St Mungo's Recovery Approach

Rapid evidence review

July 2020

St Mungo's
Ending homelessness
Rebuilding lives

St Mungo's Recovery Approach: Rapid evidence review
July 2020
Author: Lauren Bennett

About Revolving Doors Agency

Revolving Doors is a national charity that aims to change systems and improve services for people in the revolving door of personal crisis and crime. We bring independent research, policy expertise and lived experience together to support effective solutions to end the revolving door. We work alongside policymakers, commissioners, local decision-makers and frontline professionals to share evidence, demonstrate effective solutions and change policy. We embed the involvement of people with lived experience in our work, including through peer research, interviews, lived experience teams and forums based in London, Birmingham and Manchester.

About St Mungo's

St Mungo's vision is that everyone has a place to call home and can fulfil their hopes and ambitions. As a homelessness charity and housing association our clients are at the heart of what we do. We provide a bed and support to more than 2,700 people a night who are either homeless or at risk, and work to prevent homelessness. We support men and women through more than 300 projects including emergency, hostel and supportive housing projects, advice services and specialist physical health, mental health, skills and work services. We work across London and the south of England, as well as managing major homelessness sector partnership projects such as StreetLink and the Combined Homelessness and Information Network (CHAIN). We influence and campaign nationally to help people to rebuild their lives.

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1. Introduction

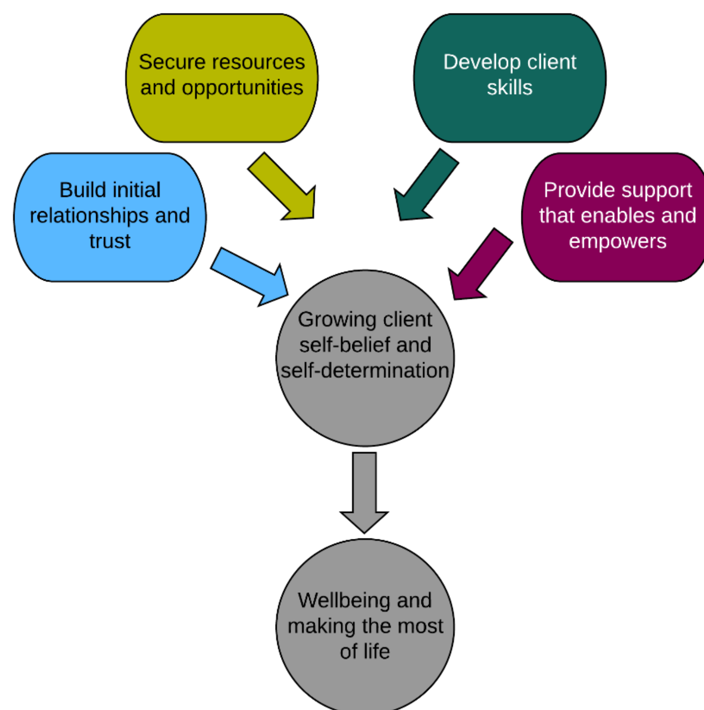
Revolving Doors Agency were commissioned by St Mungo's to undertake a rapid evidence review to validate and improve its Recovery Approach. This report outlines our findings, to show where different elements of the Recovery Approach are supported by evidence, about what works in recovery from the homelessness sector and related sectors, and where there are gaps and/or limitations in the model or research. This report also provides examples of other approaches for supporting people experiencing homelessness and/or people with multiple and complex needs, for comparison.

The Recovery Approach

St Mungo's Recovery Approach summarises the principles and activities that guide all aspects of how St Mungo's services support clients to rebuild their lives. Hence, it outlines their approach to promoting recovery amongst clients. The aim of recovery is to achieve what each client sees as a fulfilling life with purpose and meaning, and for them to be part of mainstream society.

The Recovery Approach breaks down into four 'building blocks'. These are outlined in Figure 1 below and summarise the areas of practice that St Mungo's believe promote recovery. Each block is then broken down into further sub-blocks and activities, which are explored in more detail in the review. Rather than delivering aspects of the Recovery Approach in isolation, the building blocks are intended to work in combination to ensure that clients receive a range of personalised support that addresses their needs and enables them to lead a fulfilling life.

Figure 1: The St Mungo's Recovery Approach



St Mungo's Recovery Approach was developed mostly through staff and client consultation: it therefore articulates significant lived and professional experience in terms of knowing 'what works' in supporting homeless clients in their recovery journeys. St Mungo's is also aware of a strong academic evidence base for many elements of the framework. However, to date the Recovery Approach in its entirety has not been informed by any form of comprehensive secondary research.

The rapid evidence review

The initial aims of the rapid evidence review were to:

1. Validate and challenge St Mungo's approach to recovery, including through comparing the Recovery Approach to other recovery models, or recovery approaches for which there is a strong evidence base.
2. Identify gaps, particularly in the evidence base, to inform future research and evaluation activities, as well as gaps in practice.
3. Produce a new piece of research that summarises the best evidence about what works in recovery. This work can therefore be used to positively influence the homelessness sector and its stakeholders, including policy makers and commissioners.
4. Support St Mungo's to better embed the Recovery Approach across all their systems and processes.

However, when deciding the scope of the review it was agreed that to be able to recommend how the Recovery Approach could be better embedded across St Mungo's, we would need to understand the St Mungo's delivery context and client needs, neither of which could be explored through desk research alone. It was understood that the fourth objective was therefore out of scope of the current research, but that the evidence review could be used to inform additional research with clients, staff and partners, which in turn would support St Mungo's to better embed the Recovery Approach across the organisation.

The first aim also proved difficult in practice. At the inception, to limit the scope to a manageable size, we agreed to focus on particular elements of the Recovery Approach, which limited our ability to comment on the Recovery Approach as a whole. Furthermore, we found that other models implemented by different organisations in the homelessness sector were copyrighted and therefore not available publicly. Models from other sectors had potentially limited applicability to St Mungo's client group and were mostly screened out due to the agreed selection and exclusion criteria, and RAG rating (see below). To address this, we have highlighted relevant good practice throughout the review. We also discuss some general models and some local approaches that may be of interest.

Methodology

In consultation with the St Mungo's team, we began by agreeing key search terms, an initial search plan, and selection and exclusion criteria. These were refined during the scoping stage where appropriate. To limit the scope to a manageable quantity of the most relevant evidence, we concentrated on English-language sources from the last 20 years.[1]

[1] As the review process started in 2019, this included sources from 1999 onwards.

Table 1: Rapid evidence review search terms

Primary search terms	Secondary search terms	Additional terms for refinement
1. Outreach 2. Engagement 3. Move-on	1. Choice and control 2. Empowerment 3. Personalisation 4. Peer support 5. Positive risk 6. Recovery 7. Relationships 8. Strengths and assets 9. Service user involvement 10. Service user voice	1. Homeless 2. Homelessness 3. England 4. Complex needs 5. BAME

The search was documented systematically, to demonstrate sources identified, publication details, key findings and in which areas the source relates to the Recovery Approach. We then created a RAG (red, amber, green) rating system to consider the quality and relevance of each source to help us decide what evidence was most suitable for inclusion in the review.

We used the following search methods to identify sources:

- A database search of academic literature, including Google Scholar, the British Library, National Institute of Health Research (NIHR) Journals Library and Wiley Online.
- A database search of grey literature (such as unpublished research reports, evaluations and conference papers), including on Open Grey and Gov.uk.
- A call for evidence to our Research Network of over 90 multidisciplinary researchers.

Across the initial 70 sources that were initially reviewed:

- 28 were deemed 'Amber' relevance and 42 were considered 'Green' relevance.
- 11 sources were considered 'Amber' quality and the remaining 59 were considered 'Green'.
- 58 sources were published in the last ten years.
- 49 sources focused on people experiencing homelessness.

More detail on our methodological approach can be found in Annex 1.

This report

The remainder of this report outlines the findings of the rapid evidence review. The report structure follows the four building blocks of the Recovery Approach. Each section begins with a brief definition of the building block and the elements within it, before reviewing the evidence and learning in relation to each element. Boxes throughout the sections highlight examples of good practice, alternate approaches and guidance that has been published elsewhere that could support delivery of the Recovery Approach. Each section finishes with a summary of key points. A brief chapter looks at learning from other models and approaches. The final section provides an overall summary of the evidence base underlying the Recovery Approach, considering where the evidence is the strongest and where there are gaps. We finish with some brief recommendations for potential next steps to build on this review and take the evidence base forward.

2. Building initial relationships and trust

The first building block of the Recovery Approach is building initial relationships and trust. This is understood as persistently reaching out and developing initial relationships with new clients, with the aim of engaging clients in services that can support them on their recovery journey.

A. Generic aspects of an effective helping relationship

The importance of relationships and building trust is reflected in a range of sources, not only limited to research on homelessness services. Cockersell (2012) described relationship building as the '*bread and butter*' of work with individuals experiencing homelessness;[2] a strong relationship with a social worker is associated with a higher quality of life for adults experiencing homelessness.[3] Furthermore, a 2011 evidence review confidently concluded that meaningful interaction does help to build greater understanding and trust between people of different backgrounds.[4]

Person-centred approach

For the purpose of this review, person-centred support is understood as taking a personalised approach to supporting individuals to meet their range of needs, rather than a 'one-size fits all' perspective. Building on the definitions used in health and social care, a person-centred approach considers an individual's preferences, needs, aims and goals in the design of support to enable them to live an independent and fulfilling life.[5] It therefore contrasts with principles such as convenience and efficiency which underly some services.

Personalisation is a theme in the literature on support for people experiencing homelessness. For example, a 2019 evidence review found that person-centred support, including choice for the individual, has proven to be effective in supporting people entrenched in rough sleeping into accommodation.[6] There have also been policy commitments to personalisation, including in the UK government's 2018 Rough Sleeper Strategy, which highlighted the need for support to be tailored to individual needs.[7] Personalisation is also embedded as a key principle in the provision of care for specific groups within the Care Act 2014.

Research conducted by Rosengard et al. (2007) explained that individual aspirations may change if individuals engage with a service or professional that they can *'relate to, develop confidence in, and trust to engage with*.'[8] Similarly, research into the delivery of personalised budgets highlighted the importance of support staff that could be both responsive and proactive, as well as patient, when addressing needs.[9]

Numerous studies have also demonstrated how individual needs will differ based on characteristics and circumstances, and many resources have been created to reflect this. For example, Neto and Gavrielides (2010) explain that understandings of what it means to be homeless are likely to differ

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[2] Cockersell, P. (2012), Homelessness, complex trauma and recovery, in Johnson, R. and Haigh, R. (Eds), *Complex Trauma and Its Effects*, Pavilion, pp. 169-80.
[3] Chinman et al. (1999), *The development of relationships between people who are homeless and have a mental disability and their case managers*, Psychiatric Rehabilitation Journal, 23(1), pp.47-55.
[4] OPM (2011), *The benefits of meaningful interaction: Rapid evidence assessment of existing literature*, Department for Communities and Local Government
[5] The Health Foundation (2016), Person-centred care made simple, *What everyone should know about person-centred care*
[6] Mackie et al. (2019), *Ending Street Homelessness: What Works and Why We Don't Do It,* European Journal of Street Homelessness, 13(1)
[7] Ministry of Housing, Communities & Local Government (2018), *Rough Sleeping Strategy*
[8] Rosengard et al. (2007), *A literature review on multiple and complex needs*, Scottish Executive Social Research
[9] Brown, *Right time, right place?*

across and within communities. Within the same ethnic community, recent arrivals to the UK may have different understandings of what it means to be homeless, compared with UK-born individuals, who may be more informed about the housing system and their rights to services.[10] The authors recommend that differences in the causes, manifestations, and understandings of homelessness across and within communities need to be taken into account in the design and delivery of homelessness services; and that services need to be sensitive to structural inequalities.[11] Racial disadvantage may also interact with wider barriers related to age, gender, disability, and sexual orientation.

