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ADDRESSING HOMELESSNESS IN CANADA: IMPLICATIONS FOR INTERVENTION STRATEGIES AND PROGRAM DESIGN

A REVIEW OF THE LITERATURE

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Abstract

Homelessness is a significant social phenomenon in Canada. The currently available body of research presents varied and often conflicting views with regards to effective intervention strategies for homeless populations. The purpose of this paper is to explore some of the contemporary discourse surrounding homelessness in Canada as well as available models for addressing the issue. More specifically, this paper will focus on implications for service design and provision in Montreal with the intention of informing research related to program creation, maintenance and evaluation at the Old Brewery Mission.

Introduction

Homeless people are largely understood to be those sleeping in homeless shelters or those haggard few begging on street corners. However, this simplification overlooks the realities of the situation. Many sleep outdoors. Others, perhaps dressing well, refuse to beg and instead choose to spend their days in shopping centres or drop-ins. Others yet are employed. What, then, is truly implied by the term *homelessness*? That is the question this section attempts to address.

The term *homelessness* is broad and surprisingly ill-defined in the academic literature. While various organizations, both domestic and international, often have their own interpretations of the term, there is no official definition in Canada (Echenberg & Jensen, 2008). Currently there is even debate over the appropriateness of the term itself, and the word *houselessness* has been proposed as a more accurate and neutral alternative (Echenberg & Jensen, 2008; Hulchanski, 2000) This proposition arose due to the ambiguity of the term homelessness, which originally emerged to reflect the then primary issue of poor quality housing stock for the poor, implying that while these individuals were housed, they had no home. Houselessness, more recently, resolves this ambiguity by distinguishing the more fundamental issue of not having any housing whatsoever (Fischer, 1989; Hulchanski, Homeless Hub, Canadian Homelessness Research Network., & University of Toronto. Cities Centre., 2009)

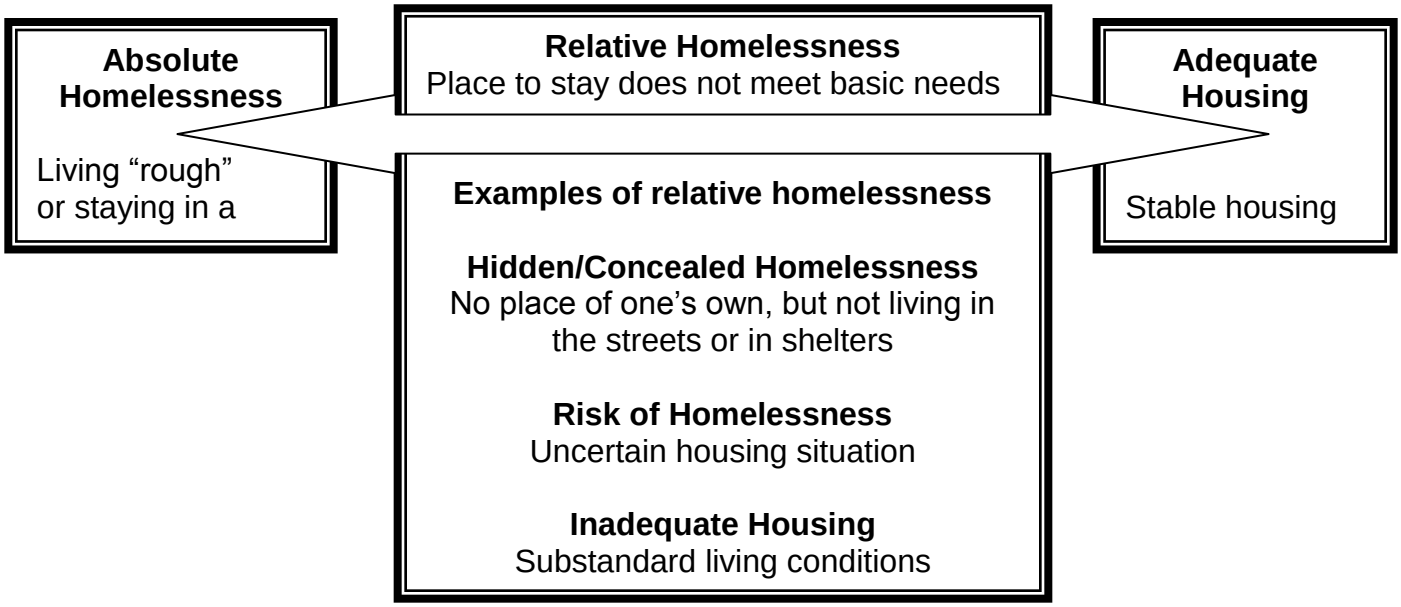
In Canada, homelessness is often illustrated on a continuum with absolute homelessness on one end and relative homelessness on the other end. This continuum is depicted below in Figure 1. *Absolute homelessness* refers to those people sleeping "rough" or staying in shelters while *relative homelessness* speaks to situations where

people have substandard living conditions or are at risk of homelessness. In the middle of the continuum there are those people who do not have a place of their own but are not staying on the streets or in shelters, referred to as *hidden or concealed homelessness* (Echenberg & Jensen, 2008).

It is important to include not only those people who are currently facing homelessness, but also those people who are *at risk of homelessness.* This term, also called *insecure housing*, refers to those individuals who are facing an uncertain housing situation in the future due to eviction, the end of a lease or violence (Hulchanski, 2000; Springer, 2000). People that are at risk of homelessness are especially difficult to quantify because they may not be consuming services that are generally associated with the homeless population, such as emergency shelters.

Other individuals that can be included under the broad category of *homeless* are the people that inhabit *inadequate housing*. Inadequate living conditions can be characterized as being too small, unsafe, in need of repairs or generally as not meeting the basic needs of the inhabitants (Echenberg & Jensen, 2008). Substandard housing is significant because it often plays a role in the lives of people before they become homeless and then again as they transition out of homelessness (Springer, 2000). Like people who are living in insecure housing arrangements, people who are inadequately housed can be difficult to quantify.

Figure 1. The Homeless Continuum.



According to Habitat International, housing is not only a basic human right, but having adequate housing also provides a foundation for other human needs such as social relationships and the ability to engage in community participation (Springer, 2000). Homelessness, however one chooses to define it, undoubtedly robs individuals of some degree of safety, security and stability. For the purposes of this paper, the term homelessness will be employed because it remains more common than any other term. Further, the term homelessness will be narrowly used to refer to individuals that are living on the streets or in shelters unless otherwise specified. The following section will present some of the information that exists on the scope, causes and research challenges associated with homelessness.

Demographics of Homelessness

Homelessness is a complex and enduring problem. As discussed above, the definition of homelessness has yet to yield to a consensus in Canada. This is

significant because the decision of who constitutes as being homeless and who does not has serious implications for policy makers (Springer, 2000). This section will explore some of the trends associated with homeless populations with a particular emphasis on a Canadian context. When investigating issues with limited Canadian literature, research will be drawn from comparable international sources.

Enumerating Homelessness

One of the difficulties inherent in studying homelessness is the reality that homeless populations are difficult to accurately count. By nature, homeless individuals are often in periods of transition, and there are major challenges in measuring a population with no stable address. While studies have been undertaken in other nations to ascertain the exact number of homeless people at a given time, such studies are expensive and may not even account for people who fall under the *hidden or concealed homeless* categorizations (Echenberg & Jensen, 2008). Using varied definitions, it has been suggested that there are anywhere between 150 000 to 300 000 people, or 0.4-0.9% of the population, that can be classified as homeless in Canada (Echenberg & Jensen, 2008).

To date, two major strategies have been employed to estimate homeless populations. Point prevalence counts estimate the number of people who are homeless at any given point in time. It is generally done by conducting a survey of shelters and head count of known homeless hotspots on a given night. This method has been criticised because it does not explore how long a person has been homeless, thus not capturing the complexity or severity of the problem (Hulchanski, 2000). The other measure of homeless populations is described as period prevalence and speaks to how

many people have been homeless over a specified period of time (Hulchanski, 2000). Although this method is praised for its relevance in preventative program development (Hulchanski et al., 2009), it still remains vulnerable to overlooking difficult to count, hidden populations of homeless people (Berry, 2007).

There are conflicting views surrounding the importance of establishing a firm number of homeless people in Canada. On one hand, such data can inform projections of service needs (Canadian Institute for Health & Canadian Population Health, 2007). This in turn may have a positive influence on service design and delivery, resource management and policy decisions (Berry, 2007). On the other hand, it has been argued that a focus on enumeration diverts attention from the actual problem of homelessness itself (Hulchanski, 2000). Hulchanski (2000) argues that available research already situates homelessness as a severe problem that affects many thousands of people in Canada. Consequently, he asserts that this alone should be argument enough to shift attention from superficially quantifying the issue to meaningfully addressing the problem.

