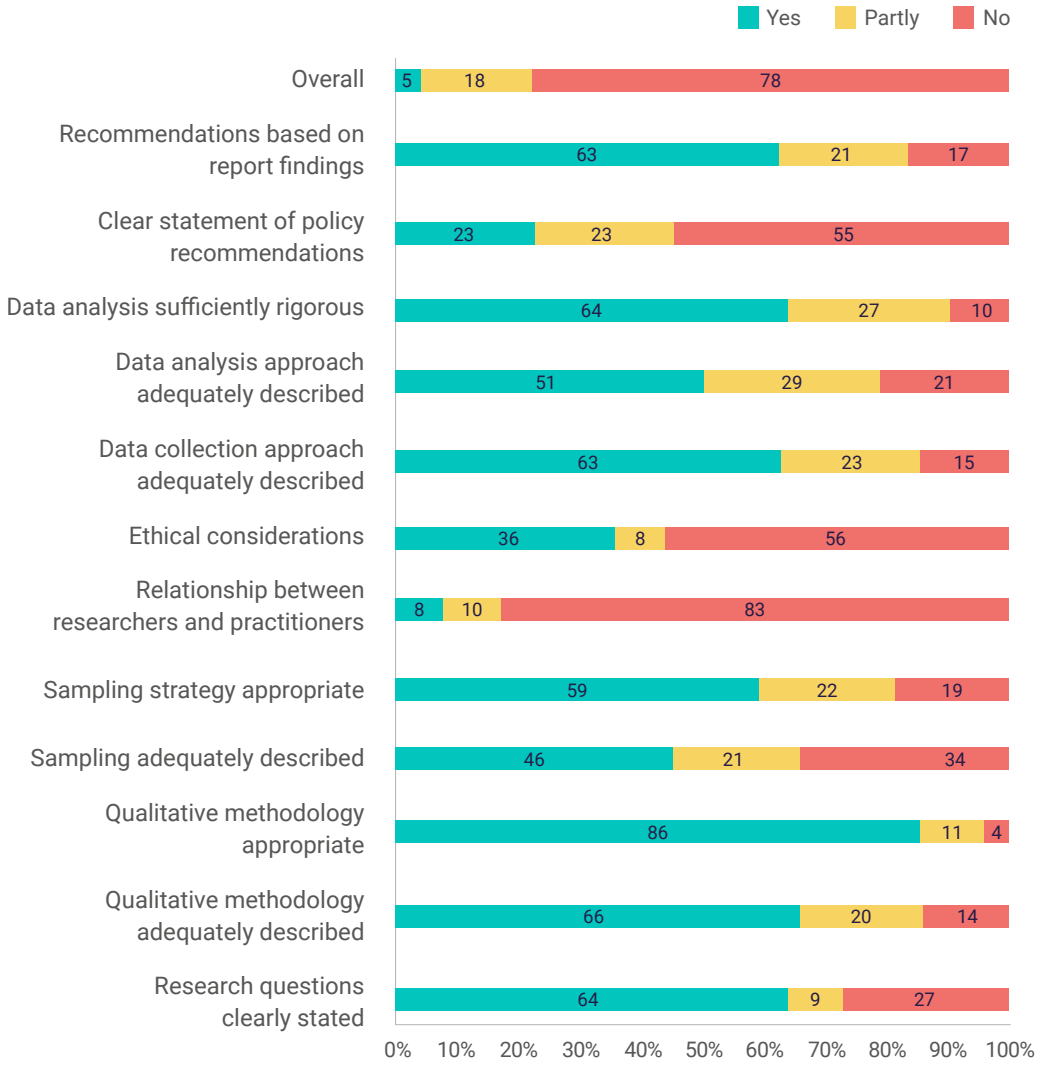
6.7 Confidence in Findings

A total of 76% of included studies were rated as low confidence regarding their findings. Approximately 18% were assessed as medium confidence, while only approximately 4% were assessed as high confidence. An assessment of confidence in the findings was not carried out for five studies from the UK, as they were protocols.

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

We follow ‘the weakest in the chain’ principle, a low score on just one of the questions leads to a study being assessed as low confidence. Thus, a high number of studies were likely assessed as being of low confidence in their findings due to an insufficient description of the relationship between the researchers and participants.