Research by Cardiff University found that women experiencing homelessness were more likely to have experienced violence and abuse from a partner, self-harm and their children being looked after by someone else.[12] Homeless Link, therefore, recommended that there is a need for personalised, gendered and trauma-informed responses from specialist services that are equipped to address these aspects experienced by women.[13] In addition, a 2014 survey of LGBTQ+ young people in England found that 77% of respondents felt that coming out at home was the main factor in causing their homelessness.[14] Once homeless, LGBTQ+ young people are more likely to face violence and discrimination than young people who are not LGBTQ+. They are also more likely to develop substance misuse issues and experience sexual exploitation.[15] Hence, it is important that homelessness services are perceived to be inclusive and safe spaces, so that LGBTQ+ people feel able to engage with support.

Lastly, the barriers faced by couples and people experiencing homelessness who are in relationships will differ to those faced by single people experiencing homelessness. Recent research by Brighton Women's Centre showed that there is a clear need for investment in further training for accommodation teams to ensure they feel confident about supporting couples and their relationships,[16] and St Mungo's have created a toolkit to support this.[17]

Consistent, non-judgmental, and empathetic support

Studies of services delivered as Psychologically Informed Environments (PIE) have explored client and staff relationships. A 2017 study in two PIE hostels in London showed that residents recognised positive effects of keyworker relationships. This included feeling cared for and having honest communication.[18] This reflects research which established that effective therapeutic relationships are characterised by warmth, trust and acceptance,[19] and suggests that these processes are key regardless of setting. More recently, a report on how drug-related harm can be reduced amongst people experiencing homelessness, stated that '*professional values of respect and non-judgmentalism married with a warm empathic and compassionate approach were perceived as foundational to working with*

[10] Neto G. and Gavrielides T. (2010), L*inking black and minority ethnic organisations with mainstream homeless service providers*, Race Equality Foundation
[11] *Ibid.*
[12] Homeless Link (2019), *Promising practice from the frontline: Exploring gendered approaches to supporting women experiencing homelessness and multiple disadvantage*
[13] *Ibid.*
[14] The Albert Kennedy Trust (2015), *LGBT Youth Homelessness: a UK national scoping of cause, prevalence, response, and outcome*
[15] *Ibid.*
[16] Clement S. and Green W. (2018), *Couples First? Understanding the needs of rough sleeping couples*, Brighton Women's Centre
[17] St Mungo's (2019), *Homeless couples and relationships toolkit*
[18] Phipps et al. (2017), *Psychologically informed environments for homeless people: resident and staff experiences*, Housing Care and Support, 20(1), pp.31-42
[19] Asay, T and Lambert, M. (1999). The empirical case of the common factors in psychotherapy: quantitative findings, in Hubble et al. (eds.), *The heart and soul of change: what works in therapy,* American Psychological Association, pp. 23-55

vulnerable people.'[20] Such ways of working are also consistent with the literature on trauma-informed care that highlights the need for empathetic staff that are aware of individual histories.[21]

A practical guidance document produced by Homeless Link and Housing First England[22] outlined a range of competencies and skills required amongst Housing First staff. This included:

- The ability to work flexibly, creatively and in a solution-focused way.
- To be non-judgemental, empathetic and tenacious.
- To have a sense of humour and be personable.

Patient satisfaction surveys in the UK and internationally suggest that consistent and reliable relationships with staff are the most valued aspect of care.[23] A study that explored the relationship between project workers and people experiencing homelessness found that residents had historically received inconsistent support. Therefore, staff tried to counter this through being consistent and providing long-term support that was responsive to residents' needs.[24]

Consistent and long-term support relates to Attachment Theory. The theory highlights the need for individuals to develop relationships with caregivers from a young age, and that when this does not happen, emotional and social development is hampered.[25] The lack of secure attachments amongst many people who experience homelessness is sometimes then reinforced if they are rejected by services or experience fragmented service provision.[26] Hence, UK government guidance suggests that greater awareness of issues related to attachment and loss can help services to recognise these vulnerabilities early on, and take steps to engage clients whilst being sensitive to their previous experiences.[27]

Making Every Adult Matter (MEAM) is a coalition of national charities that are supporting local areas to develop effective support for people facing multiple disadvantage. MEAM clients had positive experiences of their coordinator when they fulfilled their promises, were friendly, treated them equally, offered a consistent presence and were available when needed.[28] Another programme for people with multiple and complex needs, Fulfilling Lives, found that consistent, long-term support and persistence were important features for successful support.[29] Similarly, research by Joseph Rowntree Foundation found that persistent encouragement and support was key to homeless

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[20] Advisory Council on the Misuse of Drugs (2019), *Drug related harms in homeless populations and how they can be reduced*, Home Office

[21] Hopper et al. (2010), *Shelter from the storm: Trauma-informed care in homelessness services settings*, The Open Health Services and Policy Journal, 3(2), pp.80-100

[22] Housing First and Homeless Link (2018), *Housing First How To: Tips from Frontline Professionals: skills and learning needs of Housing First Workers*

[23] Bucci et al. (2015), *Using attachment theory to inform the design and delivery of mental health services: A systematic review of the literature*, Psychology and Psychotherapy: Theory, Research and Practice, 88, pp.1–20

[24] Watson, C. (2018), *Building connection against the odds: exploring the relationship between project workers and people experiencing homelessness,* University of Hertfordshire

[25] Ainsworth M., (1973); Bowlby J., (1969)

[26] Anderson, S. (2011), *Complex Responses: Understanding poor frontline responses to adults with multiple needs: A review of the literature and analysis of contributing factors*, Revolving Doors Agency

[27] National Mental Health Development Unit and the Department for Communities and Local Government (2010), *Meeting the psychological and emotional needs of homeless people*

[28] Cordis Bright (2019), *MEAM Approach Evaluation: Year 2 report*, National Lottery Community Fund

[29] Moreton et al. (2018), *Evidence Review: Fulfilling Lives: Promising practice: Key findings from local evaluations to date*, CFE Research

individuals with complex needs committing to meaningful change and successfully overcoming barriers.[30]

B. Street outreach

A key part of building initial relationships and trust is the street outreach process. Rowe (1999) explored the importance of relationships in the process of outreach, suggesting that people who are homeless often experience a '*pervasive sense of negativity and alienation*.'[31] He concluded that '[*outreach workers] believe that connection with a caring human being, not tangible resources alone, is necessary to pull people out of a sea of negativity*.'[32]

St Mungo's is one of the largest providers of outreach services for people who are rough sleeping in England. Outreach staff aim to meet people who are sleeping rough and help them to move away from the streets. The priority is to support people into accommodation and, thereafter, to establish trusting relationships, working (in partnership, where appropriate) to support people on their journey towards recovery.

Street outreach is an important component of many interventions aimed at people sleeping rough, including Housing First, No Second Night Out and Personalised Budgets. In very broad terms, street outreach is the delivery of services to people who are street homeless. Assertive Outreach is a particular form of street outreach that targets the most disengaged people who are sleeping rough and who have chronic support needs, and seeks to end their homelessness.[33] Assertive outreach reflects the need for a persistent approach to reach those who are initially unwilling or unable to engage.

Much is known about how outreach is implemented in practice, so it possible to define the concept, consider client satisfaction and discuss the barriers to implementation.[34] For example, findings from several studies that sought the views of people experiencing homelessness show that they were often reluctant to engage with outreach services because services had previously either tried to send them to undesirable institutional settings, or had promised assistance that they had later failed to deliver.[35] To address this barrier, some studies emphasise the importance of employing people as outreach workers who are or who have experienced homelessness. This is thought to increase trust and people's willingness to engage in services.[36]

No Second Night Out (NSNO) provides a rapid response for people sleeping rough for the first time in England. It began in 2011 and aims to stop individuals sleeping rough for a second night and ensure that homelessness does not become entrenched. NSNO can be delivered in a range of ways, but typically includes a mixture of outreach and initial relationship building, a NSNO hub where staff can link individuals to accommodation and other support, and a referral telephone line.

There is a limited evidence base on NSNO. Reflecting the aim of the service, the available evidence is focused on the short-term impact of access to and retention of accommodation, rather than wider

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[30] McDonagh T. (2011), *Tackling homelessness and exclusion: Understanding complex lives*, Joseph Rowntree Foundation
[31] Rowe M. (1999), *Crossing the border: Encounters between homeless people and outreach workers*, University of California Press
[32] *Ibid.*
[33] Phillips et al. (2011) *Assertive Outreach, AHURI Positioning Paper No. 136*, AHURI
[34] Olivet et al. (2010), *Outreach and engagement in homeless services: a review of the literature*, The Open Health Services and Policy Journal, 3: pp.53-70
[35] Parsell et al. (2014); Lost et al. (2010) and Kryda, A. and Compton M. (2009)
[36] Kryda, A. and Compton, M (2009); Fisk et al. (2000)

and longer-term impacts.[37] Less is also known about how this works for different subgroups. Overall, NSNO has been found to be effective in finding the vast majority of clients temporary accommodation quickly.[38] Some clients have been complimentary of the support, which they found beneficial, but others were dissatisfied due to the type and level of support provided and the accommodation offered being viewed as substandard.[39] The effectiveness of NSNO is undermined by accommodation shortages (especially in London).[40] Furthermore, there are concerns about individuals having to put themselves in vulnerable positions to be observable and 'found' by outreach workers.[41] This links with research conducted by May (2007), which stated that street outreach teams focused on central areas of cities were unlikely to reach many women sleeping rough who hid themselves away on the outskirts of the city.[42]

As Mackie et al.(2017) explain, because Assertive Outreach is a component of wider programmes, it is challenging to identify which impacts are attributable to outreach services.[43] There is no data on potential cost savings resulting from Assertive Outreach, but numerical outcomes of Assertive Outreach can be found in evaluations of the Rough Sleepers Initiative and Rough Sleepers Unit programmes in England and Scotland respectively, and in studies on Street to Home in Australia. For example, Assertive Outreach significantly reduced the number of people sleeping rough in England and Scotland. There was a decrease of two-thirds within three years under the Rough Sleepers Unit Programme in England[44] and by more than a third within two years in the Scottish Rough Sleepers Initiative.[45] However, 40 per cent of those helped into sustainable housing through the Rough Sleeper Unit returned to the street,[46] hence the conclusion that assertive outreach will have limited value if it is not accompanied by suitable housing.[47]

Olivet et al. (2010) provide a helpful overview of key findings from research on outreach and engagement. They concluded that the current literature suggests that outreach and engagement should be viewed as a mainstay of services for people experiencing homelessness because '*meeting people where they are*' increases the likelihood of improving housing and health outcomes.[48] For example, Lam and Rosenheck (1999) found that street outreach to people experiencing homelessness with serious mental illness was both justified (due to the group's needs, experiences and motivations) and effective. This was because, when differences in characteristics and initial circumstances were taken into account, clients reached in this way showed improvement equal to that of other clients across most outcome areas.[49] Fisk et al. (2006) provided evidence that assertive outreach is effective in engaging and linking people experiencing homelessness with substance use