Regional Disparities

While many stakeholders recognize that homelessness is a pervasive problem in Canada, it is important to note that not all geographic areas are affected equally, resulting in disparities between provinces, cities and regions. 2001 Statistics Canada data indicated that Quebec, Alberta, Ontario, British Columbia and Manitoba experienced substantially higher rates of people living in shelters than other provinces and territories (Statistics Canada, 2001). It is important to note that this study only took into account the number of people living in shelters at a specific point in time (point-

prevalence count) and did not account for people who are in and out of shelters as well as hidden homeless populations.

The same data portrayed greater proportions of people living in shelters in large cities and minimal shelter service users in small towns (Statistics Canada, 2001). Resources such as shelters, food banks and other social services tend to be clustered in large urban centres. If people wish to access such resources, it is necessary that they be in close proximity. To this end, as is supported by Statistic Canada research, many visibly homeless people find themselves in urban rather than rural areas (2001).

Background on Montreal Demographics

Like other cities, estimating the prevalence of homelessness in Montreal is not precise. In 2001 Statistics Canada reported that there were approximately 3365 visibly homeless people in the province of Quebec. Over half of this population (1785) was residing in Montreal (Statistics Canada, 2001). However, as was discussed prior, counting the homeless is an imperfect science. For example, Begin et al. (1999) estimated Montreal's homeless population to be 10-28,000. In this city, males between 35 and 64 make up a disproportionate percentage of the visible homeless population (Statistics Canada, 2001). In the winter of 2004, men accounted for 91% of shelter users in Montreal (Hurtubise, Babin, & Grimard, 2007)

Typologies of Homelessness

It is a common misconception that the homeless population is composed of a homogenous group with similar needs and characteristics. This misconception, often informed by the most visibly homeless, overlooks the fact that people may become

homeless, and remain so, for a variety of reasons (Wasserman & Clair, 2011). Much of the current literature breaks homeless individuals into three categories based on distinct patterns of homelessness: the transitionally homeless, the episodically or cyclically homeless, and the chronically homeless (Culhane & Metraux, 2008; Echenberg & Jensen, 2008; Kuhn & Culhane, 1998). Although still too simplistic to account for the diversity that exists with regards to homeless populations, such categorizations are helpful to determine appropriate policy decisions and interventions in shelter settings (Culhane & Metraux, 2008).

Transitional homelessness. The group most common in shelter populations is considered to be transitionally or temporarily homeless. It is believed that this group consists of approximately 80% of the total shelter population (Kuhn & Culhane, 1998). This group is typically characterized by shorter shelter stays and fewer issues with mental health and addictions (Culhane & Metraux, 2008). People who match this description may have found themselves homeless due to a natural disaster, unemployment or separation (Echenberg & Jensen, 2008; Kuhn & Culhane, 1998).

Episodic or cyclical homelessness. The second typology cited in the literature is episodic or cyclical homelessness. This term refers to those people who find themselves homeless after periods of being housed outside of a shelter and account for approximately 10% of shelter populations (Kuhn & Culhane, 1998). This group tends to vary in age and be characterized by concurrent issues of addictions and mental health as well as high rates of chronic unemployment. It is suggested that in some cases the only reason people in this category do not become chronically homeless is due to the

time they spend in institutions other than shelters such as prisons, hospitals and treatment facilities (Culhane & Metraux, 2008).

Chronic homelessness. The third group is classified as the population that is chronically homeless. While accounting for only about 10% of the shelter population, the chronically homeless tend to consume half of all shelter days (Kuhn & Culhane, 1998). Chronically homeless individuals tend to be older and to have been homeless longer than individuals in the other two groups. These individuals are also more likely to be living with disabilities, mental health issues and addictions (Culhane & Metraux, 2008). According to Tsemberis, Gulcur and Nakae (2004), most shelter programs are ill-equipped to meet the specialized needs of this population.

The above classifications, while not inclusive of all situations involving homelessness, can assist in furthering our understanding of the phenomenon itself. Indeed, while there are many observable patterns related to homelessness, such as addictions, unemployment, and mental health issues, there are other situational factors at play. That said, homelessness may be triggered by a number of events including family breakdown, the loss of a job or lack of affordable housing. The following sections will explore some of these mitigating factors and the ways in which they create needs for specialized service provision

Characteristics of Homeless Populations

Despite the accepted notion that homeless populations are heterogeneous in nature (Peressini, 2007) a review of the literature suggested that there are common characteristics that repeatedly surface and therefore must be addressed. Isolating the causes of homelessness is difficult to accomplish in the social sciences. We review

some of the issues that are frequently found to characterize homeless populations. Importantly, these should not be interpreted as causal factors.

Poverty. Almost 10% of Canadians (approximately 2.95 million people) are living on a low income (Collin & Jensen, 2009). Poverty, or lack of income, is consistently cited as the leading cause of homelessness (Laird & Sheldon Chumir Foundation for Ethics in Leadership., 2007) instance, an Ontario survey of homeless people (N=268) found that 75% of respondents cited poverty as the main cause of their current homelessness (Peressini, 2007). Similarly, the 2005 Greater Vancouver Regional District homeless count found that 44% of all homeless people surveyed (N=1 909) stated economic issues (lack of income or job) as the cause of homelessness (Social Planning and Research Council of BC, 2005). Groups that are more at risk of living in poverty include children, lone-parent families, women, unattached individuals, seniors, people with disabilities, aboriginal people, recent immigrants and visible minorities (Collin & Jensen, 2009).

Mental health. High rates of mental health issues have been linked to homelessness. The deinstitutionalization movement began in Canada in the 1960s with the rapid closure of beds for psychiatric patients and continued into the 1990s with a decline in inpatient care (Sealy P & Whitehead PC, 2004). Subsequently, this led to many people with mental illness to experience periods of homelessness in the post-deinstitutionalization era (Stuart & Arboleda-Flórez, 2000). Canadian studies have shown that people who are homeless experience higher rates of mental illness than the general population (Public Health Agency of Canada, 2006). While schizophrenia has a 6% lifetime prevalence among Toronto's homeless, affective disorders are more

common at 20-40% (Frankish, Hwang, & Quantz, 2005). Some studies estimate mental health problems exist in 40-60% of the homeless population (Hurtubise et al., 2007). People who are homeless are also at a greater risk for suicidal feelings and heightened levels of stress (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005). It must be noted that although mental illness may precede homelessness, homelessness may exacerbate mental illness and its symptoms(Canadian Institute for Health & Canadian Population Health, 2007).

Substance abuse. Substance abuse is another issue commonly found within homeless populations. Addiction is often closely tied with mental illness as many people will self medicate, thus presenting with concurrent disorders (Tsemberis et al., 2004). In one study, substance abuse was found within 83% of the chronically homeless, 66% of the episodically homeless and 49% of the transitionally homeless (Kuhn & Culhane, 1998). Alcohol tends to be the most commonly used substance among homeless populations, with reported rates falling anywhere between 53-73% (Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006). In addition, one Toronto study involving 368 homeless adults (Khandor & Mason, 2008) found high rates of drug use: marijuana (60%), cocaine (52%) crack (49%), oxycontin (25%), morphine (18%), heroin (14%) and other opiates (25%).

Physical health. An expansive literature review conducted in Vancouver found a strong relationship between homelessness and poor physical health (Eberle, Kraus, Serge, & Hulchanski, 2001). Mortality rates are much higher for street involved people than for housed populations, similar to those found in underdeveloped countries (Hwang SW, 2000; Roy E et al., 2004; Turnbull, Muckle, & Masters, 2007). For instance,

mortality rates for street youth in Montreal are 9 times higher for males and 31 times higher for females, when compared to housed populations (Roy E et al., 2004). A variety of health conditions are relatively common in shelter users, such as tuberculosis, HIV, arthritis, hypertension, diabetes, fungal infections, and parasites (Hwang, 2001). In addition, symptoms of traumatic brain injury (TBI) have been reported in up to 53% of homeless people (Hwang et al., 2008). Furthermore, most, if not all of these variables figure more prominently for the chronically homeless (Kertesz SG et al., 2005)

Due to the conditions inherent in being homeless, people without a fixed address are more likely to find themselves in health-compromising situations (Canadian Institute for Health & Canadian Population Health, 2007). Assaults are common, with 40% of men reporting one in the previous year, and 20% of women reporting rape in the same time frame (Crowe & Hardill, 1993; Kushel MB, Evans JL, Perry S, Robertson MJ, & Moss AR, 2003). Homeless individuals are more likely to consume more social services, experience more social problems and are more likely to become involved in criminal activity (Eberle et al., 2001). Finally, these issues may be exacerbated by histories of violence and abuse as well as "linguistic barriers and cultural biases" (Scott, 2007; Whitzman, 2006).