Figure 13: Distribution of responses to the CASP checklist for included studies (UK, overall)



Appendices

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

1. Legislation

1.1 Housing/Homelessness Legislation

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

1.2 Welfare benefits

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

1.3 Health and Social Care Legislation

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

2. Prevention

2.1 Welfare and Housing Support

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

2.2 Housing supply

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

or Roofless OR People experiencing homelessness OR Rough sleepers) AND (Housing OR Housing Schemes OR Housing Programmes)

2.3 Family mediation and conciliation

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

2.4 Landlord-tenant mediation

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

2.5 Discharge interventions

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

3 Services and Outreach

3.1 and 3.3

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

3.2

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

3.4

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Outreach access and recover OR assertive outreach OR street team OR multidisciplinary street team OR intensive outreach OR community prevention)

3.5 and 3.7

Reconnection and CTI done (no need to run again)

3.6

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Assets-based programmes OR strength-based programmes OR Assets-based interventions OR strength-based interventions OR psychologically informed environments) OR strength profiling)

3.8

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

residential treatment OR non residential treatment OR specialist integrated care OR coordination of care OR intergovernmental OR integrated housing services)

3.9

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

3.10

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

4. Accommodation and accommodation-based services

4.1-4.4

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

and accommodation-based services OR Shelters OR Hostels OR Temporary Accommodation OR Host Homes OR Housing Placement OR Housing support) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers)

4.5 Rapid Rehousing

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

4.6 Housing First

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

4.7 Social Housing (with or without support)

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

4.8 Private rental sector (with or without support)

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

4.9 Continuum of care

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

5. Employment

5.1 Mentoring, coaching and in-work support

(Effectiveness OR impact evaluation OR Implementation OR Barriers and

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

5.2 Flexible employment

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

5.3 Vocational training and unpaid work experiences

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

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

5.4 Paid work experiences

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

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

6. Health and Social care

6.1 Physical and mental health

6.1.1

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

6.1.2

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

6.2 End of life care

(Effectiveness OR impact evaluation OR Implementation OR Barriers and facilitators OR Process Evaluation OR Evaluation) AND (Homeless OR Houseless or Roofless OR People experiencing homelessness OR Rough sleepers) AND (End of life care interventions OR End of life planning OR Palliative care OR respite care OR Hospital care)

6.3 Addiction support

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

7. Education and Skills

7.1 Life and social skills training

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

7.2 Mainstream education

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

7.3 Homelessness awareness programmes in schools

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

7.4 Recreational and creative activities

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

8. Communication

8.1 Advocacy Campaign

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

8.2 Public information campaigns

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

8.3 Service availability

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

9. Financing

9.1 Social Impact Bonds

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

9.2 Direct financial support from public

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

Appendix 2: Organisational/institutional websites searched

Country/Region (with dates searched in parentheses)	Websites searched (Organisation/ Institution name and URL)
Australia (4th August 2023)	FACS New South Wales https://www.facs.nsw.gov.au/providers/homelessness-services/resources/research-and-evaluation/chapters/reports Mission Australia www.missionaustralia.com.au The Deck thedeck.org.au FACS Victoria Invalid URL FACS Western Australia Invalid url Queensland Invalid url Australian Institute of Family Studies https://aifs.gov.au/publications/search?f%5B0%5D=sm_vid_Tags%3AHousing%20and%20homelessness APO apo.org.au

Country/Region (with dates searched in parentheses)	Websites searched (Organisation/ Institution name and URL)
Canada (8th-9th August 2023)	Homeless Hub (Journal articles) https://www.homelesshub.ca/search-library?keywords=evaluation&publication_date=1970-01-01%2000%3A00%3A00&f%5B0%5D=field_resource_type%3A253 Homeless Hub (Reports) https://www.homelesshub.ca/search-library?keywords=evaluation&publication_date=1970-01-01%2000%3A00%3A00&f%5B0%5D=field_resource_type%3A259 Homeless Hub (Dissertations) https://www.homelesshub.ca/search-library?keywords=evaluation&publication_date=1970-01-01%2000%3A00%3A00&f%5B0%5D=field_resource_type%3A262 Inn from the cold https://innfromthecold.org/ University of Ottawa https://uniweb.uottawa.ca/#!psychology/themes/999:246/publications
Europe (8th August 2023)	FEANTSA https://www.feantsa.org/en
UK (7th August 2023)	Centre for Housing Policy, York https://www.york.ac.uk/chp/ Crisis https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/ Homeless Link https://homeless.org.uk/ i-sphere https://i-sphere.site.hw.ac.uk/ Joseph Rowntree Foundation jrf.org.uk Shelter shelter.org.uk Social Care Institute for Excellence https://www.scie-socialcareonline.org.uk/ The National Lottery Community Fund https://www.tnlcommunityfund.org.uk/
USA (7-8th August 2023)	HUD Program Evaluation Division https://www.huduser.gov/portal/research/eval.html https://www.huduser.gov/portal/index.php?qbing=evaluation&q=search.html&x=0&y=0 https://www.huduser.gov/portal/publications/pdr_studies.html Department of labour Search term: Homeless evaluation https://search.usa.gov/search?utf8=%E2%9C%93&affiliate=www.dol.gov&query=homeless+evaluation