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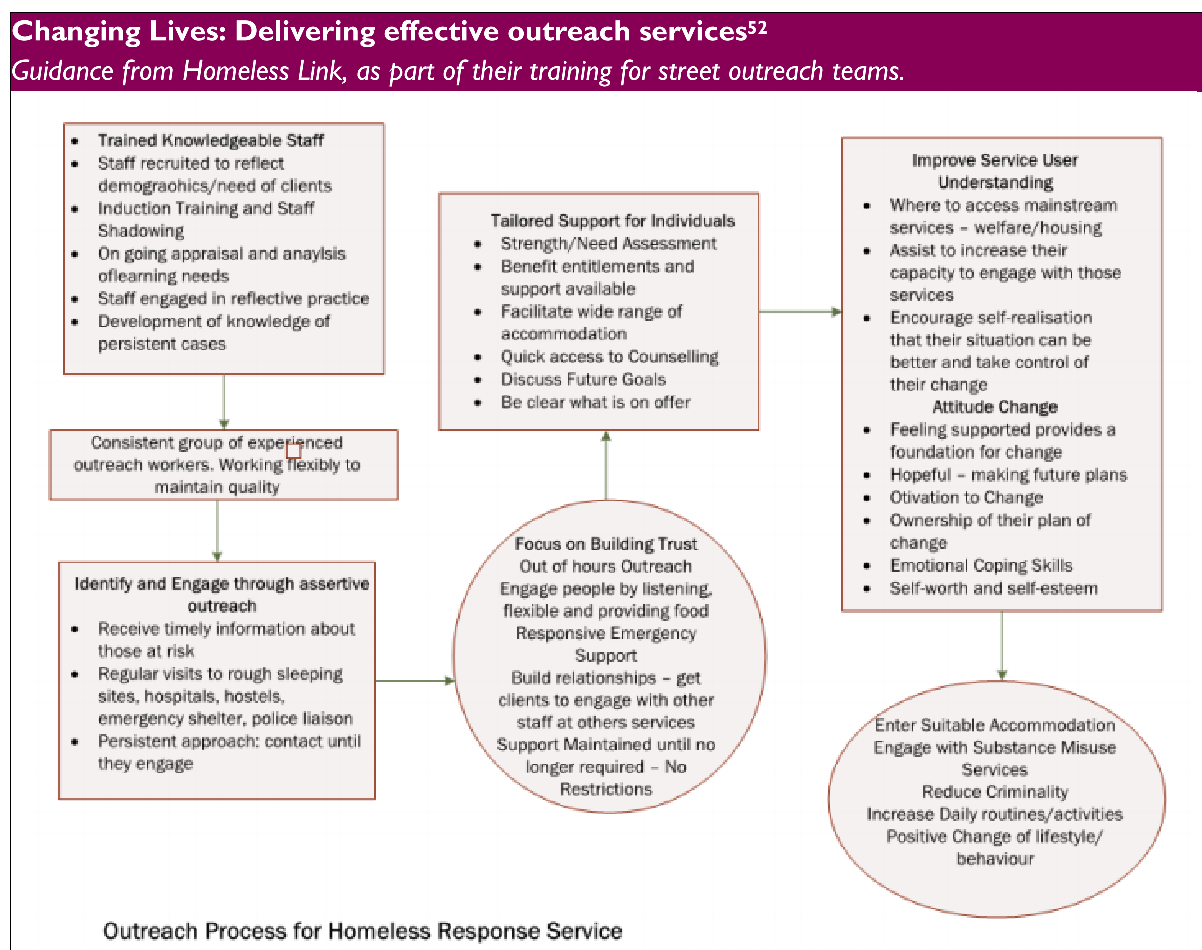
[37] Mackie et al. (2017), *Ending Rough Sleeping: What Works?* Crisis
[38] Homeless Link (2014), *No second night out across England*, Homeless Link
[39] *Ibid.*
[40] Jones et al. (2013), *No Second Night Out: A study of medium-term outcomes: Summary report*, Broadway Homelessness and Support
[41] Turley et al. (2014), *No Second Night Out Greater Manchester and Street Buddies. An Evaluation for Riverside Salford*, University of Salford
[42] May et al. (2007), *Alternative Cartographies of Homelessness: Rendering visible British women's experiences of 'visible' homelessness*, Gender, Place and Culture, 14
[43] Mackie, *Ending Rough Sleeping: What Works?*
[44] Randall, G. and Brown, S. (2002) *Helping Rough Sleepers Off the Streets: A Report to the Homelessness Directorate*, ODPM
[45] Fitzpatrick et al. (2005) *Final evaluation of the Rough Sleepers Initiative*, Scottish Executive
[46] Randall and Brown, *Helping Rough Sleepers Off the Streets*
[47] Parsell, C. (2011) *Responding to People Sleeping Rough: Dilemmas and Opportunities for Social Work*, Australian Social Work, 64(3), pp. 330-345
[48] Olivet et al., *Outreach and engagement in homeless services*
[49] Lam J., and Rosenheck R. (1999), *Street Outreach for Homeless Persons with Serious Mental Illness Is It Effective?* Medical Care 37 (9)

disorders to substance misuse treatment services.[50] However, it should be noted that these studies took place in the United States and Canada, and were all completed prior to 2010.

Overall, the literature highlights that outreach services work best when embedded with wider services, such as substance misuse, mental health and health services. The success of outreach approaches appeared to be linked to the ability of the service to offer a wide range of support. For example, the limited capacity of assertive outreach services in Street to Home in Australia was recognised as a limitation of the approach, and was attributed to tenancy failures and concerns amongst housing providers.[51]

Changing Lives: Delivering effective outreach services[52]

Guidance from Homeless Link, as part of their training for street outreach teams.



C. Building relationships in other settings

Once individuals are engaged with services there is a need for additional or ongoing relationships. This means that support can be delivered successfully, and positive outcomes are achieved. Moreover, positive relationships within services may help to prevent street homelessness, as 57% of rough sleepers seek help before they spend time on the street.[53]

[50] Fisk et al.(2006), *Assertive Outreach: An Effective Strategy for Engaging Homeless Persons with Substance Use Disorders into Treatment*, The American Journal of Drug and Alcohol Abuse, 32

[51] Phillips R. and Parsell C. (2012), *The role of assertive outreach in ending 'rough sleeping'*, AHURI Final Report No.179. Australian Housing and Urban Research Institute

[52] https://www.homeless.org.uk/sites/default/files/site-attachments/Changing%20Lives%20Outreach%20Guidance%20and%20Templates.pdf

[53] (2012), *57% of rough sleepers seek help before the streets,* Advances in Dual Diagnosis, 5 (3)

Literature examining hostels for people experiencing homelessness has consistently identified relationships between staff and clients as the most important feature influencing client experiences.[54] However, relatively little is known about the support practices that promote social connectedness and recovery.[55] In hostel settings, within staff-client relationships, people experiencing homelessness receive support to move towards independent living. Positive interactions with staff may increase self-worth and can also result in day centres being viewed as an environment that removes the stigma experienced elsewhere.[56] Hence, the conclusion by Johnsen et al. (2005) that good staff are those who minimise feelings of 'otherness'.[57] Research carried out on behalf of Centrepoint found that the caring and respectful attitudes that staff had for young people experiencing homelessness were key to positive experiences of support.[58] These positive relationships also meant that young people felt comfortable to discuss difficult topics with staff, which they might not have done if members of staff had not taken the time to get to know them. Where people experiencing homeless recalled negative experiences in hostel settings, reasons for this included that they did not feel listened to by staff, and that they felt as if staff treated them like children.[59]

A study into mental health support among people experiencing homelessness found that clients appreciated being able to talk to staff without being judged or forced down a certain route. Clients also found it emotionally cathartic to be able to share their problems, and valued support that combined practical and relational elements.[60] Furthermore, a review of community-based services for adults experiencing homelessness, mental health and substance misuse**,** stated that the key ingredients for positive interpersonal relationships included; respect for the individual, upholding the person's dignity, building mutual trust, and showing warmth and caring through acts of kindness.[61]

Watson et al. (2013) found that the relationships that clients formed with their support workers in supported housing provided an opportunity to learn new ways of relating to others, which helped them to overcome trust issues, and build or restore relationships with family and friends.[62] However, both staff and clients raised concerns about the short-term nature of support, hence the authors highlighted the need to manage this sensitively, especially when staff are temporary. Several of the studies discussed above also highlighted the benefits of informal activities (such as helping with shopping and going for a walk) to build rapport between clients and staff.

Much more research has been conducted about the Housing First approach. Housing First is an intervention that was developed for people who are homeless and experiencing mental health and substance misuse problems. Housing First provides individuals with housing and subsequently attempts to engage them in services to address their mental health issues, substance misuse and wider needs. In Housing First provision, having few barriers to accessing accommodation has been

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[54] Johnsen et al. (2005), *Day centres for homeless people: spaces of care or fear?,* Social & Cultural Geography, 6, pp.787-811
[55] Tiderington, E. (2017), *"We always think you're here permanently": The paradox of "permanent" housing and other barriers to recovery-oriented practice in supportive housing services*, Administration and Policy in Mental Health and Mental Health Services Research, 44, pp.103–114
[56] Johnsen et al., *Day centres for homeless people: spaces of care or fear?*
[57] *Ibid.*
[58] Mullen P. (2018), *What does a good professional relationship look like for homeless young people*? Centrepoint
[59] Stevenson, C. (2013), *A qualitative exploration of relations and interactions between people who are homeless and use drugs and staff in homeless hostel accommodation*, Journal of Substance Misuse, 19(1), pp.134-140
[60] Archard P. and Murphy D. (2015), *A practice research study concerning homeless service user involvement with a programme of social support work delivered in a specialized psychological trauma service*, Journal of Psychiatric and Mental Health Nursing, 22(6), pp.360-70
[61] O'Campo et al. (2009), *Community-based services for homeless adults experiencing concurrent mental health & substance use disorders: a realist approach to synthesizing evidence*, Journal of Urban Health, 86, pp.965-989
[62] Watson, D. (2013), *Understanding the Critical Ingredients for Facilitating Consumer Change in Housing First Programming: A Case Study Approach*, The Journal of Behavioral Health Services & Research, 40, pp.169–179

identified as an important starting point in creating positive staff-client relationships.[63] The harm reduction, rather than abstinence approach and (where possible) the separation between property management and case management roles, was also felt to help develop trust. This was because clients felt that they could be honest about substance misuse and wider problems without fear of eviction. Where staff had responsibility for enforcing rules as well as providing support, this led to indifference or negativity amongst clients.[64] Another study emphasised the significance of security and continuity in creating positive relationships between clients and staff. Ongoing, continuous support, regardless of circumstances results in a sense of stability and allows trust to be developed,[65] reflecting previous evidence outlined on the importance of consistent relationships.

Lastly, the sources discussed in this sub-section often highlighted the need for a supportive working culture and adequate resources to support positive relationships between clients and staff in homelessness services. For example, where there were staff shortages it made it more difficult for staff to provide the required level of support, which sometimes led to tensions with clients.

Summary – building initial relationships and trust

This section has explored the evidence on the first block of the Recovery Approach: building initial relationships and trust. It has covered generic aspects of an effective helping relationship, street outreach, and building initial relationships in services and accommodation for people experiencing homelessness.

There is an array of literature on generic aspects of an effective helping relationship from the homelessness sector, but also from health and social care and in relation to a broader vulnerable population. The evidence supports St Mungo's approach to working with clients, particularly in relation to taking a person-centred approach, being non-judgemental and providing consistent and empathetic support. In hostel settings, effective relationships with staff increase self-worth and remove feelings of 'otherness'. Research has highlighted the benefits of informal activities to build rapport in both hostels and supported accommodation, and features of Housing First have been found to enable trusting relationships, including the separation of housing management and support roles.

Although it is possible to define street outreach, how it has been implemented and barriers to its success, there is less evidence on the impact of this approach – particularly in relation to wider individual outcomes such as health and wellbeing. Furthermore, as street outreach is often part of a package of provision for people experiencing homelessness, it is difficult to separate the effects of the relationship aspect. A review of what works for reducing numbers of people sleeping rough has recommended further research on the benefits of street outreach models for different sub-groups. It is also noticeable that many of the sources identified in relation to street outreach are more than ten years old.

We will build on the evidence about trauma and psychologically informed approaches, which we have touched upon here, as we go through this review, as they relate to several other areas of the Recovery Approach.

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[63] *Ibid.*

[64] Watson, D., *Understanding the Critical Ingredients for Facilitating Consumer Change in Housing First…*

[65] McNaughton M. (2011), *'Housing First' or 'treatment first'? Considering successful strategies for the resettlement of homeless people*, Housing Studies, 26(5), pp. 767-777

3. Securing resources and opportunities

The second building block of the Recovery Approach is 'securing resources and opportunities.' This aspect involves providing or facilitating opportunities, and securing resources for clients, such as helping to securing accommodation and income. Ensuring the safety of clients underlines ways of working.