Gender differences. Despite some conflicting findings (Rich & Clark, 2005), research has indicated that men and women may experience homelessness differently. Some evidence has suggested that gender may not only inform pathways into homelessness, but also the most effective routes out of homelessness. These findings are important because they speak to the need for targeted services in order to yield the most effective results.

Men are more likely to attribute their homelessness to loss of a job, mental health problems or addiction. Women, on the other hand, tend to attribute homelessness to different issues, namely the loss of social support, eviction or interpersonal issues (Peressini, 2007). While homeless men report higher rates of chronic homelessness, homeless women are more likely to have histories of violence and abuse (Rich & Clark, 2005). Homeless men are much more likely to employ shelter services, and thus are a more visible population (Rich & Clark, 2005). Homeless women are more likely to constitute a larger portion of the "hidden homeless" and are more likely to have children in their care (Scott, 2007).

Some evidence has indicated that men and women may benefit from different forms of homeless intervention. One study found that men are more likely to respond positively to a comprehensive model (supported or supportive housing) than to a case management model (Rich & Clark, 2005). The same study found both interventions to be effective with homeless women, although periods of stable housing increased slightly with the case management model (2005). Although such evidence may be useful in designing programs and intervention strategies, it must be noted that due to limited literature the topic requires further research.

Aboriginal populations. In Canada, Aboriginal peoples are disproportionately overrepresented in homeless populations (Canadian Institute for Health & Canadian Population Health, 2007). Hwang (2001) found that they are overrepresented by a factor of about 10, and they are more likely to sleep on the streets rather than in shelters. Currently, this population has a higher infant mortality rate and a lower life expectancy than the Canadian average. In addition, housing conditions are poorer in First Nations

communities and rates are disproportionately high for substance abuse disorders and chronic health conditions(Health Canada, 2009). Due to this group's history of cultural assimilation and family disruption due to colonization, Aboriginal peoples experience unique barriers that may not be addressed in mainstream homeless interventions (Scott, 2007).

Age distinctions. As previously stated, Canada's homeless population is incredibly diverse and the age range of the population is no exception. While youth under 19 made up 4% of the homeless people surveyed by the Social Planning and Research Council of BC (2005), 9.5% of youth are currently living in low income households (Collin & Jensen, 2009). It has additionally been suggested that as many as 65 000 youth are relatively or absolutely homeless at some point each year (Evenson, Barr, & Raising the Roof, 2009).

It has been suggested that people over the age of 65 consist of approximately 6% of the visible homeless population in Canada (Stuart & Arboleda-Flórez, 2000), while people over 55 represent 9% (Social Planning and Research Council of BC, 2005). Defined as "the most vulnerable of this impoverished population," numbers of homeless seniors have been increasing in Canada (Stergiopoulos & Herrmann, 2003). Adults between the age of 25-55 represent the majority of the homeless population in Canada, estimates varying around approximately 75% (Social Planning and Research Council of BC, 2005).

Theoretical Foundations

Discourses surrounding homelessness have over the years largely been dichotomized into two opposing schools of thought, namely *personal* and *structural* causes of homelessness (Clapham, 2003). Homelessness, and all related issues (substance abuse, issues in mental health, unemployment among others) may be viewed on one hand as the result of personal failings, or on the other hand as the consequence of structural barriers. This section will briefly describe each theoretical model and explore the ways in which they may be integrated to inform effective intervention strategies.

Personal Responsibility Model

The personal responsibility model has traditionally informed social policy for the impoverished, dating historically to the English poor laws (Rose, 2003). This framework stresses the importance of personal choice above environmental elements and suggests a distinction between those who are “deserving” and “undeserving” of intervention (Clapham, 2003). This model regards homelessness as an individual pathology as opposed to a social problem (Jacobs, Kemeny, & Manzi, 1999). Despite the assumption of personal failing as the driver of homelessness, the typical treatment solution entails providing little other than a structured and restrictive shelter environment. This would then seem to undermine the individual agency that the problem's construction would require (Greenwood et al., 2005).

Structural Model

The structural framework is a more recent approach to addressing the issue of homelessness. Structuralism places a greater emphasis on societal elements, such as housing costs, unemployment rates, and society's overall shortcomings with respect to ameliorating public responses to homelessness. Rather than an individual failing, this approach regards homelessness as a societal issue to be addressed through public policy (Clapham, 2003). This position is supported by the historical development and variation of homelessness. For example, little homelessness existed in Canada prior to the 1980's, when deinstitutionalization and coincident cuts in funding to social housing forced many people from situations in which they were considered housed, leading to a large boom in homelessness (Hulchanski et al., 2009).

The structural-personal divide is a helpful theoretical foundation as it offers differing perspectives to understanding the issue of homelessness; however, each model has been criticized for being overly simplistic. As a result, much of the literature now suggests an integration of individual and structural factors when discussing causes of homelessness (Fischer, 1989; Fitzpatrick, Kemp, & Klinker, 2000).

Interventions in Homelessness

Over the past two decades, numerous divergent models of homelessness intervention strategies have emerged. Although each model strives toward a similar end (transitioning people out of homelessness) different strategies are informed by divergent theoretical frameworks, namely the structuralism and personal responsibility

paradigms reported above. This section will review some of the current models and their effectiveness based on available research and literature.

Models

Shelters. Shelters play an vital role in mitigating homelessness and are important transitional spaces because they facilitate interactions between homeless individuals and resources (Kuhn & Culhane, 1998). In 2008 there were 1128 shelters recorded in Canada, most of which are clustered in large urban centres (Echenberg & Jensen, 2008). One study of 587 shelters in the US identified four specific roles fulfilled by the majority of establishments. These roles can be broken down into the following: services meeting basic needs, treatment services, services promoting self-sufficiency and specialized services for women and children. A fifth category was also added to include supplementary services such as legal aid (Wong, Park, & Nemon, 2006).

Shelters may be broken down into three categories to better meet the needs of target populations. *Emergency shelters* are used in situations of crisis and can be a means to gain access to further support. *Transitional shelters* have a heavy focus on promoting self-sufficiency and serve as a temporary space while an individual is locating more permanent housing. *Permanent shelters* are more like residential housing programs and are viewed as a long-term housing situation for people unable to secure independent housing (Wong et al., 2006).

Shelters have the potential to help people transition out of homelessness, but they have recently been criticised for not addressing the cause of the problem. Rather, it has been argued that current models have shifted and become less like transitional spaces and more like long-term solutions to homelessness (Culhane & Metraux, 2008).

This analysis prompted the development of a *housing first (HF)* model based on the notion that housing is a basic right for all people (Tsemberis et al., 2004).

Treatment first. The HF model is often contextualized as being an alternative to the more traditional, and more commonly employed, Treatment First (*TF)* model (Henwood & Padgett, 2011). The TF framework assumes that it is best for people to progress through a series of stages in order to prepare for "housing readiness." Such stages include a period of sobriety, psychiatric treatment and the development of certain skills deemed necessary for independent living (Greenwood et al., 2005). This model views permanent housing as an end goal that must be earned through the accomplishment of specified tasks, rather than as a first priority. This corresponds highly with a conception of homelessness that focuses on individual shortcomings.

Housing first. The HF model was initially developed in 1992 by a program called Pathways to Housing as a way to meet the housing needs of the chronically homeless population in New York (Tsemberis et al., 2004). The basic tenets of this model are that housing is the first priority for the homeless, whose definitional problem is, after all, not having a home, and as such it should not be contingent on sobriety or psychiatric treatment. In most cases, maintaining housing depends solely on providing rent (30% of an individual's income) and meeting with support team members on a regular basis (Henwood & Padgett, 2011). This model, then, is based on ideologies of self control, consumer satisfaction, and autonomy; service users are offered services or referrals but are not required to comply with treatment in order to maintain housing status (Greenwood et al., 2005). It is also congruent with a structural conception of homelessness.