Appendix 3: List of hand-searched journals

Name of the Journal	URL	Dates searched
Health & Social Care in the Community	https://onlinelibrary.wiley.com/loi/13652524	17th September, 2023
Housing Care and Support	https://www.emerald.com/insight/publication/issn/1460-8790	21st September, 2023
Housing Policy Debate	https://www.tandfonline.com/loi/rhpd20	21st August, 2023
Housing Studies	https://www.tandfonline.com/loi/chos20	21st August, 2023
International Journal of Housing Policy	https://www.tandfonline.com/loi/reuj20	21st September, 2023
Journal of Social Distress and the Homeless	https://www.tandfonline.com/loi/ysdh20	17th September, 2023
Parity	https://search.informit.org/journal/par	21st September, 2023

Appendix 4 (a): Definitions of Intervention categories and sub-categories

Intervention	Intervention sub-category	Definition
Legislation		**Marked if any sub-category in this category is marked**
	Housing/ Homelessness Legislation	Legislation pertaining to availability of / access to housing, or the rights of those experiencing homelessness
	Welfare Benefits	Legislation for welfare programmes to help people experiencing homelessness, or to help prevent people who are at risk of becoming homeless from losing their home.
	Health and social care legislation	Legislation for access to health and social care to help people experiencing homelessness, or to help people who are at risk of becoming homeless.
Prevention		**Marked if any sub-category in this category is marked**
	Welfare and Housing Support	State contribution towards housing costs and other welfare payments and services, whether directly made to tenants or indirectly paid to service provider (e.g. landlords - examples in the UK: Local Housing Alliance, Universal Credit, etc; US: vouchers) from the state or non-state actors. This includes other welfare benefits such as childcare if studied in the context of homelessness.
	Housing supply	Policies promoting the development of new housing supply that is affordable and accessible (whether for social or private purposes) - this includes the construction, conversion of homes, and repurposing. Interventions comprise changes to legislation, financing mechanisms and other support for developers and those conditioning units for these purposes.
	Family mediation and conciliation	Counselling and mediation of conflicts, usually between young people and their family so they may avoid becoming homeless or reduce other risky behaviours. (Landlord-tenant mediation is a separate category)

Prevention	Landlord-tenant mediation	Mediation between landlords and tenants to encourage landlords to accept tenants with history of homelessness, substance abuse etc and to address conflicts. This may include, but is not limited to mediation around arrears, noise and substance abuse, damage to property, eviction, etc. Mediation with neighbours is also included here.
	Discharge interventions	Provision of services, including accommodation, to people being discharged from institutions (care, hospitals, prison, armed forces) to avoid people being discharged into homelessness. This may include coordination between agencies, accommodation, and other services tailored to their needs. It refers to both interventions whilst in the institution and community-based interventions focused on recently discharged persons.
Services and outreach		Marked if any sub-category in this category is marked
	Direct feeding (e.g. soup runs)	Provision of food in street and day centre settings to people experiencing homelessness.
	In-kind support (excl. food)	Provision of clothing, hygiene products, household items etc., but excluding food
	Day centres	Centres open only during the day to provide food and services for people experiencing homelessness. This code is used if the day centre itself is being evaluated in the study rather than being the setting for the intervention.
	Outreach	Outreach refers to work with people sleeping rough or in temporary or unstable accommodation. Outreach workers go out, including late at night and in the early hours of the morning, to locate people who are rough sleeping or work with day centres, shelters etc. The role of outreach teams varies but usually outreach workers seek to engage with people and check their immediate health and well-being, collect basic information about their situation, facilitate access to emergency accommodation or other accommodation (such as hostels or Housing First), and inform them about day centres and other services they might have available. Outreach models vary and may include enforcement (e.g. police officials) to remove people from the streets or enforce specific behaviours.