A. Increasing security

Maslow's hierarchy of needs outlines five tiers of requirements that are important for an individual to achieve complete development and, ultimately, fulfil their potential.[66] The base of this hierarchy is physiological needs such as securing shelter and food. Hence, a key aim of homelessness services is to support people to secure accommodation and income in order to manage day to day. There are also wider benefits of securing accommodation. As Public Health England states: good housing helps people stay healthy and provides a base from which to sustain a job, contribute to the community, and achieve a decent quality of life.[67] Safe and suitable housing also supports people to better manage their health and care needs. Furthermore, recent St Mungo's research emphasised that the provision of accommodation can act as a harm reduction intervention because the harms associated with drug and alcohol use are greater when people are sleeping rough.[68]

Benefit claimants who are homeless are twice as likely to be sanctioned and have their allowances and housing benefits cut, which can lead directly to further impoverishment.[69] Without access to welfare benefits, people experiencing homelessness are likely to struggle to source basic provisions and find accommodation. Therefore, as Crisis explained, welfare assistance with housing and other costs is a lifeline that helps them leave the devastation of homelessness behind.[70]

It is key that the people who are or have experienced homelessness are supported to find a job that is aligned to their interests and future ambition. It is not necessarily securing employment that supports recovery. Instead, it is about whether the role is meaningful and motivational to the individual, which helps them to establish a strong positive identity and become aware of their own agency.[71] A research project that followed the stories of 50 people experiencing homelessness over their first six to 12 months in new jobs showed that they did not need much targeted support from their employer to stay in and succeed in work. The report found that people experiencing homelessness, instead benefited from good, all-round employment practice such as well-planned inductions, regular supervisions, clear guidance about their role, and support around understanding how to behave in the workplace.[72]

Good immigration advice is essential to supporting migrants out of poverty, and poor advice at an earlier stage may also be detrimental to success in a future case. Joseph Rowntree Foundation (JRF) highlighted the need for cultural sensitivity in creating trust and confidence as many non-EEA nationals may have experienced persecution. They also suggest that a therapeutic or psychologically informed environment may be necessary because of experience of abuse and trauma resulting in

[66] McLeod, S. (2007), Maslow's Hierarchy of Needs, Simply Psychology
[67] Public Health England (2015), *Preventing homelessness to improve health and wellbeing*, Homeless Link
[68] St Mungo's (2020), *Knocked back: Failing to support people sleeping rough with drug and alcohol problems is costing lives: full report*
[69] Downie et al. (2018), *Everybody In: How to end homelessness in Great Britain*, Crisis.
[70] *Ibid.*
[71] Terry, L and Cardwell, V (2015), *Understanding the whole person; what are the common concepts for recovery and desistance across the fields of mental health, substance misuse, and criminology?*, Revolving Doors Agency
[72] St Mungo's Broadway Homelessness and Support and Business in the Community (2013), *Keeping Work. Supporting homeless people to start, stay in, and thrive at work: A guide for employers*

posttraumatic disorders or other mental health problems.[73] In addition, research by Crisis concluded that partnerships between migrant support services and homelessness agencies that use migrant organisations' expertise will be important to ensure that appropriate services are designed to end homelessness for this group.[74] Crisis also found that working with community groups was important because undocumented migrants are a particularly difficult-to-reach group as they may be reluctant to engage with services for fear of being detained or removed.

Lastly, in order to enable individuals to fulfil their potential and sustain their tenancy, it is vital that wider needs such as mental health and/or substance misuse issues are addressed. Hence, homelessness services also support people to access and engage with healthcare and specialist support to address wider issues. This is discussed further in the promoting wellbeing section in Chapter 4.

B. The advocacy role

Advocacy involves an individual getting support from another person to help them express their views and wishes, and to help them stand up for their rights. The extent professionals may provide advocacy to individuals experiencing homelessness will differ. For example, some advocates will act as a 'bridge' between services, helping them to understand individual needs and circumstances. Others will ensure individuals can access services and are prioritised by staff or will encourage individuals to engage with services that they were reluctant to talk to or might have not known about. Therefore, they will provide a link into services, but stop short of the bridging role outlined above. There is also peer advocacy, whereby the advocate is someone with lived experience of similar issues. Different studies focus on one or more of these elements. Therefore, it is difficult to disentangle what type of advocacy is most effective, or how these particular ways of working lead to positive outcomes. Furthermore, although advocacy interventions are valued by those with lived experience, there is limited evidence of the impact of advocacy in the literature on interventions for marginalised and excluded populations, including people experiencing homelessness.[75]

Why is advocacy important?

As Cornes et al. (2011) argued, some people, particularly those experiencing multiple exclusion homelessness, do not fit the eligibility requirements of many services and/or will struggle to address their range of needs through one service.[76] People experiencing homelessness also face pervasive discrimination.[77] Therefore, to address people's complex support needs and overcome prejudices, it may be necessary for keyworkers to advocate where necessary to help people to access services and become aware of their rights.

For example, JRF research (2011) recommended that homelessness organisations review job descriptions for support workers, as they recognised that staff often went far beyond providing housing-related support.[78] Support workers and other professionals who help people with multiple and complex needs often co-ordinate a range of support services, helping to overcome some of the challenges around service fragmentation.[79]

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[73] Petch et al. (2015), *How to improve support and services for destitute migrants*, Joseph Rowntree Foundation
[74] Downie et al., *Everybody In: How to end homelessness in Great Britain*
[75] Luchenski et al. (2017), *What works in inclusion health: overview of effective interventions for marginalised and excluded populations,* Lancet, 391
[76] Cornes et al. (2011), *Working together to address multiple exclusion homelessness*, Social Policy and Society, 10(4)
[77] Lynch P. and Stagoll B. (2002), *Promoting equality: homelessness and discrimination*, Deakin Law Review, 7, pp. 295–321
[78] Joseph Rowntree Foundation (2011), *Tackling homelessness and exclusion: Understanding complex lives*
[79] Rosengard et al. (2007), *Literature Review on Multiple and Complex Needs*

People experiencing homelessness can have multiple identities, linked to characteristics such as gender, ethnicity, age, disability and/or health conditions and geography. Hence, some studies have focused on the benefits of advocacy for different groups. For example, research on intense advocacy interventions for women who are homeless in the UK and the US has shown reductions in psychological distress, healthcare use, and drug and alcohol use, as well as improved self-esteem.[80] Other examples include research on the experiences of refugee and asylum seeker communities, which highlighted the need for advocacy to ensure access to required services,[81] and studies into mental health advocacy for black and minority ethnic people that raised concerns about advocacy not meeting the specific needs of such communities.[82]

Health advocacy

There is evidence for the benefits of an advocate helping people experiencing homelessness to meet their specific health and social needs. A study conducted in Liverpool in 2004 assessed the effectiveness of a health advocate that worked with people experiencing homelessness in a primary care setting.[83] The health advocate's role was to encourage individuals and families who were homeless to access services through making links between the primary healthcare team and other agencies that could meet their needs. Findings showed that, compared with people who did not receive advocacy support at the same health centre, those recruited and supported by health advocates had statistically significant improvements to their quality of life.[84]

The study also explored the impact of health advocates on the workload of primary healthcare staff. It found that health advocacy can positively change the pattern of help-seeking by adults experiencing homeless. [85] Those who were proactively registered by an advocate used less healthcare resource, compared with those who registered at the health centre at their time of need. Potential reasons for this include that the health advocate supported individuals to address concerns before they became pressing, through referrals and communication with health and wider services. Outreach health advocacy addressed psychosocial issues and reduced the workload for primary care staff (due to a reduction in appointments, referrals and prescriptions).[86] Therefore, the costs of providing health advocacy was offset by a reduction in demand for health-centre based care.

Advocacy support for people with multiple and complex needs

The role of an advocate has been highlighted as particularly important when providing support to people with multiple and complex needs. A 2007 literature review, commissioned by the Scottish Government, argued that independent advocacy is important in ensuring that the views and wishes of people with multiple and complex support needs are accounted for when accessing services.[87] Similarly, individuals with lived experience of multiple exclusion, including homelessness, emphasised

[80] Speirs V, Johnson M, Jirojwong S. (2013), *A systematic review of interventions for 36 homeless women*, Journal of Clinical Nursing, 22, pp.1080–93.
[81] Roberts and Harris (2002); Roshan N. (2005)
[82] Rai-Atkins et al. (2002); Foley R. and Platzer H. (2007); Newbigging K. and McKeown M. (2007), Barrio et al. (2008)
[83] Graham-Jones et al. (2004), *Tackling the needs of the homeless: a controlled trial of health advocacy*, Health and Social Care in the Community, 12(3), pp.221-232
[84] *Ibid.*
[85] Reilly et al. (2004), *Can a health advocate for homeless families reduce workload for the primary healthcare team? A controlled trial*, Health and Social Care in the Community 12, pp.63–74.
[86] *Ibid.*
[87] Rosengard et al., *Literature Review on Multiple and Complex Needs*

the value of the 'personal assistant' role, whereby a support worker can help with factors such as dealing with utility companies and attending GP appointments.[88]

The link worker model originated in the UK in the early 1990s in direct response to people falling through the gaps between services and coming into repeat contact with the criminal justice system. Link workers provide support and advocacy for their clients, linking them to services that will address their multiple needs and stabilise them. There is very little formal evidence for the link worker model, but early findings are promising, particularly in reducing homelessness and rough sleeping and improving access to services including healthcare.[89]

Furthermore, evaluations of programmes that support people with multiple and complex needs have demonstrated the benefits of staff who assist people with 'navigating' the system and advocating on their behalf. Fulfilling Lives Programme advocates were credited with helping clients to express their needs and get the help and support they need.[90] Similarly, the evaluation of the Making Every Adult Matter (MEAM) Approach, found that services such as Jobcentre Plus and GP surgeries were seen as more accommodating towards individuals following advocacy and feedback by a coordinator.[91]

C. Peer support and advocacy

As well as professional advocacy, as described above, there are also many examples of advocacy and support delivered by peers or people with lived experience. For the purpose of this review, peer support is understood as services that are delivered by individuals who have common life experiences with the people they are serving.[92] Peers are understood to have a unique ability to help each other because of their shared connection and deep understanding of certain experiences.[93]

Bradstreet (2006) outlines three types of peer support: informal (naturally occurring), participation in peer-led services, and intentional peer support (IPS).[94] IPS involves creating specific roles within organisations for those with lived experience of the issues at hand. As Barker (2018) explains, it is widely accepted within homelessness services, offender rehabilitation, addiction treatment and mental and physical health services that peer support can be helpful.[95]

Peer support in homelessness services

There is a limited amount of evidence on the effectiveness of intentional peer support particularly with a homeless population. However, a 2017 review of existing studies found that peer support can have a significant impact on the quality of life for people experiencing homelessness, their drug and/or alcohol use and their social support, due to factors such as shared experiences and role modelling.[96] A more recent study on homeless health peer advocacy similarly found that peer

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88 Cornes et al. (2011), *Rethinking Multiple Exclusion Homelessness: Implications for workforce development and interprofessional practice: Summary of findings*, Economic and Social Research Council
89 Terry et al., (2015), *Comprehensive services for complex needs: assessing the evidence for three approaches: Wraparound, Multisystemic Therapy and the link worker model,* Revolving Doors Agency
90 Moreton et al. (2018), *Evidence Review: Fulfilling Lives,* National Lottery Community Fund
91 Cordis Bright (2019), *MEAM Approach Evaluation: year 2 report*
92 The Substance Abuse and Mental Health Services Administration (2015)
93 *Ibid.*
94 Bradstreet S. (2006), *Harnessing the 'Lived Experience': Formalising Peer Support Approaches to Promote Recovery,* Mental Health Review Journal 11 (2), pp.33-37.
95 Barker, S. (2018), *Peer Support and Homelessness*, University of Southampton, Faculty of Environmental and Life Sciences, PhD Thesis
96 Barker S. and Maguire N. (2017), *Experts by Experience: Peer Support and its Use with the Homeless,* Community Mental Health Journal, 53, pp.598-612.

support had a positive impact for clients experiencing homelessness.[97] This was because of the social support provided and relationships developed, which were based on shared experience, and the ability to empathise and develop mutual trust and understanding. There were also positive health impacts as demonstrated by the significant reduction in missed outpatient appointments amongst clients receiving peer advocacy support. This is reflected in Groundswell's study into the critical success factors that enabled people to effectively move on from homelessness, which found that one of the seven key factors was peer support.[98] People who had moved on were able to gain skills, knowledge and positive relationships through peer support.