Comparing outcomes of TF and HF. Due to a lack of true experimental research, there has been some debate as to whether the HF model or the TF model provides more positive results with regards to housing stability, mental health improvement, and addictions treatment (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009). A summary of the two models comparing the theory, service delivery approach, target population, and outcomes is provided below in Figure 2. The HF approach treats permanent housing as a necessary intervention while the later views it as a desirable outcome (Henwood & Padgett, 2011). Although there are some studies that link the TF model with an increase in treatment adherence and abstinence (Fisk, Sells, & Rowe, 2007; Kertesz et al., 2009) there exists a substantial body of research indicating greater efficacy with a HF approach (Stanhope & Dunn, 2011). For instance, the HF model has been linked with shorter period of homelessness and lower rates of psychiatric symptoms associated with higher levels of consumer choice (Greenwood et al., 2005; Mares & Rosenheck, 2011). HF has also been linked with higher retention rates and housing stability for people with serious mental illnesses (Tsemberis et al., 2004). One recent study found the HF model to be effective in reducing consumption among chronically homeless people with substance use disorders (Collins et al., 2012). Studies have suggested that this model is more suitable for people facing chronic homelessness (Pearson, Montgomery, & Locke, 2009), and people with concurrent disorders (Padgett, Gulcur, & Tsemberis, 2006). Finally, one study found that front-line workers for HF models placed a higher emphasis on clinical intervention and treatment, while front-line workers for the TF model found themselves consumed with helping their clients locate housing (Stanhope, Henwood, & Padgett,

2009). These findings suggest that when housing is made a first priority for homeless people, it helps serve as a foundation for further interventions on the individual level (for instance, minimizing psychiatric symptoms).

Figure 2. A Comparison of the Housing First and Treatment First Models

	Housing First	Treatment First
Theoretical Framework	Access to affordable, adequate housing is the first priority and not contingent on treatment or abstinence.	Mental health/addictions treatment is the first priority and treatment adherence/abstinence is essential to prove housing readiness.
Program Model Description	The HF model provides chronically homeless people with a long-term place to live. Service users pay 30% of their income towards monthly rent and are required to meet regularly with a case manager or worker. Services such as addictions and mental health treatment are offered but not mandatory.	The TF model provides short-term accommodation (through transitional housing or shelters) while service users progress through a number of stages to reach housing readiness. Service users must prove their ability to live autonomously through abstinence, treatment adherence and the acquisition of other life skills.
Service Delivery	HF models often work in conjunction with Assertive Community Teams (to be described below).	TF models often employ case management or in some cases intensive case management.
Target Population	Chronically homeless people, especially those suffering from mental health issues, substance use disorders or both.	Chronically, cyclically and transitionally homeless people.
Outcomes	Shorter periods of homelessness, (Greenwood et al., 2005; Mares & Rosenheck, 2011; Stanhope & Dunn, 2011) a decrease in psychiatric symptoms (Greenwood et al.,	Participants more likely to adhere to treatment plans (Fisk et al., 2007; S. Kertesz et al., 2009)

	2005), criminal activity (DeSilva, Manworren, & Targonski, 2011) reduction in alcohol intake (Collins et al., 2012) and lower residential costs (Padgett et al., 2006)

Case Management and Alternatives

While traditionally case management has been the dominant model in homeless interventions (Morse, 1998), other models have appeared more recently. Although there has been research comparing case management with other models, true experimental studies are less common (Morse, 1998) and it is near impossible to account for extraneous variables (Orwin, 1994). This section will look at some of the literature surrounding case management and will explore some of the alternatives currently in use.

Case Management. Case management traditionally refers to a model in which case managers link clients with services from other organizations and providers (Johnsen et al., 1999). More often, case management is associated with a TF framework where case managers are expected to uphold strict rules and move service users along a continuum (Henwood & Padgett, 2011). Although there is some debate as to the value of case management, studies tend to find limited effectiveness in its use as an intervention strategy for homeless populations. For instance, case management has been found to be more effective with female populations than male populations (Rich & Clark, 2005) and is often at risk of consumer disengagement due to strict program restrictions and a lack of one-on-one attention (Stanhope et al., 2009). It has

been noted, however, that comparative research findings regarding case management may be influenced by poor evaluation methodology and a lack of treatment intensity due to the frequently large caseloads and limited training of case managers (Orwin, 1994).

Intensive Case Management. Case management has often been criticised in the literature for providing a lack of one-on-one attention to service users (Stanhope et al., 2009). While standard case management often requires staff to manage a caseload of 30 clients or more, intensive case management reduces this caseload considerably to approximately 10-15 cases per worker (Samele et al., 2002). Evidence from several studies has suggested that intensive case management, when compared with standard case management provides higher consumer satisfaction (Samele et al., 2002) and longer periods of housing stabilization (Nelson, Aubry, & Lafrance, 2007).

Assertive Community Treatment. The Assertive Community Treatment model (ACT) focuses on mental illness, employing an interdisciplinary team that may include social workers, nurses, substance abuse counsellors and psychiatrists (Tsemberis et al., 2004). Generally associated with a HF framework, this intervention strategy has recently become a realistic alternative to the traditional case management model, and provides service users with support in the community (Henwood & Padgett, 2011). ACT teams are typically characterized by shared caseloads, around the clock staff availability, client-centered support and an emphasis on preventing hospitalization (Johnsen et al., 1999). Recent studies have found that the ACT model is positively associated with housing stability (Tsemberis et al., 2004), client satisfaction and adherence to treatment plans (Johnsen et al., 1999). When standard case management models have been used as a control, ACT models have in some cases proven to be

more effective in providing housing stability for homeless people living with mental illness (Lehman, Dixon, Kernan, DeForge, & Postrado, 1997; Nelson et al., 2007). Finally, when combined with an integrated treatment (when the same clinician provides both mental health and addictions treatment) ACT models result in higher consumer satisfaction for homeless people with concurrent disorders (Morse et al., 2006).

Housing: Supportive vs. Supported

People who are either chronically or cyclically homeless may benefit from living accommodations that offer a range of supportive services. Supportive and supported housing have proven to be effective in increasing consumer satisfaction and housing stability for individuals living with mental illness, addictions, or both (Kirsh & Wellesley, 2009). While there appears to be some confusion in the literature with regards to the difference between supported and supportive housing, Tabol, Drebbing and Rosenheck (2010) have made the following distinction: *Supportive housing* refers to a residential environment with in-house support staff while *supported housing* refers to independent living arrangements with access to a variety of community based services.

Supportive housing environments, such as group homes, tend to be more restrictive and may require residents to comply with mental health or addictions treatment (Tabol et al., 2010). *Supported housing* is more recent, having emerged more fully in the 1980s, and was a response to a growing body of research indicating that people with mental health and addictions issues prefer to live alone but have accessible workers in the community (Tanzman, 1993). Based on principles of community integration and consumer empowerment, especially in the contextual aftermath of deinstitutionalization, supported housing models have been associated with

the stabilization of otherwise hard-to-serve client subgroups (Culhane & Metraux, 2008; Tabol et al., 2010; Walker & Seasons, 2003).

Programs

The homeless intervention frameworks explored above generally serve as the foundation for the design of specific programs. It is helpful for service providers to understand the theoretical underpinnings of the dominant programs designed to address homelessness. Having an understanding of the theoretical background on which specific models are based will ideally empower service providers to choose the program that best fits the needs of their service users. This section will briefly describe and deconstruct some of the larger and well-documented programs targeted at homeless populations.

Continuum of Care. The *Continuum of Care* (CoC) is a program that adopts a TF paradigm, conceptualizing permanent housing as a long term end goal rather than as an immediate necessity. In 1995, the CoC was introduced by the US Department of Housing and Urban Development as a means to streamline services and funding under the McKinney-Vento Homeless Assistance Act (Burt et al., 2002). In this model, the service provider acts as a gatekeeper and decides when a service user is ready to live independently (Greenwood et al., 2005). As the name of the program suggests, service users must move through a series of steps and accomplish tasks deemed necessary to independent living, including psychiatric and substance abuse treatment. Like the TF model, there are certain assumptions inherent in this model, namely that homeless people need to develop certain skills before they are ready for the responsibility of maintaining permanent housing accommodations (Greenwood et al., 2005).

In a *Continuum of Care* program, the emergency shelter acts as a gateway for all potential service users. In an ideal trajectory people move to transitional housing, designed to be "short term and service intensive," before they are finally graduated to permanent housing. Permanent supportive housing is reserved only for those individuals who are perceived to never be able to live independently due to issues with mental illness or addiction (Wong et al., 2006). Criticisms of the program tend to focus on the stages as a series of hurdles for consumers due to the fact that the priorities of the program may not line up with the priorities of the client (Tsemberis et al., 2004). In addition, this program has been criticised for its restrictive admission policies which may limit access for certain populations (Wong et al., 2006).

Pathways to housing. Drawing from a HF approach as opposed to the TF framework, *Pathways to Housing* is a program that offers clients the choice of what services they receive and when they receive them. Program participants tend to choose housing as their primary goal and may or may not choose to pursue other forms of treatment. Persons with the most challenging circumstances are the target population. These persons are often excluded from other programs due to serious mental illness or substance use disorders (Tsemberis & Asmussen, 1999). This program is based on a harm reduction model and requires that participants consent to a money management program in order to ensure that rent, utilities and other necessities are provided for (Tsemberis et al., 2004). The Pathways to Housing program, while relatively recent, has proven to be successful in many respects. Initially starting in New York City, the program model has spread to other cities around North America. Recent research has suggested that the program not only increases housing stability among

the chronically homeless, but decreases rates of hospitalization (Pathways to Housing, 2005).