Services and outreach	Reconnection of people experiencing street homelessness	Reconnecting people experiencing homelessness (rough sleepers) or at risk of homelessness (e.g. dischargees) to their 'home' location (usually another city, state or country where they have networks, access to services, etc) by providing the cost of transport for relocation.
	Psychologically informed environments	Psychologically informed environments are interventions designed to take into account the psychological profile of the client. Community Reinforcement Approach (CRA) is included here.
	Case management (inc. Critical Time Intervention)	Individual-level approach to ensure coordination of services. The case worker (can be social worker or dedicated case worker from another agency) works directly with the client to ensure that the client has access to all applicable services e.g. health, training and social activities. A specific application of the case work approach is critical time intervention (CTI) which provides a person (or family) in transition between types of accommodation and at risk of homelessness with a period of intensive support from a caseworker. The caseworker will have established a relationship with the client before the transition – for example, before discharge from hospital or prison. Critical time intervention involves three stages: (1) direct support to the client and assessing what resources exist to support them, (2) trying out and adjusting the systems of support as necessary, and (3) completing the transfer of care to existing community resources.
	Service coordination, co-location or embedded in mainstream services	System-based approaches to ensuring coordination of service delivery. Coordination may refer to ensuring communication between relevant services. Coordination also includes providing services in the same location or adjacent to mainstream services. Co-location refers to multiple services being available in the same physical location (e.g. housing and job search services in the same location) . Embedded refers to services being integrated in the same place (e.g. housing and other services within a hospital context). A specific example is coordinated assessment. Refers to case workers making broad assessments of people at risk as homelessness on different factors that affect their risk. Try to ensure different services employ the same assessment tools to standardise practice.
	Veterinary services	Access to veterinary services for pets of people experiencing homelessness

Services and outreach	Legal advice	Legal assistance and advice delivered away from primary service/office to the homeless population.
Accommodation and accommodation-based services	Shelters	Homeless shelters are a basic form of temporary accommodation where a bed is provided in a shared space overnight. One of the key features of a homeless shelter is that it is transitional and an option for those homeless who are not yet eligible for more stable accommodation. Shelters are not usually seen as stable forms of accommodation as the individual must vacate the space during daytime hours with their belongings. One of the key differences with hostels is the need to vacate the premises during the day.
	Hostels	Hostels for homeless people are designed to provide short-term accommodation, usually for up to two years depending on available move-on accommodation. Typically shared accommodation projects with individual rooms and shared facilities including bathrooms and kitchens. Hostels have staff on site 24 hours a day and during the daytime provide support to residents on issues including welfare benefits and planning their move from the hostel into more medium to long-term accommodation.
	Temporary accommodation	Temporary accommodation includes a range of housing options which are more stable than shelters or hostels, such as transitional housing and residential programmes.
	Host homes	Emergency Host homes are emergency short-term placements in volunteers' own homes in the community for people who are homeless or at risk of homelessness. Hosting services are often aimed at young people with low support needs, but exist for other groups too, such as people who have been refused asylum.
	Rapid Rehousing	Rapid rehousing places those who are experiencing homelessness into accommodation as soon as possible. The intervention provides assistance in finding accommodation, and limited duration case work to connect the client to other services.
	Housing First	Housing First offers accommodation to homeless people with multiple and complex needs with minimal obligations or conditions being placed upon the participant. Housing First provides safe and stable housing to all individuals, regardless of criminal background, mental instability, substance abuse, or income.

Accommodation and accommodation-based services	Social housing (with or without support)	Housing that is provided in the social sector. It may sometimes be provided alongside support services, this may be temporary or permanent. Examples of support that may be provided are health and money management (excluding Housing First and Rapid Rehousing). This is based on an institutional setting.
	Private Rental Sector (with and without support)	Housing that is provided in the private rental market where the tenant is fully responsible. This may or may not include additional support services as the focus is on the type of tenancy agreement (private).
	Continuum of Care	An approach to accommodation whereby people experiencing homelessness move through different forms of transitional accommodation until they are deemed 'housing ready' (e.g. stopped substance abuse) and allocated independent settled housing.
Employment	Mentoring, coaching and in-work support	Mentoring and coaching to support job search including activities like practice interviews, review CVs, etc and on the job support for work performance.
	Flexible employment	Employment which can accommodate needs for the person experiencing homelessness.
	Vocational training and unpaid work experiences	Unpaid job placement or vocational training to provide work experience for people experiencing, or at risk of, homelessness.
	Paid work experiences	Paid job placement to provide work experience for people experiencing, or at risk of, homelessness.
Health and social care	Health services (physical and mental)	Providing direct access to, or facilitating access to, physical and mental health services for people experiencing homelessness.
	End of life care	End of life care for people experiencing or at risk of homelessness.
	Addiction support	Services for people experiencing, or at risk of, homelessness who have substance misuse problems (including alcohol and other substances)