Within existing research, there is a stronger evidence base around the impact of providing peer support. For example, Croft et al. (2013) found evidence that individuals in educational roles in a homelessness context benefitted from providing peer support as this made them feel empowered and helped to make sense of past experiences.[99] Likewise, Groundswell found that delivering peer support and client involvement activities was instrumental for some individuals in helping them transform their attitudes towards themselves. It helped to rebuild self-esteem and confidence, as people could contribute and recognise that they had something to offer.[100] Less is known about the impact of receiving peer support.

The findings from the ongoing Homeless Health Peer Advocacy (HHPA) evaluation, conducted by London School of Hygiene and Tropical Medicine should be useful. As this research is exploring the impact of Groundswell Peer Advocates on the use of health care for adults in London who are homeless.[101]

Example of principles that can support good quality peer support

Taken from Homelessness and Health: Resources to Support Peer Activity, Groundswell[102]

Groundswell designed a toolkit that supports people to engage in peer activity around homelessness and health. It provides inspiration, practical advice and examples of peer activity in action. The resource outlines four principles of peer activity for services:

1. Support. Providing support to people taking on peer roles is vital. Make sure you consider the resources to provide genuine support.

2. Identify the need. Health is a difficult issue to deal with effectively in homelessness services, and a peer project could support this. There may be people in your service who are ready to move on, or to give something back. Providing meaningful opportunities for these people to hone their skills, learn new skills and contribute can bring benefits to them and to your service.

3. Enhance not replace. Peers are most effective in bridging a gap, not replacing or substituting support that should be available from the service. Peers, like any volunteers, need support and resources and these things require investment – they are not a source of cheap labour.

[97] Finlayson et al. (2016), *Saving Lives, Saving Money: How Homeless Health Peer Advocacy Reduces Health Inequalities*, Groundswell, The Young Foundation and The Oak Foundation
[98] Groundswell UK (2008), *A participatory research study: Creating an evidence base of the critical success factors that have enabled people to successfully move on from homelessness*
[99] Croft et al. (2013), *Tuberculosis peer educators: personal experiences of working with socially excluded communities in London*, International Journal of Tuberculosis and Lung Disease, 17
[100] Groundswell UK, *A participatory research study…*
[101] https://www.lshtm.ac.uk/research/centres-projects-groups/hhpa
[102] https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-HomelessHealth_PeerActivityToolkit_2012.pdf

4. Be open to suggestions and challenge. Involving people with personal experience of an issue or service is an excellent way of ensuring quality of service, but there needs to be room for challenge and change.

Peer support for people with multiple and complex needs

Involving people with lived experience in service design and delivery is becoming more common in programmes aimed at people with multiple and complex needs.[103] Recent evaluations show that such interventions were good value for money and that clients had positive experiences. For example, Birmingham Fulfilling Lives' Lead Worker Peer Mentor programme involved peer mentors with lived experience of the issues affecting clients helping individuals to navigate services and access suitable support. Clients reported improved confidence and feeling 'included again'; peer mentors also helped them to resolve pressing issues.[104] Additional research found that the service was good value for money. £1.11 of social value was created for every £1 spent on the programme, because of factors such as a reduction in criminal convictions, evictions and use of costly public services amongst clients.[105]

Liaison and Diversion (L&D) is another example of support for people with multiple vulnerabilities. L&D services identify and support people with a range of vulnerabilities when they first have contact with the criminal justice system. A review of two L&D peer support pilots, in Birmingham & Solihull and Wiltshire, found that there had been a positive impact on most clients as a result of receiving peer support. Clients felt understood, respected and cared for, and experienced more stable living conditions, better financial circumstances and engaged more often and effectively with wider services.[106] Peer support also provided good value for money, providing a positive return of £2.28 for every £1 invested, as a result of factors including reduced costs associated with housing/homelessness.[107]

Peer support in mental health services

Most of the evidence around the value of peer support comes from studies evaluating peer support programmes in mental health. Peer support programmes have a long history within the mental health arena and have become integral to service delivery within the field.[108] For example, a review published in 2003 found over 700 programmes that involve peers/consumers in mental health services in England. [109]

To identify why peer support has proved successful in mental health services, Gilard et al. (2014) aimed to identify the factors causing change.[110] The study found that peer support was beneficial as peers can: use a shared experience to develop trust more easily with those who are typically harder to engage; demonstrate that recovery is possible to both clients and professionals, and; use their skills and experience of problem-solving to prevent issues arising amongst those that they are supporting.

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[103] Including the National Lottery funded Help through Crisis programme and the National Expert Citizen's Group
[104] Revolving Doors Agency (2019), *Highlights from the Evaluation of Birmingham Changing Futures Together*
[105] Kibberd E. (2020), *A Final Evaluation of the Lead Worker Peer Mentor Service,* NEF Consulting
[106] Revolving Doors Agency and NEF Consulting (2018), *NHS England Liaison and Diversion peer support: A review of Pathfinder sites*
[107] *Ibid.*
[108] Faulkner, Basset, & Ryan, 2012
[109] Wallcraft et al. (2003), *On our own terms: Users and survivors of mental health services working together for support and change*, Sainsbury Centre for Mental Health
[110] Gillard et al. (2014), *Developing a change model for peer worker interventions in mental health services: a qualitative research study,* Epidemiology and Psychiatric Sciences, 24

Additionally, the international literature demonstrates a range of outcomes for individuals that have been part of peer support initiatives, including reduced hospital admissions, an increased sense of empowerment, reduced stigma, and an increase in social support. For example, an evaluation of an Australian mental health peer support service found that in the first three months of operation, more than 300 bed days were saved when peers were employed as supporters for people requiring 'hospital avoidance' or early discharge support.[111] Furthermore, a small-scale study of mental health initiatives in Canada found that clients receiving peer support had more stable health, income and work, increased participation in education and training, and stronger social networks, compared to those who had not received peer support after both nine and 18 months.[112]

However, research and guidance on peer support also highlights the challenges involved in the development of effective peer support. For example, a review of the literature on peer support in mental health services outlines that careful training, supervision and management of those providing peer support is required.[113] Similarly, an evaluation of the selection, training and support of peer support workers to support people discharged from acute psychiatric units found that skilled, sensitive supervision and support is essential for the success of such roles.[114]

Summary – securing resources and opportunities

This section has reviewed the principles of advocacy and peer support as part of the second building block of the St Mungo's Recovery Approach: securing resources and opportunities. The review has found that both advocacy and peer support are increasingly being used in a range of services, including those working with people experiencing homelessness, to help clients to overcome personal and systemic barriers. Although it is recognised that both approaches are highly valued by clients and professionals, the evidence base around the impact of intentional schemes is much more limited.

Within this evidence base, and as found in other reviews,[115] most studies have focused on the outcomes of intentional peer support interventions rather than exploring what elements contributed to the effectiveness of these peer support programmes. Whilst there is evidence around the value of peer relationships, more research is needed to explore how this value can be harnessed within formalised peer support programmes, to improve understanding of how and why formalised schemes can be effective. Furthermore, there is a particular need to conduct research around formalised schemes for the homeless population, as the evidence base is weak compared with the mental health field.

There are, however, some clear recommendations to take forward. Firstly, reflecting Barker and Maguire's recommendation, homeless organisations adopting a peer model should focus their outcomes on areas where peers are shown to have impact, such as increasing mental and physical health.[116] Organisations would also benefit from having a clearly defined peer support intervention, for example by being specific about who the support is intended to benefit (peers, clients or both)

[111] Lawn, S., Smith, A., & Hunter, K. (2008), *Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service*, Journal of Mental Health, 17(5), pp.498–508

[112] Ochocka J et al. (2006), *A longitudinal study of mental health consumer/survivor initiatives: Part 3—A qualitative study of impacts of participation on new members*, Journal of Community Psychology, 34 (3)

[113] Repper J. and Carter T. (2011), *A review of the literature on peer support in mental health services, Journal of Mental Health*, 20(4), pp.392-411

[114] Simpson et al. (2014), *Results of a pilot randomised controlled trial to measure the clinical and cost effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK*, BMC Psychiatry 14 (30)

[115] Barker (2018); Watson (2017)

[116] Barker and Maguire, *Experts by Experience: Peer Support and its Use with the Homeless*

so that the effectiveness of such interventions can be explored. Lastly, as outlined by several studies, it is vital to provide adequate support to peers so that they can be successful and benefit from the experience.

4. Support clients to develop their skills

This building block of the Recovery Approach focuses on supporting clients to develop their skills so that they can manage day-to-day living and deal with challenges. This in turn should help clients to grow in confidence, secure what they want and enjoy the psychological benefits of learning, socialising and keeping active. As part of the recovery process St Mungo's help people to develop three main sets of skills: living and independence skills, problem-solving, and emotional resilience/coping.

A. Coping skills amongst people experiencing homelessness

As outlined in the St Mungo's Recovery Approach, having practical coping or problem-solving skills means that someone can identify problems and the most appropriate means of addressing them.

Research conducted by Crisis demonstrated the wide range of backgrounds amongst single people who have experienced homelessness.[117] It emphasised the need for service providers to personalise services to cater both for individuals who have previously led capable and resilient lives, and those who have restricted functioning and have experienced little stability. Individuals struggling to cope with their circumstances had low capability/resilience prior to becoming homeless and suffered from severe mental health and/or substance misuse issues. The study also found that despite lower levels of need prior to engaging in homelessness services, foreign citizens faced barriers related to their right to access services, which sometimes led to setbacks regarding their resilience. Similarly, research in the US that explored the dynamics of homelessness, resulted in categories of risk and protective factors being developed, which the authors argue can lead to more appropriate and targeted services that consider varying needs and strengths.[118] The authors used these factors (listed in Table 2) to create three categories: those who are protected, those at risk, and those who are risky.

Table 2: Characteristics of young people experiencing homelessness[119]

Risk factors	Protective factors
Emotional distress	School
Unprotected sex	Employment
Smoking	Health
Alcohol use	Positive friends
Drug use	Survival skills
Hard drug use	

A greater amount of evidence on resilience and homelessness appeared to focus on young people experiencing homelessness. A 2017 review of studies about resilience amongst youth experiencing homelessness provided a good overview of available evidence.[120] It found that there was a negative relationship between resilience and mental health and risk behaviours, such as substance misuse. Hence, Cockersell's recommendation that there needed to be clinical interventions alongside social ones in homeless settings, to improve the wellbeing of the homeless population and reduce

[117] Smith et al. (2007), *Valuable Lives: capabilities and resilience amongst single homeless people*, Crisis and London Metropolitan University
[118] Milburn et al. (2009), *Who is doing well? A typology of newly homeless adolescents*, Journal of Community Psychology, 37(2)
[119] *Ibid.*
[120] Cronley C. and Evans R. (2017), *Studies of resilience among youth experiencing homelessness: A systematic review*, Journal of Human Behaviour in the Social Environment, 27 (4)

homelessness.[121] The review mentioned above also found a positive correlation between resilience and self-esteem. It states that the greater the self-esteem of the young person experiencing homelessness, the less likely they were to feel suicidal.[122]

There is evidence that resilience decreases the longer someone is on the street.[123] Life on the streets or in hostels can reduce wellbeing, skills and self-esteem, whilst requiring coping mechanisms to be developed which may seem extreme or inappropriate in wider society.[124]

However, once people who are homeless find accommodation, they sometimes struggle to cope and manage their tenancy. For example, a study that explored outcomes for older people experiencing homelessness that were resettled in England found that one of the reasons for the high rate of tenancy failures was that individuals had poor coping skills.[125] This issue had not been identified before they were rehoused, and was further exacerbated by poor housing conditions. Linked to this, the absence of opportunities to practice household management skills on the street or in hostel settings was found to be a further barrier to building coping skills and resilience. It was felt that the opportunity to assess the household skills of individuals before they were rehoused would have helped to identify their inability to cope.