Housing first in Canada. In Toronto, a Canadian version of Pathways to Housing was established in 2005. This program, called *Streets to Homes* is similar to the *Pathways to Housing* in many respects, but differs in two main ways; first, Streets to Homes uses intensive case management as opposed to an ACT team, and second, Streets to Homes has a much wider target population (chronically, transitionally and cyclically homeless) A program survey of 88 participants reported that 91% felt their quality of life improved, 49% saw a decrease in alcohol consumption, 74% saw a decrease in drug use, and overall use of emergency services decreased (Toronto Shelter and Housing, 2010).

In 2008, the federal government allocated 110 million to the Mental Health Commission of Canada in order develop the At Home/Chez Soi program which formally launched in November 2009. The project is being implemented in Moncton, Toronto, Montreal, Winnipeg and Vancouver and employs a HF approach which entails providing homeless people with housing and support services “tailored to meet their needs” (Mental Health Commission of Canada, 2011). This trial period is scheduled to end in 2013, at which point findings regarding the effectiveness of the program will be analyzed and published (Goering et al., 2011)..

Other programs. While the TF programs (Continuum of Care) and HF programs (Pathways to Housing, Streets to Homes and At Home/Chez Soi) remain two dominant and dramatically different models, there are numerous smaller program models offering varying degrees of effectiveness. The use of transitional housing, for example, is

heavily endorsed by proponents of the Continuum of Care and regularly employed by the Pathways to Housing model in the event that a permanent unit is not immediately available (Tsemberis & Asmussen, 1999). Transitional housing programs have been found effective in themselves when employing an approach that recognizes the importance of consumer independence (Lincoln, Plachta-Elliott, & Espejo, 2009), and providing a variety of optional services, such as treatment plans (Murray & Baier, 1995), programming designed to improve self-sufficiency, and employment-readiness training (Muñoz, Reichenbach, & Hansen, 2005). Finally, models based on harm reduction principles, (mainly found in programs with a HF framework) such as Ottawa's Managed Alcohol Program appear to be successful in meeting client needs, decreasing periods spent on the street or in an emergency shelter reducing overall system costs and improving health outcomes for a small sample of participating clients. (Podymow et al., 2006).

Implications for Program Design and Evaluation

The design and evaluation of programs targeting homeless populations are methodologically challenging for a variety of reasons. While research studies are crucial for determining program efficacy, findings are sometimes contradictory. More replication of studies with similar intervention models among different populations are needed. For example, while a variety of studies target housing interventions for chronically homeless people with concurrent disorders, there is less available data regarding appropriate interventions for cyclically homeless people with difficulty maintaining employment. Sample sizes are usually small which results in low statistical

power. Monitoring and data collection is problematic; people who are homeless have by definition no fixed address and can therefore be difficult to locate for longitudinal studies. Finally, outcome measures are not consistently employed in research studies. Crook et al. (2005) identified multiple models for measuring quality of life, housing status, psychological wellbeing, substance abuse recovery and social participation as they relate to homeless populations. This lack of standardization can make it challenging to compare interagency findings and evaluate program effectiveness.

Methodological Considerations

Program evaluation can be divided into two broad categories: *process* or *formative evaluation* and *outcome* or *summative evaluation* (Royse, Thyer, & Padgett, 2010). Formative evaluations may be conducted throughout a program and are used to guide and direct programs through the adjustment and enhancement of interventions. Through the development of a program description and the process of program monitoring and quality assurance, formative evaluations address such issues as client enrollment, drop-out rate as well as issues in management and staffing (Royse et al., 2010). Summative (or outcome) evaluations, on the other hand, seek to understand whether or not a program had a desired impact or outcome. An ideal outcome evaluation addresses the counterfactual, i.e., what is the impact of program participation on a given participant with and without the intervention (Engel & Schutt, 2005).

The best method of establishing a counterfactual in social science is to implement a randomized field experiment (RFE) where a sample of program participants is randomly assigned to treatment and control groups. Outcomes are then compared between the two groups before and after treatment. RFEs are difficult to

implement in social services because withholding treatment to the control group is usually not acceptable. Consequently, single system research designs are more commonly employed. While experimental research designs rely on an experimental group and a control group single-system designs focus on the progress of one group at a baseline phase and again at an intervention phase (Bloom & Fischer, 2006).

It has been suggested that in order to conduct a comprehensive program evaluation, a mix of both qualitative and quantitative methods are required. This mixed methodology is important because it ensures that quantifiable data is further supported and enriched by qualitative findings (Culhane, Eldridge, Rosenheck, & Wilkins, 1999). A mixed methods approach may also help explain why certain interventions are effective or ineffective. For instance, while a quantitative analysis may show that a large proportion of clients leave a program prematurely, a qualitative approach may explore the thoughts, feelings and perceptions of these clients toward the program, thus creating a more holistic evaluation tool and providing a deeper understanding of why the program may be meeting with certain successes or failures (Crook et al., 2005).

Speaking to different actors within the system under evaluation is an important consideration when conducting a program evaluation. While service providers may conceptualize program goals and service delivery in one way, service users may provide a conflicting perspective. Likewise, service users and service providers may define important concepts such as *need* and *success* in very different ways (Clapham, 2003). Moreover, neither staff nor service users should be considered to be homogenous group

Outcome Measurements

In order to conduct a program evaluation, it is necessary to identify the elements that will qualify as outcome measurements. Outcome measurements are essentially the intended benefits of the program, although occasionally additional, and sometimes unintended, findings will surface (Planigale, 2010). According to one source, outcomes "may relate to behaviour, skills, knowledge, attitudes, values, condition, or other attributes. They are what participants know, think, or can do; or how they behave; or what their condition is, that is different following the program" (United Way of America, 1996)

Outcome measurements can be conceptualized on three different levels. *System level* outcomes focus on the overarching conceptual framework under which the organization functions, including the collaboration of actors and organizations within the community. *Service program level* outcomes speak to the structure and delivery of an organization or program that aims to provide a specific service to a target population. Finally, *client level* outcomes focus on individual service users and the way in which goals, such as housing stability, employment and consumer satisfaction, are met (Crook et al., 2005).

The evaluation of program models may use a variety of different outputs to measure the effectiveness of the service being delivered. One literature review found that a large portion of client outcomes for homeless interventions focus on issues related to mental health and addictions (Crook et al., 2005). While a broad outcome such as "mental health improvement" can be difficult to define, it can be gauged through indicators such as adherence to treatment plans (Bradford, Gaynes, Kim, Kaufman, &

Weinberger, 2005), decreased hospitalization periods (Pathways to Housing, 2005) and self reported quality of life indicators (Stefancic, Schaefermcdaniel, Davis, & Tsemberis, 2004). Self-report measures are important for gauging client perceptions but, due measurement concerns of reliability and validity, are less effective for measuring program impacts and outcomes. Other examples of outcome measurements for homelessness interventions include reduced economic and social costs associated with program participation (Eberle et al., 2001; Fisk et al., 2007; Nelson et al., 2007) and of course, amount of time spent off the streets and in stable housing (Nelson et al., 2007; Pearson et al., 2009; Tsemberis et al., 2004).

Program evaluation and the identification of desired outcome measurements are beneficial to a variety of stakeholders, including service users, service providers, funders, policy makers, advocates, planners and the general public (Crook et al., 2005). An effective measurement system, once executed, will provide feedback to staff through the identification of strengths and weaknesses in program design and delivery. Furthermore, better knowledge of client outcomes will allow service providers to compare alternative interventions and plan for future resource allocation and training requirements (United Way of America, 1996). It must be noted, however, that while outcomes measurement provide an array of benefits, there remains a possibility of unintended consequences (Planigale, 2010). For instance, outcome measurements can be costly and may cause staff to feel threatened. Additionally, information gathered from program evaluation research may be lacking, or alternatively, may not be applied in a suitable way (Planigale, 2010). Staff and administrators need to understand the complexity of research efforts. Further, the organizational culture must be reflective and

self-critical. Despite the challenges inherent in adopting an evaluative approach to service delivery, a carefully developed and implemented research plan has potential to enhance service delivery and outcomes for clients.

Follow-up and Related Limitations

One of the biggest challenges that presents itself in homelessness research is the ability to maintain contact with service users over a specified period of time (Greenwood et al., 2005). Many studies are limited by high rates of attrition which make it difficult to track clients once they have left a program, thus presenting a challenge to evaluate its overall impact (Crook et al., 2005). A study conducted by Stefancic, Schaefer, McDaniel, Davis and Tsemberis achieved retention rates among the highest in the field; 96% at 6 months and 87% at 48 months (2004). Such impressive retention rates were hard earned, as a team of approximately 10 people worked diligently to maintain contact with 225 hard-to-reach participants. Some methods employed included a sharing of caseloads, partnerships with community organizations, extensive outreach and the use of locater sheets which were regularly updated and included the contact information of friends and families (Stefancic et al., 2004).