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

Appendix 4 (b): Definitions of Intervention categories and sub-categories

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

	Alignment with existing protocol/ procedures/ guidelines	Whether a project or programme is well aligned with existing procedures etc.
	Monitoring data/ Data sharing	Availability, collection, and usefulness of monitoring data
	Partnership/ collaboration with external agencies	Formal and informal working arrangements with other agencies
Staff/case worker	Buy-in (commitment to programme)	Understanding and support from delivery (implementation) level staff / case workers
	Communication and engagement with programme recipient	De facto and de jure arrangements for and occurrence of communication with programme recipients by staff / case workers
	Communication and engagement with other agencies	De facto and de jure arrangements for and occurrence of communication with other agencies by staff / case workers
	Emotional skills (Awareness, building trust, taking a personalised approach)	Level of emotional intelligence and skill displayed by staff / case workers
	Technical skills (capabilities, training)	Technical capacity of staff / case workers to perform their jobs, and support for that capacity
	Buy-in (emotional acceptance of programme)	Acceptance of the support offered by the project or programme by intended recipients
	Access to non-housing support (medical, financial, training etc.)	Access to non-housing support services necessary for programme implementation to be successful
	Housing-related security	Provision to stay in appropriate housing to prevent a recurrence of homelessness
	Adequacy of information provided	The quantity and quality of the information provided about the programme to intended beneficiaries
	Accessibility (time and place)	Accessibility of the services provided by the programme in terms of time and space

Appendix 5: Additional tables

	Number		Share of intervention category		Ratio
	Facilitator	**Barrier**	**Facilitator**	**Barrier**	**F/N**
Contextual factors					
Housing Market	43	201	20.5	47.0	0.21
Labour Market	3	34	1.4	7.9	0.09
Welfare Support	110	148	52.4	34.6	0.74
Law	54	45	25.7	10.5	1.20
Total	210	428	100.0	100.0	0.49
Policy makers / funders					
Buy in	139	96	41.9	27.8	1.45
Contracting	84	79	25.3	22.9	1.06
Framework provision	109	170	32.8	49.3	0.64
Total	332	345	100.0	100.0	0.96
Program administrator/ manager/ implementing agency					
Buy in	190	125	16.5	9.8	1.52
Targeting	145	124	12.6	9.7	1.17
Referral	132	114	11.4	8.9	1.16
Resources	230	453	19.9	35.5	0.51
Alignment	77	136	6.7	10.7	0.57
Monitoring and data	110	161	9.5	12.6	0.68
Partnerships	270	162	23.4	12.7	1.67
Total	1154	1275	100.0	100.0	0.91
Staff / case worker					
Buy in	191	87	14.8	13.8	2.20
Engagement with programme recipient	374	181	29.0	28.6	2.07
Engagement with other agencies	201	82	15.6	13.0	2.45
Emotional skills	312	114	24.2	18.0	2.74
Technical skills	213	168	16.5	26.6	1.27
Total	1291	632	100.0	100.0	2.04
Recipient					
Buy in	327	251	25.1	24.7	1.30
Access to non-housing support	437	219	33.5	21.5	2.00
Housing-related security	199	144	15.3	14.1	1.38
Adequacy of information	136	161	10.4	15.8	0.84
Accessibility	205	243	15.7	23.9	0.84
Total	1304	1018	100.0	100.0	1.28
Overall					
Contextual factors	210	428	4.9	11.6	0.49
Policy makers / funders	332	345	7.7	9.3	0.96
Program administrator/ manager/ implementing agency	1154	1275	26.9	34.5	0.91
Staff / case worker	1291	632	30.1	17.1	2.04
Recipient	1304	1018	30.4	27.5	1.28
Total	4291	3698	100.0	100.0	1.16