More recently, St Mungo's research that explored reasons why some people return to rough sleeping after time off the streets, identified issues with maintaining tenancies, linked to ability to manage and cope, as a factor.[126] Staff interviewed explained that people are not always ready for the reality of having their own accommodation. Clients reported struggling to manage finances and feeling overwhelmed about maintaining a clean home, positive relationships and utility bills. Such concerns wore down resilience over time and were made more challenging by addiction and past experiences of failure or rejection, which made people reluctant to try again. Clients were sometimes unaware of the support available to help with managing money and tenancies. This is reflected in the psychology literature which states that individuals overcome by self-doubt quit rather than succeed.[127]

B. Independence skills

Self-care

Self-care refers to what people do to prevent disease and maintain good health. It can alleviate negative health consequences of people experiencing homelessness. However, recent research with people experiencing homelessness found that there was low engagement with self-care.[128] Reasons for this included poverty; low health literacy to interpret health-related information; pessimism that they could not improve their health, or that barriers were too big to overcome; and a lack of social support.[129] There are also practical barriers, including lack of access to items that can help promote self-care such as clean clothes, dental products and medication. The study therefore highlighted the

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[121] Cockersell P. (2011), *Homelessness and mental health: Adding clinical mental health interventions to existing social ones can greatly enhance positive outcomes*, Journal of Public Mental Health, 10(2), pp.88-98
[122] Cronley and Evans, *Studies of resilience among youth experiencing homelessness*
[123] *Ibid.*
[124] Lownsbrough, H. (2005), *What role can life skills play in helping homeless people prepare for employment,* Demos
[125] Crane M and Warnes A.M. (2002), *The outcomes of rehousing older homeless people: a longitudinal study*, Ageing & Society, 27(6)
[126] St Mungo's (2018), *On my own two feet: Why do some people return to rough sleeping after time off the streets?*
[127] Bandura (1997), Bandura and Locke (2003)
[128] Paudyal et al. (2019*), If I die, I die, I don't care about my health: perspectives of self-care of people experiencing homelessness*, Health & Social Care in the Community
[129] *Ibid.*

need to address these resource-related barriers to increase self-efficacy and motivation to take up self-care.

In addition, although ill-health can be a trigger of homelessness,[130] there is little evidence on homelessness prevention activity that occurs in response to health and wellbeing needs. Primary prevention activity is not widespread and there are gaps in the available evidence.[131]

C. Problem-solving skills

Problems reported by individuals who have transitioned away from homelessness include financial issues, interpersonal problems (e.g. conflict with neighbours) and health problems.[132] People experiencing homelessness may have been accustomed to staff supporting them to address their problems; part of gaining independence is about learning how to tackle issues alone and knowing when to ask for help. There is evidence that problem-solving interventions, such as Problem-Solving Therapy (PST), can effectively improve people's cognition and functioning, which can lead to employment opportunities and/or improved quality of life.[133] PST is a cognitive-behavioural intervention that has been used with people who were experiencing homelessness and had been in the armed forces in the US.[134] It trains individuals who experience mental illness in adaptive problem-solving skills. PST is an effective treatment for depression through helping people overcome daily problems and improving overall wellbeing.[135]

Cognitive impairments are considered prevalent amongst the homeless population, and can significantly affect someone's ability to obtain and maintain stable housing, as well as to benefit from supportive services.[136] Memory issues or difficulties in relation to planning and speech can result in poor problem-solving and social skills, and impair someone's ability to make sensible decisions – behaviours that can be misunderstood by staff who may mistake them for noncompliance. Research has shown that the following techniques can be beneficial when supporting individuals with cognitive impairments in homelessness settings: using very clear, concise, and specific language; providing information slowly, with opportunity for questions; and teaching individuals about breaking down goals or tasks into smaller actions so that they are not overwhelmed.[137]

Participation in learning and training can also help with the development of problem-solving skills. For example, Hammond (2004), found that learners increased in confidence, took more control of their lives, and felt empowered to tackle issues and deal with problems.[138] As Luby and Welch (2006) explain, this is highly significant for people experiencing homelessness who may not otherwise have confidence in their own abilities to live independently.[139] Problem-solving skills are also

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[130] Public Health England (2019), *Health Matters: Rough sleeping: Public Health Matters Blog,* UK Government

[131] Homeless Link (July 2015), *Preventing homelessness to improve health and wellbeing*

[132] St Mungo's (2018); Backer and Howard (2007)

[133] Gabrielan et al. (2019), *Problem Solving Skills and Deficits Among Homeless Veterans with Serious Mental Illness*, American Journal of Orthopsychiatry, 89(2), pp. 287-295

[134] *Ibid.*

[135] Bell A. and D'Zurilla, T. (2009), *Problem-solving therapy for depression: a meta-analysis*, Clinical Psychology Review, 29(4), pp. 348-353

[136] Backer, T. and Howard, E. (2007), *Cognitive Impairments and the Prevention of Homelessness: Research and Practice Review*, Journal of Primary Prevention (28), pp.375–388

[137] *Ibid.*

[138] Hammond (2004), The impact of learning on mental health, well-being and effective coping, in Brassett et al., *The Benefits of Learning, The Impact of Education on Health, Family Life and Social Capital*, The Wider Benefits of Learning

[139] Luby, J. and Welch J. (2006), *Missed Opportunities: The case for investment in learning and skills for homeless people. A research summary*, Crisis

referenced as desirable in many job descriptions, so developing these can also help with longer-term employment prospects.

D. Strengthening resilience

Coping also requires emotional resilience. This is so individuals can deal with the emotional impact of setbacks and failures constructively, and so that they do not stop trying to overcome barriers. As such, recovery has also been described as a process of growth, involving hope and resilience.[140]

This rapid evidence review has found a limited number of explicit sources on resilience amongst the homeless population. However, resilience is a theme in the literature on trauma-informed and psychologically informed approaches that are applied in homelessness settings. For example, different therapeutic approaches, such as Cognitive Behavioural Therapy and Dialectal Behaviour Therapy, aim to support people to deal more effectively with distress. They can, therefore, reduce behaviours, such as substance misuse, self-harm, and impulsive actions which result in negative consequences such as arrest and eviction.[141] In addition, Ellis (2015) argues that the positive changes that occur after trauma should be recognised and celebrated to promote factors that improve resilience capacity among clients.[142]

Individual circumstances and capacities to manage homelessness and transitions away from this differ. Research conducted by Crisis explored the factors that enabled single people experiencing homelessness to turn their lives around. This found that interventions such as creative arts and learning opportunities enhanced resilience, which in turn helped people to realise their capability. [143] Feeling part of a community and having constructive relationships with family and/or friends were identified as helping people to cope with hardship and homelessness, while friendly staff were key to interventions being viewed as helpful.

Another study that explored the experiences of young people that had recently become homeless, recommended the early identification and targeting of resilient young people experiencing homelessness to facilitate the transition to stable accommodation before their resilience deteriorated.[144] Other research into youth homelessness has found that engaging in creative activities was associated with enhanced coping skills,[145] as Crisis also found. Lastly, strong social networks and positive role models have also been identified as factors that can help to positively influence resilience amongst young people experiencing homelessness.[146]

Increasing resilience is also covered in literature and resources from the domestic violence and violence against women and girls (VAWG) sectors. For example, a study on growth and resilience following domestic violence found that access to resources (such as finance and shelter) and positive social support, were key in increasing resilience and enabling recovery.[147] Positive social support

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[140] Jacobson and Greenley 2001; Onken et al. 2007
[141] Keats et al. (2012), *Psychologically informed services for homeless people: Good practice guide,* Department for Communities and Local Government and University of Southampton
[142] Ellis B. (2015), *Beyond Risk and Protective Factors: Rethinking the Role of Stress in Regulating Child Development and Resilience*, Frances McClelland Institute for Children, Youth, and Families and University of Arizona
[143] Smith et al. (2007), *Valuable Lives…*
[144] Lee et al. (2012), *Resiliency and survival skills among newly homeless adolescents: Implications for future interventions, Vulnerable Child Youth Study*, 6(4)
[145] Cronley C. and Evans R. (2017), *Studies of resilience among youth experiencing homelessness*
[146] *Ibid.*
[147] Anderson et al. (2012), *Recovery: Resilience and Growth in the Aftermath of Domestic Violence*, Violence Against Women, 18(11), pp.1279-1299

resulted in clients receiving guidance about safety and coping strategies, and finding other people to talk to about their concerns.

Promoting and building resilience
Violence Against Women and Girls Network resource

Keene (2015)[148] outlined three key factors promoting psychological resilience:

1. **Internal support**: abilities and skills such as communication, problem-solving, behavioural, and emotional regulation, hope, and a positive view of oneself.
2. **External support**: caring supportive relationships with friends, family and neighbours.
3. **Existential support**: cultural values and faith/belief systems.

They also outline three key types of strategies for building capacity for resilience:

1. **Risk-focused**, which aim to prevent/reduce adversity exposure.
2. **Asset-focused**, looking towards increasing resources or access to resources.
3. **Process-focused**, harnessing the power of adaptive systems/networks.

E. Promoting wellbeing and good health

Wellbeing describes how people feel and how they function, on both a personal and a social level, and how they evaluate their lives.[149] There is a link between coping skills, resilience and wellbeing: studies have shown that wellbeing can be attained through the development of coping skills and resilience.[150] Additionally, there is good evidence that poor mental health undermines resilience and the capacity to function successfully and effectively.[151] Promoting wellbeing amongst people that are homeless is particularly important in improving quality of life and enabling people to cope with their problems. With higher levels of substance misuse and mental and physical health issues, needs are much higher in the homeless than the housed population.[152] Furthermore, recent research has found that support with mental ill-health is the most common support need of those accessing day centres and accommodation services.[153] Lastly, as people experiencing homelessness face multiple and interrelated barriers, issues such as poverty, illiteracy and stigma also influence their wellbeing and ability to look after themselves.[154]

Delivering health and wellbeing support

As unhealthy behaviours, such as poor diet, drugs and alcohol misuse, tend to 'cluster' together in individuals[155] there are benefits to targeting health and wellbeing interventions in places such as temporary accommodation and outreach services to support the homeless population. However, clients may not encounter healthcare staff, or will use mainstream services so could still fall through the gaps and not receive targeted support. Moreover, it is important to understand which factors

[148] Keene C. (2015), *How can I support survivors in building resilience?,* VAWnet
[149] New Economics Foundation (2012), *Measuring Wellbeing: A guide for practitioners*
[150] Jain T. and Sharma S. (2019), *Stress and Resilience: Review and Future Directions,* Journal of Advanced Research in Humanities and Social Science, 6(4)
[151] Friedli, L. (2009), *Mental Health, Resilience and Inequalities*, World Health Organization
[152] Fazel et al., 2008, 2014
[153] Homeless Link, 2019
[154] Paudyal et al. (2019); Crane et al. (2018)
[155] International Self Care Foundations (2018), *The seven pillars of selfcare*

underpin behaviour to identify the types of intervention that would be effective, rather than focusing purely on health outcomes.[156]

There is positive evidence on the use of drop-in centres to support people experiencing homelessness with their wellbeing. For example, a US study of the impact of an urban drop-in centre that offered young people that were homeless therapy and case management showed significant improvements in substance misuse and mental health for 12 months after the young people first had contact with the service.[157] Co-location of services in one place could also be beneficial to support people experiencing homelessness to access health services. A well-regarded study of a US clinic that integrated homeless, primary care and mental health services for ex-military staff who experienced homelessness with serious mental illness or substance misuse, found improved access to primary care services and reduced emergency services, but no improvements to perceived physical health status over 18 months.[158]

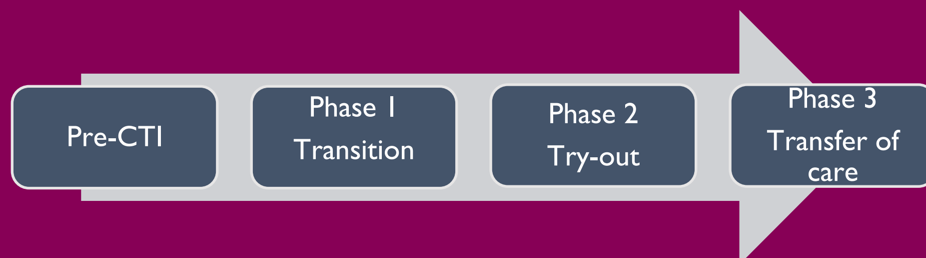
Promising practice: Critical Time Intervention[159]

Critical Time Intervention (CTI) is an evidence-based, time-limited case management model designed to prevent homelessness in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. It was developed in the US in the 1990s and has since been implemented in Europe.