A similar limitation stems from the very nature of collaborative homelessness interventions. Many organizations working with homeless populations specialize in one or two services and refer service users elsewhere for additional needs; for instance, a homeless individual may live in a shelter residential program but may use employment, addictions and mental health resources in three separate locations. This is especially true in a continuum of care or case management model, as explored in previous sections. Although community partnerships are important in service delivery, this

collaborative effort can make it difficult to isolate the exact causes of particular outcomes (Morse, 1998).

Limitations in evaluation may be directly linked to the presence of unidentifiable extraneous variables. An extraneous variable can be defined as a "variable that influences both the independent and dependent variables so as to create a spurious association between them that disappears when the extraneous variable is controlled" (Engel & Schutt, 2005, p. 158). Research that does not control for extraneous variables has low-internal validity (Engel & Schutt, 2005). An example of this phenomenon is illustrated by Orwin et al., (1994) with regards to the case management service delivery model: The authors stated that research consistently depicts case management to be an ineffective model for addressing homelessness. They then go on to explore how other factors, such as inexperienced staff and a low contact frequency may actually influence the evaluation of this model (Orwin, 1994).

Summary of the Research

Research has consistently indicated that although there are no official estimates of the national homeless population, the numbers range in the thousands and there are always groups of "concealed homeless" that will be overlooked by enumeration techniques (Echenberg & Jensen, 2008; Hulchanski, 2000; Springer, 2000). It has been found, however, that homeless people typically fall into one of the following broad and potentially overlapping categories: The transitionally homeless, the episodically homeless, and the chronically homeless. These groups are generally composed of

people with like characteristics and would benefit from targeted intervention services (Culhane & Metraux, 2008; Kuhn & Culhane, 1998).

There are high rates of mental illness, addictions, dual diagnosis, trauma, disability, criminal activity, and poverty within homeless populations (Canadian Institute for Health & Canadian Population Health, 2007; Eberle et al., 2001; Greenwood et al., 2005; Kuhn & Culhane, 1998; Whitzman, 2006). Numbers indicate that certain populations may be more vulnerable to homelessness, such as people with mental health or addictions issues. Moreover, Aboriginal Peoples make up a disproportionate percentage of the homeless population in Canada (Health Canada, 2009). While homelessness may affect people of all ages, most homeless people are adults falling between the ages of 25 to 55 (Social Planning and Research Council of BC, 2005). There is also ample evidence to suggest that men, the greater portion of the visible homeless population, have different routes into homelessness than do women. Consequently, men and women may benefit from different homelessness intervention strategies (Rich & Clark, 2005; Whitzman, 2006).

Service Provision

Individual program evaluations and comparative studies have presented some interesting findings on successful residential structure and service provision. Prominent findings featured in this paper will be summarized and analysed below.

A review of the literature suggests that there are a variety of different shelter models, some of which that provide only the most basic necessities while others offer an array of services. Examples of successful in-shelter programming includes, but is not limited to: education, mental health, employment training, and life-skill workshops

(Bradford et al., 2005; Culhane & Metraux, 2008; Helfrich & Fogg, 2007; Kuhn & Culhane, 1998; Muñoz et al., 2005; Nelson et al., 2007). Finally, qualitative evidence suggests that in order to target hard-to-reach populations, shelters should value the privacy and autonomy of their residents while creating an environment of warmth and respect (Lincoln et al., 2009).

Studies also consistently find "HF" models to have higher rates of housing stability and consumer satisfaction than standard "TF" models (Greenwood et al., 2005; Kertesz et al., 2009; Padgett et al., 2006; Pearson et al., 2009; Tsemberis & Asmussen, 1999). Case management, which is often associated with the TF model, is more successful when implemented with reduced caseloads, essentially transforming it into to an intensive case management model (Nelson et al., 2007; Samele et al., 2002). However, the most effective model currently appears to be the ACT model, especially when combined with supported housing (Henwood & Padgett, 2011; Johnsen et al., 1999; Nelson et al., 2007; Tabol et al., 2010; Tsemberis et al., 2004).

While this information addresses many issues related to available homeless interventions, there remain several gaps in the literature. First, while there is an array of studies supporting the effectiveness of a HF model for the chronically homeless, **there appears to be little research covering effective interventions for the transitionally homeless**. According to the research, approximately 80% of the homeless population will effectively transition out of homelessness rapidly and without assistance (Kuhn & Culhane, 1998). This leaves many questions unanswered, such as: How should service providers intervene to make this transition quicker and more long-lasting? What services or interventions reduce the likelihood of a person relapsing into homelessness?

It is important to advance our knowledge regarding appropriate treatment and intervention strategies so the transitionally homeless do not become the cyclically or chronically homeless.

The lack of knowledge about effective shelter interventions is a second gap. More specifically, there is a lack of literature regarding best practices in shelter settings. While a substantial portion of research has been conducted on housing options (HF, supportive/supported housing), similar studies examining outcomes in shelters are difficult to locate. This is not surprising considering the inherent difficulties in tracking and maintaining contact with homeless people once they have left the shelter environment.

Finally, **findings and solutions are difficult to assert due to methodological limitations inherent in studying the social sciences.** This is largely due to the fact that true experimental studies are rare in the study of homelessness. Of the major studies cited in this paper, very few are true experiments (Greenwood et al., 2005; Morse et al., 1997; Padgett et al., 2006). The remainder tend to be either longitudinal studies or one group, pre-test, post-test studies (Collins et al., 2012; DeSilva, Manworren, & Targonski, 2011; Fisk et al., 2007; Helfrich & Fogg, 2007) or have comparison groups but do not use random assignment (Mares & Rosenheck, 2011). Further research is required to confirm already existent findings with regards to HF initiatives.

Implications for Research at the Old Brewery Mission

The Old Brewery Mission (OBM) provides a number of services to the homeless population in Montreal, including emergency, transitional and social housing services. The purpose of this literature review is to explore implications for service design and delivery within the context of the Webster Pavilion, the largest resource for homeless men in Quebec. While the Webster Pavilion operates a traditional emergency shelter which provides men with access to a meal, a shower and a place to sleep, research will be primarily focused on the following transition services: l'Étape, l'Escale and the Community Support Program.

The transitional services at the OBM are designed to support service users as they locate income and housing. L'Étape is a short term program (30 days) that "is meant to serve as a bridge between basic services providing nightly food and shelter while working towards the goal of regaining increased autonomy" (Old Brewery Mission, 2010). More specifically, this program seeks to establish baseline stability through access to income and personal identification (health card, SIN card, birth certificate etc). A continuation of l'Étape, l'Escale offers service users a slightly extended period (3 months) including meals and counselling services with the purpose of social reintegration. Finally, the Community Support program provides support to participants once they have left the shelter.

The OBM transitional programs appear to be largely *atheoretical* (Royse et al., 2010) as they are based primarily on tradition and have experienced a substantial amount of program drift since their inception in 2009. For instance, while the original documentation describing their functioning conceptualized a higher intensity of case

management, current case loads do not reflect this. Further, intake and procedures have changed over time. Despite these qualities, it is evident that OBM programs reflect the principles viewed within a TF, or more specifically, a Continuum of Care model. This is observed through the graduation of clients from l'Étape to l'Escale and eventually to the Community Support Program or Le Pont, as they prepare for housing readiness. Furthermore, service users are offered weekly case management, the service delivery practice most commonly associated with this model. Unlike traditional TF models however, the OBM offers very little in the way of in-shelter "treatment." Besides basic case management, the OBM offers no other programming or interventions to address issues associated with homelessness such as substance use disorders, mental health issues, employment and life-skills training. Instead, clients with serious issues that cannot be handled by the OBM (such as addictions and mental health problems) are referred elsewhere for support.

The research presented in this literature review has a number of implications for program creation, maintenance and evaluation at the OBM. First, while the OBM currently offers the same programming to all homeless service users, research has indicated that **certain groups benefit from targeted intervention strategies**. This information could be incorporated into the OBM service delivery model at intake and assessment. For example, a simple set of questions to determine a person's pattern of homelessness could be asked at intake. Once service users have been identified as chronically, cyclically or transitionally homeless, services can then be tailored to clients based on their individual needs. For example, while the minimal interventions offered by l'Escale and l'Étape may be sufficient to move the transitionally homeless into

housing, people identified as chronically homeless can be targeted with more intensive services and resources to meet the needs commonly associated with this population.