Appendix 6 (a): Distribution of included studies by sub-intervention categories

Intervention category	Intervention sub-category	Number of Studies (Overall)	Number of Studies (Newly added to 4th edition)	Number of Studies (Added to 5th edition)
Legislation	Housing/Homelessness legislation	28	6	8
	Welfare benefits	11	4	1
	Health & social care	8	2	6
Prevention	Welfare and housing support	94	20	26
	Housing supply	13	3	2
	Family therapy and mediation	12	0	1
	Landlord tenant mediation	9	1	0
	Discharge	25	2	10
Services and Outreach	Feeding	17	2	8
	In kind support	5	19	4
	Day centres	16	2	0
	Outreach	80	26	15
	Reconnection	12	3	1
	Psychologically informed environments	18	7	4
	Case management/ Critical time intervention	79	20	24

Services and Outreach	Service coordination	79	13	30
	Veterinary services	1		1
	Legal advice	13	1	1
Accommodation based services	Shelters	59	14	15
	Hostels	10	0	4
	Temporary accommodation	60	21	15
	Host homes	6	4	0
	Rapid rehousing	10	1	2
	Housing First	135	32	27
	Social housing	97	29	30
	Private rented sector (with and without support)	29	4	5
	Continuum of care	18	5	4
Employment	Mentoring and coaching	27	3	7
	Flexible employment	6	2	1
	Vocational training and unpaid	13	1	1
	Paid Work experiences	20	4	6
Health and social care	Health services	215	33	75
	End of life	3	0	1
	Addiction support	70	14	30

Education and Skills	Vocational training	5	1	0
	Work experience	5	1	2
	Life skill training	25	2	3
	Education	28	4	5
	Creative activities	23	4	7
Communication	Advocacy campaigns	21	2	4
	Public information campaigns	4	0	0
	Service availability	9	2	3
Finance	Social impact bonds	14	0	10
	Direct financial support from public	15	2	5

Appendix 6 (b): Distribution of included studies by sub-intervention categories in UK

Intervention category	Intervention sub-category	Number of Studies
Legislation	Housing/Homelessness legislation	15
	Welfare benefits	4
	Health and Social Care	2
	Welfare and housing support	24
Prevention	Housing supply	3
	Family therapy and mediation	4
	Landlord tenant mediation	3
	Discharge	7
Services and Outreach	Feeding	3
	In kind support	4
	Day centres	3
	Outreach	18
	Reconnection	3
	Psychologically informed environments	10
	Case management / Critical time intervention	22
	Service coordination	17
	Veterinary services	1
	Legal advice	4
Accommodation based services	Shelters	10
	Hostels	6

Accommodation based services	Temporary accommodation	7
	Host homes	2
	Rapid Rehousing	1
	Housing first	25
	Social housing	13
	Private rented sector (with and without support)	7
Employment	Mentoring and coaching	10
	Flexible employment	3
	Vocational training and unpaid	5
	Paid Work experiences	8
Health and Social care	Health services	53
	End of life	1
	Addiction support	20
Education and skills	Vocational training	2
	Work experience	1
	Life skill training	11
	Education	5
	Creative activities	8
Communication	Advocacy campaigns	8
	Public information campaigns	1
	Service availability	4
Finance	Social impact bonds	10
	Direct financial support from public	7

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Endnotes

1. The second edition initially contained 597 studies; however, after removing a duplicate, this number was reduced to 596.
2. OpenAlex is an open-source index of hundreds of millions of publication records from the global research system. See here. EPPI Reviewer has a 'Bring up-to-date' feature which lets the user select certain items in a review/map or all the included items in a review against which the software runs searches from OpenAlex. There is also a provision to choose different search modes. We used the 'Bi-citation AND Recommendation' mode for searches.
3. The map includes studies identified by searches conducted up to September 2023.
4. After deduplication, one study was removed from the previous edition of the map, leading to 596 studies from the previous edition (2023 edition).
5. This map also includes 126 studies published in 2023. The machine learning and website searches were conducted until September 2023, along with the effectiveness edition. Since most searches for this map were conducted until September 2023, this map does not include studies from the last quarter of that year, and it does not indicate the total number of eligible studies for this map in 2023.
6. These figures are from the sub-category level of coding of barriers and facilitators aggregated across category, so a single study may appear more than once in each category if it is coded against more than one sub-category in that category.
7. The remaining 3% of studies are protocols which are not subject to critical appraisal.