CTI aims to facilitate community integration and continuity of care by ensuring that a person has stable ties to their community and support systems during critical periods of transition.

It is a community-based model that decreases in intensity over time. Staff have small caseloads and take a harm-reduction approach. They have weekly team supervision and regular full caseload reviews.

Figure 3: CTI model



Staff begin by developing a trusting relationship with client (pre-CTI) before providing support and starting to connect their client to people and agencies that will assume the primary role of support (Phase 1: Transition). Thereafter staff will monitor and strengthen the support network and their client's skills, for example by mediating conflict where necessary (Phase 2: Try-Out), before terminating CTI services when a support network is safely in place (Phase 3: Transfer of Care).

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[156] West et al. (2019), *Achieving behaviour change: A guide for local government and partners,* Public Health England
[157] Slesnick et al. (2007), *Six- and Twelve-Month Outcomes among Homeless Youth Accessing Therapy and Case Management Services through an Urban Drop-in Center*, Health Services Research, 43(1), pp.211-229
[158] McGuire et al. (2009), *Access to Primary Care for Homeless Veterans with Serious Mental Illness or Substance Abuse: A Follow-up Evaluation of Co-Located Primary Care and Homeless Social Services*, Administration and Policy in Mental Health and Mental Health Services Research, 36, pp.255–264
[159] https://www.criticaltime.org/cti-model/

Assertive Community Treatment (ACT) involves a multidisciplinary team with small, shared caseloads, home-based treatment and out-of-hours availability, as well as peer support.[160] It was designed to treat patients with severe mental ill-health. Studies on ACT in the US have shown more positive findings than those in Europe.[161] For example, trials in the UK found no advantage over usual care from community mental health teams in reducing the need for inpatient care and in other clinical outcomes, but participants found ACT more acceptable and engaged better with it.[162] Furthermore, case management with Assertive Community Treatment was shown to reduce homelessness with a greater improvement in psychiatric symptoms when compared with standard case management for the treatment of homeless populations with severe mental illness in the US.[163] There is also strong evidence from abroad about the effectiveness of the Critical Time Intervention model. For example, a recent evidence review found that taking a CTI approach significantly increased tenancy sustainment for a range of groups of people leaving state institutions, such as hospitals.[164]

Although people using Housing First are not characterised by universal or rapid improvements in mental and physical health or addiction, some improvements do occur.[165] For example, a review of trials of Housing First in England showed significant improvements in areas such as quality of life; but mixed evidence for improving mental health and substance misuse, when comparing experiences with those not receiving Housing First support.[166] Another review of eleven housing interventions (including Housing First) found that provision of housing was effective in: decreasing substance misuse and relapses from periods of substance abstinence, decreasing health services utilisation, and improving health outcomes of homeless populations with HIV.[167]

When delivering health care, it is recognised that people with multiple health conditions require case management, and that staff caring for them would benefit from joint working with professionals with a range of expertise.[168] Specifically, in homeless populations, case management (assessment, planning, care coordination) has been associated with improvements in mental health symptoms and substance misuse compared with usual care.[169] There is also evidence that short-term recuperative care for people who have experienced homelessness after hospital discharge can reduce future hospital admission rates and use of emergency departments in homeless populations.[170]

Although various primary care models that aim to meet the healthcare needs of people experiencing homelessness have been developed in England since the 1970s, there have been very few evaluations

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[160] Nugter et al. (2016), *Outcomes of FLEXIBLE Assertive Community Treatment (FACT) Implementation: A Prospective Real-Life Study*, Community Mental Health Journal, 52(8), pp.898-907

[161] Norden T. (2014); Hugulet P. (2012); Burns P. (2010)

[162] Killaspy et al. (2009), *Randomised evaluation of assertive community treatment: 3-Year outcomes*, British Journal of Psychiatry, 195, pp.81–82.

[163] Coldwell C. and Bender W. (2007), *The effectiveness of assertive community treatment for homeless populations with severe mental illness: a meta-analysis*, The American Journal of Psychiatry, 164(3), pp.393-399

[164] SCIE (2018), *A rapid evidence assessment of what works in homelessness services*

[165] Pleace N. (2018), *Using Housing First in Integrated Homelessness Strategies: A review of the* evidence, Centre for Housing Policy

[166] Bretherton J. and Pleace N. (2015), *Housing First in England: an evaluation of nine services*, Centre for Housing Policy and University of York

[167] Fitzpatrick-Lewis et al. (2011), *Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review*, BMC Public Health, 11 (638)

[168] *Ibid.*

[169] Hwang et al. (2005), *Interventions to improve the health of the homeless - A systematic review*, American Journal of Preventative Medicine; 29, pp.311–319.

[170] Doran et al. (2013), *Medical respite programs for homeless patients: a systematic review*, Journal of Health Care for the Poor and Underserved, 24, pp.499–524.

of these services. Little is known about their effectiveness and cost-effectiveness in engaging and treating people who are homeless.[171]

Similarly, literature identified often focused on the perspective of the organisations that are working together to deliver interventions, rather than client experience of the interventions themselves. As Joly et al. (2011) outline, co-operation between statutory and third sector services to support the health of people who are experiencing homelessness has been recommended since the 1960s, to avoid duplication and dangerous gaps in care.[172] However, less is known about the effectiveness of interagency working to support the health of people who are homeless in the UK. Available examples show that organisations have not always considered the priorities of clients and, instead, were driven by the perceived risk that homelessness poses to wider society.[173] For instance, research into interprofessional working and workforce development in the field of multiple exclusion homelessness found that the interaction between complex and multiple needs is often 'written off' as 'chaotic behaviour', and usually does not result in a different or enhanced response from service providers.[174]

Barriers to accessing health and wellbeing support

Research has shown that people experiencing homelessness also face stigma and discrimination when accessing health services.[175] There are barriers around the inflexibility of services and appointment systems, and the difficulties that services have in treating people with complex and multiple needs.[176] Good practice, identified to address negative staff attitudes, include health and social care workers being aware of someone's background and life circumstances,[177] which may rely on someone feeling confident to discuss their past or an advocate doing this on their behalf. Other ways to minimise perceived stigma and discrimination in health services include: improving the ability of healthcare professionals to cope with their own feelings and emotions when working with vulnerable patients; improving the competence and confidence of staff; and addressing the lack of awareness of someone's own prejudices.[178]

Another reason people experiencing homelessness are unable to access certain health services is their multiplicity of need. For example, Gunner et al. (2019) found that substance misuse and history of self-harm often excluded patients from accessing mental health services.[179] Sometimes people experiencing homelessness will have a range of health conditions but will not meet individual thresholds to receive support for each of them. Hence, support models which aim to address multiple health issues at the same time, through a multi-disciplinary team, have been suggested to promote wellbeing amongst the homeless population.[180]

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[171] Crane et al, *Mapping of specialist primary health care services in England*
[172] Joly et al. (2011), *Interagency Working to Support the Health of People Who Are Homeless*, Social Policy and Society, 10(4), pp.523-536
[173] *Ibid.*
[174] Cornes et al, *Rethinking multiple exclusion homelessness*
[175] Paudyal et al. (2018); Gunner et al., (2019)
[176] Crane et al. (2018), *Mapping of specialist primary health care services in England for people who are homeless: Summary of findings and considerations for health service commissioners and providers*, Kings College London
[177] Padgett, D. K., & Henwood, B. F. (2012*), Qualitative research for and in practice: Findings from studies with homeless adults who have serious mental illness and co-occurring substance abuse*, Clinical Social Work Journal, 40(2), pp.187–193
[178] Knaak, S. and Patten, S. (2016), *A grounded theory model for reducing stigma in health professionals in Canada*, Acta Psychiatrica Scandinavica, 134, pp.53–62
[179] Gunner et al. (2019), *Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK*, Journal of General Practice, 69 (685), pp.526-536
[180] Paudyal et al. (2019), *If I die, I die, I don't care about my health…*

Promising practice: Pathway[181]

Founded in 2009, Pathway teams support over 3,500 homeless patients every year. The service overcomes barriers frequently experienced by people experiencing homelessness in accessing support and community healthcare in the UK.

The Pathway model trains NHS staff to help patients access the accommodation, care and support they need to recover and get life onto a better pathway after their stay in hospital.

Pathway teams are led by specialist GPs who bring their experience caring for people experiencing homelessness in the community, as well as expertise in methadone prescribing, personality disorder and chronic disease management.

Nursing staff manage the team caseload and bring vital clinical experience in homelessness, addictions and/or mental health, while housing specialists bring their expertise to the service and help build links with voluntary sector services in the community. Some Pathway teams also include Care Navigators who have personal experience of homelessness. Larger teams also include occupational therapists, social workers and mental health practitioners.

Teams work with patients to create bespoke care plans for their support, including referrals to addiction services, ongoing treatment for health issues such as hepatitis C and tuberculosis, and community services offering social care. Coordinating input from housing departments, mental health and addictions services, social services, community and charity sector partners, Pathway teams aim to provide empathetic, patient-centred, recovery-focused care.

With the help of the Pathways team, one central London hospital helped over half of the people experiencing homelessness who were admitted to find somewhere to live and reduced the number of days homeless patients had to stay in hospital by 11%. The support of Pathways also reduced total 'bed-days' taken by homeless patients by nearly one third.

Summary – supporting clients to develop their skills

This section has summarised the evidence in relation to the third building block of the Recovery Approach: supporting clients to develop their skills.

Although a limited number of studies were identified on developing coping skills and resilience in the homelessness context, this was an underlying theme in some service evaluations and research into the experiences of people experiencing homelessness. Resilience is key in enabling people experiencing homelessness to make a successful transition to stable accommodation. Research has highlighted the need for services to be flexible in recognition of the variation in levels of coping skills and resilience amongst people experiencing homelessness. Creative activities and positive relationships have been found to improve resilience and coping skills amongst people experiencing homelessness.

There was a larger amount of available literature covering wellbeing amongst people who have experienced homelessness. It is widely accepted that people experiencing homelessness have lower wellbeing compared to the general population. Numerous activities have tried to address this wellbeing gap, and to measure wellbeing outcomes. As a result, it is possible to identify good practice, such as case management and respite care, which have been found to improve wellbeing amongst the homeless population. Promoting and enabling self-care is also important in improving

[181] https://www.pathway.org.uk/about-us/what-we-do/model-overview/

wellbeing and independence. More research is needed to better understand how different organisations work in partnership to address the wellbeing needs of those experiencing homelessness and what the impact of this is, as well as how services delivering health and wellbeing support can help to prevent homelessness.

5. Provide support that enables and empowers

The final building block of the Recovery Approach is to provide support in a way that enables and empowers clients. In recognition that simply providing accommodation will not be enough for many people, St Mungo's aims to support clients to overcome practical and psychological obstacles so that they are able to successfully move forward.