Second, the literature would appear to indicate that **client outcomes are related to counsellor caseload**. While case management is a common service delivery model in homeless agencies, studies tend to agree that case management is most effective when caseloads are small (intensive case management). Presently OBM counsellor caseloads fluctuate with client residency and do not reflect an ICM model. In order to adhere to this model, the OBM counsellors would require reduced case loads. This would further necessitate the hiring of more staff to take on the remaining caseload or alternatively, reducing the number of clients admitted to the program.

Third, the OBM employs a basic case management model in which case managers have minimal formal training. There are no requirements for specific post-secondary education, and there is little in the way of professional development. In order to effectively meet the many challenges involved in working with people who are homeless, **it is imperative that case workers are well informed on a variety of topics.** Morse (1998) recommends that case workers be trained and informed on a number of topics, including psychosocial assessments, crisis intervention, suicide prevention, a comprehensive review of local services and resources and burnout prevention (among others). Furthermore, it is essential that training be continuous and that new, relevant topics be regularly added (Morse, 1998) For further information on this topic, see the *ERIPTS document Case Management and Homelessness: A Summary of the Literature*.

This literature review also identifies areas that are of methodological concern for the OBM-McGill collaborative research project that aims to identify the impact of OBM programs on service users. First, tracking and monitoring participants is labor intensive. Locating clients after they have left the shelter is very difficult. Tracking OBM service users in the community may be facilitated by several processes, including formal or informal relationships with other social service agencies and the use of many alternate contacts (Stefancic et al., 2004). Data collection between long periods of contact may be made easier with a tool such as The Residential Follow-Back Calendar (Appendix I) employed by Greenwood et al. (2005). Self-selection threatens our ability to attribute changes to the OBM interventions. For example, following only clients from the Community Support Program may provide a biased picture of program impact as clients choose to participate. Therefore, it may be personal characteristics, not the OBM intervention that can more accurately explain client outcomes.

Second, there are a variety of outcome measurements that can be employed for the purposes of evaluating the impact of the OBM transitional services. While housing stability after leaving the program is a helpful outcome measurement, there are others worth investigating, such as quality of life indicators and decreased periods of hospitalization. Examining multi-level outcomes is a worthwhile strategy. In this approach, system, service program level, client level outcomes will be measured (Crook et al., 2005). For the purposes of the OBM project, stakeholders must decide upon the most relevant outcomes to be measured within the context of resource availability.

Conclusion

The purpose of this document is to provide the McGill-OBM partnership with a comprehensive literature review on the topic of homelessness and its interventions. The completion of this literature review is an integral step in phase 1 of the research project as it enables all stakeholders to become familiar with the current research. It also constructs a solid foundation of knowledge which will inform the remainder of phase one, as well as the later design of phase 2.

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Appendix

(Insert Residential Follow-Back Calendar)

2.12 RESIDENTIAL FOLLOW-BACK CALENDAR [3] *(Separate Sheet)*

Instructions to Interviewer

Interviewer builds a chronological record of subject's residential history (including institutionalizations and temporary situations) in the past six months. Use a calendar to seek verification from the subject. For each month record residences (or lack there of). Information obtained from the Residential Follow-Back Calendar will be used to help complete the Living Situation Section (page 14).

Step 1

Fill in today's date and study subject's ID on the top right hand corner of the calendar. Fill in the names of each month on the calendar.

Start with current living situation and work backwards month by month questioning study subject as to where they have been living. Watch for periods of homelessness, jail or prison, hospitalizations, and brief residential transitions. Determine if hospitalizations were for medical, psychiatric, or detox/rehab reasons.

Step 2

Once you have the major places the subject has stayed over the past six months, go down the list of prompts on the left side of the calendar (use prompts one at a time). This helps remind the study subject of places they may have forgotten they stayed. If study subject stayed with family or friends frequently, probe for patterns and routines.

When the subject says yes to any one item/kind of place, always ask if there were any more of the same kind (i.e., if hospital, did you stay in any other hospitals?). Use non-directive questioning to determine when, how frequently and how many times the subject was in any one particular place. The subject may be unsure about when and how long and how frequently he/she stayed at any one place. Try to place the subject in time, in relation to yearly events, such as birthday, seasons, holidays, etc. (i.e., do you recall if it was before Christmas or after? Do you remember what the weather was like?)

[Read to subject]

Now I want you to think about where you have been living in the past six months. We would like to know all of the places where you've stayed during this time, including hospitals. Let's look at this calendar together, and I'll make notes as you talk. This is *(give today's date)*, so the time we'll be talking about is between *(give date of six months ago)* and today. O.K. Let's begin. Why don't we start with where you are living now and work backwards from there, month by month. Next I want to read you a list of living situations, and I want you to tell me if you have been in any of these, even if only for one night.

[3] Adapted from:

New Hampshire Dartmouth Psychiatric Research Center. Residential Follow-Back Calendar. Lebanon, NH: Dartmouth Medical School, Version June 1995.

2.12 RESIDENTIAL FOLLOW-BACK CALENDAR **Today's Date: ___ ___ / ___ ___ /**

Prompts**

01. All-night theater, subway station, or other indoor public place
02. Subway or bus
03. Abandoned building
04. Car or other private vehicle
05. On the street or in other outdoor place
06. Emergency shelter
07. Hotel/motel
08. Own SRO room (no services)
09. Someone else's SRO room (no services)
10. Supportive SRO (services on site)
11. Drop-In Center
12. Safe Haven (low demand facility, TLC, reception center)
13. Detox facility
14. Crisis housing
15. Intermediate care facility
16. Own apartment or house
17. Parent/guardian's apartment or house (temporary)
18. Parent/guardian's apartment or house (long-term)
19. Other family member's apartment or house (temporary)
20. Other family member's apartment or house (long-term)
21. Someone else's apartment or house (temporary)
22. Someone else's apartment or house (long-term)
23. Boarding house or board-and-care
24. Transitional housing program (short-term, but part of a program including access to more long-term housing
25. Transitional housing program (short-term, but not linked to more long-term housing)
26. Transitional housing program (long-term)
27. Group home
28. Long-term alcohol/drug-free facility
29. Hospital (including psych. facility)
30. Nursing home
31. Treatment or recovery program
32. Jail or prison
33. Corrections halfway house
96. Other *(specify)*
97. RF
98. NA
99. DK

Current Month				One Month Previous				Two Months Previous			
WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4

Three Months Previous				Four Months Previous				Five Months Previous				Six Months Previous			
WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4	WK 1	WK 2	WK 3	WK 4

** Prompts adapted from: Barrow, S.M., Hellman, F., Lovell, A.M., Plapinger, J.D., Robinson, D.R. and Struening, E.L. Personal History Form. New York, NY: Community Support Systems Evaluation Program, Epidemiology of Mental Disorders Research Department, New York State Psychiatric Institute, 1985.

2.13 LIVING SITUATION

Residential History: Interviewer builds a chronological record of subject's residential history (including institutionalizations and temporary situations) in the past six months, using the Residential Follow-Back Calendar and seeking verification from the subject. For each residence (or lack thereof), record on the Living Situation Form: 1) the location, 2) the type of residence (use housing categories list from Residential Follow-back Calendar), 3) the dates, as accurately as possible, 4) with whom the subject lived (in terms of relationships, no names), and 5) why the subject moved in and out (in subject's words). Note: For hospital, jail, crisis center, or family and friends overnight, ask WHY ENTERED, not why left. If subject is unable to recall exact dates, ask if he remembers the month or season. Also if you can't get dates, try to get total length of time stayed (i.e., 2 weeks, 1 month, etc.). Get as specific as client is able. Record only places where the subject stayed overnight (a few hours stay in jail is not counted here).

Post code Living Situation on Location Grid (page 17) following interview.

Refer to Location Grid Codes on the next page and ask for specific information needed to rate composition and reasons for moving in and out.

[Read to Subject]

Now I need to go over specific information about each of the places that you have lived that were listed on the calendar. We will start with where you are living now and work backwards from there.

Location Grid Codes:

TYPE

01. All-night theater, subway station, or other indoor public place
02. Subway or bus
03. Abandoned building
04. Car or other private vehicle
05. On the street or in other outdoor place
06. Emergency shelter
07. Hotel/motel
08. Own SRO room (no services)
09. Someone else's SRO room (no services)
10. Supportive SRO (services on site)
11. Drop-in Center
12. Safe haven (low demand facility, TLC, reception center)
13. Detox facility
14. Crisis housing
15. Intermediate care facility
16. Own apartment or house
17. Parent/guardian's apartment or house (temporary)
18. Parent/guardian's apartment or house (long-term)
19. Other family member's apartment or house (temporary)
20. Other family member's apartment or house (long-term)
21. Someone else's apartment or house (temporary)
22. Someone else's apartment or house (long-term)
23. Boarding house or board-and-care
24. Transitional housing program (short-term, but part of a program including access to more long-term housing)
25. Transitional housing program (short-term, but not linked to more long-term housing)
26. Transitional housing program (long-term)
27. Group home
28. Long-term alcohol/drug-free facility
29. Hospital (medical only)
30. Nursing home
31. Treatment or recovery program
32. Jail or prison
33. Corrections halfway house
34. Psychiatric hospital / facility (includes any inpatient psych. stay)
96. Other *(specify)*
97. RF
98. NA
99. DK

COMPOSITION*

01. Alone
02. Family (not with their own children)
03. Family (with their own children)
04. Friends
05. Other persons with serious mental illness
06. Other known
07. Strangers
96 Other *(specify)*
97. RF
98. NA
99. DK

MAIN REASON FOR MOVE IN

01. Better neighborhood
02. Better choice than previous living situation
03. Only option available
04. Forced by program to move here
05. Got Section 8 or other neutral subsidy
06. Needed more support
07. Hospital/psychiatric admission/decomp.
08. Return to prior living arrangement due to discharge
09. Incarceration
96. Other *(specify)*
97. RF
98. NA
99. DK

MAIN REASON FOR LEAVING

01. Evicted
02. Crowding
03. Building problems (repairs, too dangerous)
04. Program problems (too restrictive, etc.)
05. Victimized (domestic violence, other abuse)
06. Program closing
07. Neighborhood unacceptable
08. Personal safety
09. Became incarcerated
10. Entered hospital
11. Entered drug treatment
12. Reside with family other than spouse/significant partner
13. Other housing opportunity became available
14. Financial
15. Interpersonal problem
16. Residence unacceptable
17. Too distant from work/job relocation
18. To attend school
19. Too distant from friends / family
20. Reside with sig. other / spouse
21. To be on one's own / independent
22. Discharge (from hosp./jails, etc.)
23. Psychiatric relapse
24. Split res./no move out
25. Missed curfew
96. Other *(specify)*
97. RF
98. NA
99. DK

**** For composition, you may include more than one code. Categories for family include single parents living with their children and with extended family. These households may include individuals other than family. Friends may include significant other, partner, boy/girl friend, etc.***

2.13 LIVING SITUATION

1. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

2. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

3. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

4. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

5. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

6. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

7. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

8. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

9. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

10. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

11. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

12. Location:
Type of residence:
Date moved in: __ __ / __ __ / __ __ **Date moved out: __ __ / __ __ /**

With whom:
Why in:
Why out:

INTERVIEWER: Post code after interview

Location includes residences, stays in institutional and other settings from the Location Grid Codes on page 13 Record all locations on the grid.

Policy Research Associates, Inc.
Form Date: 8/17/98

2.14 Location Grid/Last Six Months

Location	A Type	B Prior Location	C Duration	D *Composition		E Reason for Move In	F Reason for Leaving
1 = current location or residence	*(Enter code number from list below and actual address or description)*	*(Code # from location column if subject has lived there before in the last six months)*	*(Record # of days)*	*(Enter up to 2 codes from list on pg.13)*		*(Enter code number from list on pg.13)*	*(Enter code number from list on pg. 13)*
1	__ __ (_____)					__ __ (_____)	
2	__ __ (_____)					__ __ (_____)	__ __ (_____)
3	__ __ (_____)					__ __ (_____)	__ __ (_____)
4	__ __ (_____)					__ __ (_____)	__ __ (_____)
5	__ __ (_____)					__ __ (_____)	__ __ (_____)
6	__ __ (_____)					__ __ (_____)	__ __ (_____)
7	__ __ (_____)					__ __ (_____)	__ __ (_____)
8	__ __ (_____)					__ __ (_____)	__ __ (_____)
9	__ __ (_____)					__ __ (_____)	__ __ (_____)
10	__ __ (_____)					__ __ (_____)	__ __ (_____)
11	__ __ (_____)					__ __ (_____)	__ __ (_____)
12	__ __ (_____)					__ __ (_____)	__ __ (_____)

*** This does not apply to institutional stays such as hospital, jail, etc.**

[TO COMPLETE THE GRID, USE THE LOCATION GRID CODES ON PAGE 13]

Grid Continues On Next Page

INTERVIEWER: Post code after interview

Location includes residences, stays in institutional and other settings from the Location Grid Codes on page 13 Record all locations on the grid.

Policy Research Associates, Inc.
Form Date: 8/17/98

2.14 Location Grid/Last Six Months

Location	A Type	B Prior Location	C Duration	D *Composition		E Reason for Move In	F Reason for Leaving
1 = current location or residence	*(Enter code number from list below and actual address or description)*	*(Code # from location column if subject has lived there before in the last six months)*	*(Record # of days)*	*(Enter up to 2 codes from list on pg.13)*		*(Enter code number from list on pg.13)*	*(Enter code number from list on pg. 13)*
13	__ __ (_____)					__ __ (_____)	__ __ (_____)
14	__ __ (_____)					__ __ (_____)	__ __ (_____)
15	__ __ (_____)					__ __ (_____)	__ __ (_____)
16	__ __ (_____)					__ __ (_____)	__ __ (_____)
17	__ __ (_____)					__ __ (_____)	__ __ (_____)
18	__ __ (_____)					__ __ (_____)	__ __ (_____)
19	__ __ (_____)					__ __ (_____)	__ __ (_____)
20	__ __ (_____)					__ __ (_____)	__ __ (_____)
21	__ __ (_____)					__ __ (_____)	__ __ (_____)
22	__ __ (_____)					__ __ (_____)	__ __ (_____)
23	__ __ (_____)					__ __ (_____)	__ __ (_____)
24	__ __ (_____)					__ __ (_____)	__ __ (_____)

*** This does not apply to institutional stays such as hospital, jail, etc.**

[TO COMPLETE THE GRID, USE THE LOCATION GRID CODES ON PAGE 13]

Grid Continues On Next Page

INTERVIEWER: Post code after interview

Location includes residences, stays in institutional and other settings from the Location Grid Codes on page 13

Record all locations on the grid.

Policy Research Associates, Inc.
Form Date: 8/17/98

2.14 Location Grid/Last Six Months

Location	A Type	B Prior Location	C Duration	D *Composition		E Reason for Move In	F Reason for Leaving
1 = current location or residence	*(Enter code number from list below and actual address or description)*	*(Code # from location column if subject has lived there before in the last six months)*	*(Record # of days)*	*(Enter up to 2 codes from list on pg.13)*		*(Enter code number from list on pg.13)*	*(Enter code number from list on pg. 13)*
25	__ __ (_____)					__ __ (_____)	__ __ (_____)
26	__ __ (_____)					__ __ (_____)	__ __ (_____)
27	__ __ (_____)					__ __ (_____)	__ __ (_____)
28	__ __ (_____)					__ __ (_____)	__ __ (_____)
29	__ __ (_____)					__ __ (_____)	__ __ (_____)
30	__ __ (_____)					__ __ (_____)	__ __ (_____)
31	__ __ (_____)					__ __ (_____)	__ __ (_____)
32	__ __ (_____)					__ __ (_____)	__ __ (_____)
33	__ __ (_____)					__ __ (_____)	__ __ (_____)
34	__ __ (_____)					__ __ (_____)	__ __ (_____)
35	__ __ (_____)					__ __ (_____)	__ __ (_____)
36	__ __ (_____)					__ __ (_____)	__ __ (_____)

*** This does not apply to institutional stays such as hospital, jail, etc.**

[TO COMPLETE THE GRID, USE THE LOCATION GRID CODES ON PAGE 13]

[If institutionalized for less than six months, refer to previous living situation. If institutionalized or living on the streets longer than six months, skip this question]

2.15 Do you currently live alone?

NO 0
YES 1

(IF YES, skip to Section Three) **RF** **7**
DK 9

2.12 Who do you currently live with?

	A FIRST NAME	B RELATIONSHIP CODE	C AGE
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Code	Relative
MO	Mother
FA	Father
SO	Significant Other (include spouse, partner, lover, boy / girlfriend, etc.)
SIB	Sibling
CH	Child
OR	Other Relative
ST	in front of any step/adoptive relationship
FO	in front of any foster relationship
GR	in front of any grandparent/grandchild
X	in front of any ex-significant other relationship (-spouse, -boyfriend, etc.)

Code	Service Provider
HSG	Housing Staff
NPP	Non-professional Provider (include volunteer, AA sponsor, student, etc.)

Code	Friends/Acquaintances
FD	Friend
AC	Acquaintance
NE	Neighbor

2.16 So including yourself, how many people live there? **NUMBER |___| |___|**