A. Positive risk management

The concept of 'positive risk-taking' (PRT) was first developed in statutory mental health services but has since been embedded in services working with other vulnerable groups, including people with learning disabilities, older people and those experiencing substance misuse and homelessness. It describes the idea that measuring risk involves balancing the positive benefits gained from taking risks against the negative effects of attempting to avoid risk altogether.[182] Furthermore, it intends to overcome systems and processes which have sometimes meant that clients have been unable to take the risks they are entitled to, leaving them at a disadvantage.[183] Neill et al. (2009) argue that a positive approach to risk requires person-centred thinking to help individuals and those who care about them most think in a positive and productive way, whilst being mindful of risk.[184]

Positive risk-taking in mental health and learning disability services

Positive risk-taking has been shown to be an important part of successful mental health recovery, but there is a need for more research to support its application in clinical practice.[185] A 2016 review of available literature found that mental health practitioners were keen to promote positive risk-taking with patients to enable their recovery. However, factors including a culture of blame should a negative outcome arise, and a lack of support and guidance from management, prevented this being embedded more widely.[186]

Bates and Silberman – Effective risk management criteria

Bates and Silberman (2007) have described effective risk management as the 'holy grail' of mental health and other care services. They describe effective risk management as finding an integrated balance between positive risk-taking around the values of autonomy and independence and a policy of protection for the person and the community based on minimising harm. They listed seven criteria that effective risk management should fulfil:

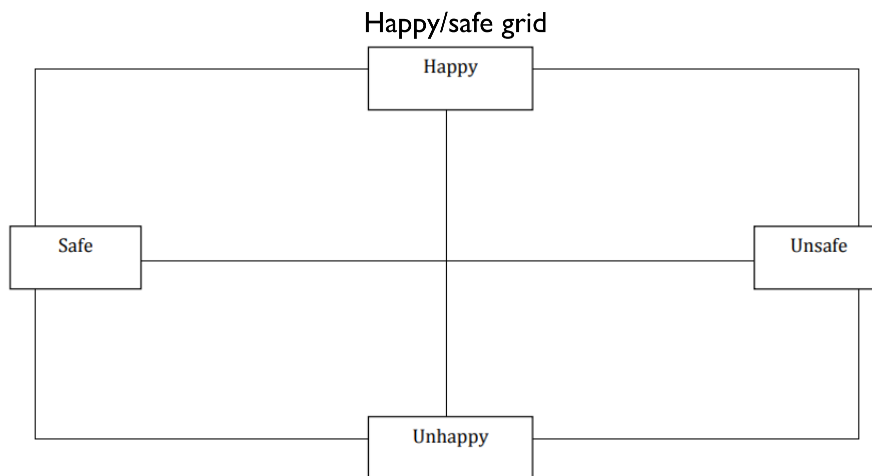
- involvement of clients and relatives in risk assessment
- positive and informed risk taking
- proportionality
- contextualising behaviour
- defensible decision making
- a learning culture
- tolerable risks

[182] Morgan S. and Williamson T. (2014), *How can positive risk-taking help build dementia friendly communities?* Joseph Rowntree Foundation
[183] Morgan S. (2014), *Working with strengths: putting personalisation and recovery into practice*, Pavilion Publishing & Media
[184] Neill et al. (2009), *A positive approach to risk requires person-centred thinking*, Tizard Learning Disability Review, 14(4), pp.16-23
[185] Reddington G. (2016), *The case for positive risk-taking to promote recovery*, Mental Health Practice, 20 (7)
[186] *Ibid.*

Similarly, a 2011 study exploring outreach workers' experiences of positive risk-taking recommended better informed, coherent organisational approaches to PRT in adult mental health and learning disability services in England.[187] The study found different understandings of PRT at different levels within organisations, and identified a need to increase staff trust and confidence in their decisions and relationships. Without such organisational coherence it was felt that some staff may see themselves as gambling when undertaking PRT. Others may return to traditional interventions, which were viewed as potentially increasing risk in the long-term, because they promote coercion and disrupt therapeutic relationships.

Person-centred risk management tools[188]

Happy/safe grid



Action plan – where next?

Positive supports	Strategies	By when?	Who is responsible?	Monitor and Review*

Decision-making grid

Important decisions about [person' life	How I must be supported	Who makes the final decision?

Neill et al. (2009) outline a process which considers purpose, people, process and progress to think about what individuals want to achieve, how they can have choice and control in their lives and how they can be a citizen in the community.[189] Tools used include a 'happy/safe' grid, that maps solutions considering the benefits and safety implications, and a decision-making agreement that enables choice and control. Contingency plans are also developed, and progress is reviewed regularly.

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[187] Robertson J.P and Collinson C. (2011), *Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services*, Health, Risk and Society, 13(2)
[188] Gadow F. and Riches V. (2014), *Practice Guide to Person Centred Clinical Risk Assessment*, Centre for Disability Studies
[189] Neill et al., *A positive approach to risk requires person-centred thinking*

Positive risk management in a homelessness context

In the context of homelessness, risk management can be about preventing a return to homelessness and providing follow-on care if someone has sustained a tenancy. It may also include managing threats to health from uncontrolled substance misuse, and reducing thoughts and feelings that lead to negative behaviours, such as low confidence and isolation. Research by Bowpitt and Harding (2009) that explored tenancy sustainability for people who previously experienced homelessness and substance misuse, argued that risk management strategies only worked in the context of restoration of lives and relationships. They felt that mutual trust and acceptance enabled sustained tenancies, rather than coercion.[190]

A report that explored how drug-related harm can be reduced amongst people experiencing homelessness highlighted that abstinence, as a condition for housing or continued housing, may exclude vulnerable populations.[191] It also found international evidence to support the effectiveness of safe injecting sites to maintain contact and engagement with highly marginalised target populations and to prevent overdose deaths. Collins et al. (2016) also found that most people with lived experience of homelessness and alcohol use disorders were uninterested in abstinence-based programmes as a means of attaining long-term alcohol abstinence.[192] Instead, research participants had creative ideas about alternative pathways to recovery. This included harm reduction approaches like switching from higher to lower alcohol content beverages, engaging in meaningful activities like art, outings, spiritual/cultural activities and making positive social connections.

Much literature has focused on the risky behaviours people experiencing homelessness may adopt and/or the risks that they are exposed to on the streets. However, recent research has been critical of how staff apply their own understanding of risk when working with individuals experiencing homelessness. For example, Macdonald (2014) argues that the construction of risk amongst young people experiencing homelessness too often dominates how services will work with them, and instead that staff should consider the individual's views and experiences of risk.[193] (This also links to taking a strengths-based approach, which is discussed below). Macdonald found that individual responses to risk shifted over time, were based on intuition and experience, were dynamic, and were not significantly impacted by interaction with professionals and services. There was a mismatch between social worker's professional knowledge of risk and how they applied this with individual experiences. Parsell et al. (2012) are similarly critical of the application of risk factors when delivering homelessness prevention support. They believe that interventions often aim to address individual problems, rather than the structural factors that contribute to homelessness.[194]

B. Methods for empowering clients

Empowering clients is about giving individuals agency to make decisions. Reflecting the principles of peer support, it involves recognising that they are 'experts in their needs'. Empowerment is also about giving individuals the confidence to make choices and take responsibility for their actions.

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[190] Bowpitt G. and Harding R. (2009), *Not Going It Alone: Social Integration and Tenancy Sustainability for Formerly Homeless Substance User*, Social Policy and Society, 8(1), pp. 1-11
[191] Advisory Council on the Misuse of Drugs, *Drug related harms in homeless populations…*
[192] Collins et al. (2016), *In their own words: Content analysis of pathways to recovery among individuals with the lived experience of homelessness and alcohol use disorders*, International Journal of Drug Policy, 27, pp. 89-96
[193] Macdonald, S. (2014), *Managing Risk: Self-Regulation Among Homeless Youth*, Child and Adolescent Social Work Journal, 31, pp.497-520
[194] Parsell et al. (2012), *Beyond the 'at risk' individual: Housing and the eradication of poverty to prevent homelessness,* Australian Journal of Public Administration, 71(1), pp.33-44

A strengths-based approach and focusing on individual capability

A way to empower clients, as adopted by St Mungo's, is a strengths-based approach. A strengths-based approach is about working collaboratively with clients to identify their capabilities and interests, then building on these to achieve positive outcomes, such as improved wellbeing.[195] This has been adopted by social workers and health professionals to promote personal and community capacity, as opposed to focusing on individual problems and the causes of these.[196] (Again, recognising the structural factors influencing circumstances.) Furthermore, as described by Morris (2002) and Saleebey (2009), delivering interventions based on individual goals and strengths reaffirms clients' right to control their lives and wellbeing.[197] Wellbeing can be improved when individuals have the freedom to pursue the aspects of life that are meaningful and valuable to them, regardless of housing status.[198]

The benefits of a strengths-based approach were reflected in a Revolving Doors review of approaches to tackling multiple and complex needs. Recognition and development of people's strengths was a common theme of 'effective' services. Other themes were including the 'natural support' of families and communities, ensuring that the client's voice is heard, and ensuring that they are placed at the heart of the approach.[199]

Strengths-based approaches also link to the capability approach, which argues that policy should primarily focus on expanding individuals' capabilities instead of resources and utilities, to create meaningful and fulfilled lives.[200] It has been widely recognised and discussed in the field of poverty and development studies, but research into the capability approach in the context of homelessness is limited. One example is a 2009 study which found that even when people who had experienced homelessness were housed, if they lacked capacity for certain functions, issues could not always be overcome.[201] The authors emphasised the desire for imagination, relationships and leisure activities, as well as material resources, amongst research respondents. More recently, Kimhur (2019) argued that there is an added value of applying the capability approach to housing studies, and a need to consider individual fulfilment and social justice as an end goal, rather than focusing solely on economic concerns.[202] Kimhur recommended focusing on multiple capabilities relevant to housing, instead of limiting policy concerns to factors such as quantity of housing units and housing affordability. This approach may also be a way to encourage collaboration from different fields, such as health and employment, to improve housing policy and outcomes for people experiencing homelessness.

Personalised Budgets

Personalised Budgets aim to support people who have been rough sleeping for a long time to move off the streets and into accommodation. Brown (2016) describes the 'model participant' as someone for whom all other attempts to help secure stable accommodation have failed.[203] The intervention broadly works by ensuring clients are assisted by a named support worker who has access to a

[195] Saleebey, (2009)
[196] Fawcett B. and Reynolds J. (2010); Saleebey (2009)
[197] Morris P. (2002); Saleebey (2009)
[198] Sen A. (2009), *The Idea of Justice*, Allen Lane
[199] Centre for Mental Health and Revolving Doors Agency (2012), *Comprehensive Services for complex needs: A summary of the evidence*
[200] Sen, A. (2004), *Capabilities, lists, and public reason: continuing the conversation*, Feminist Economics, 10, pp.77-80
[201] Nicholls C. (2009), *Housing, Homelessness and Capabilities*, Housing, Theory and Society, 27, pp. 23-41
[202] Kuhmer, B. (2020), *How to Apply the Capability Approach to Housing Policy? Concepts, Theories and Challenges, Housing, Theory and Society*
[203] Brown, P. (2016), Right time, right place? The experiences of rough sleepers and practitioners…

budget (usually between £2,000-£3,000)[204] to be spent flexibly to help clients secure and maintain accommodation. The concepts of choice and control are fundamental to the approach. People sleeping rough are encouraged to identify their own needs and act with ongoing support from a single support worker. The intervention has only been tested in the UK and very few evaluations exist. Pilot projects have often secured and maintained accommodation in around 40-60% of cases, but it is difficult to compare across projects as accommodation suitability is determined by the individual.[205] There is limited evidence of wider impacts or the impact of Personalised Budgets on different groups of people experiencing homelessness. However, there are early indications that Personalised Budgets can result in further engagement with wider services, positive health outcomes and clients re-establishing social networks.[206] There is consensus that for this intervention to be replicated and/or expanded to more areas, additional funding is required so that specialist support and access to accommodation can be provided.[207]

Social enterprise and employment support

There has been an increase in the number of social enterprises (SEs) in the UK homelessness sector, which reflects attempts to test 'innovative' ways of transforming disadvantaged people's lives in the UK.[208] These SEs have often focused on employment and vocational activities in an attempt to empower people experiencing homelessness to overcome the range of barriers faced when seeking and retaining paid employment. However, a study that explored how useful employment-focused SE's were in empowering clients who were experiencing homelessness had mixed results.[209]

There was evidence of improvements in clients' mental health and confidence, which sometimes helped people to establish relationships. Yet, participation offered little opportunity to improve clients' living circumstances. Although there was evidence of enhanced work and life skills through the provision of training and access to a workplace, there was considerable dissatisfaction with the basic level of the training and limited range of training opportunities available. Moreover, as participants were unpaid, there was no progress towards financial independence and no evidence that participation had been a 'stepping stone' to mainstream employment. Furthermore, research participants consistently identified positive staff attitudes and mutual self-help as the main reason for empowerment, rather than the opportunity to complete a job or training. Hence, the conclusion that, although it does have an important role to play, there should not be too strong a focus on employment, training or volunteering alone. This also reinforces findings from other research discussed in this review on the importance of positive relationships (see pages 45-48). Lastly, many research participants aspired to a more 'normal' work, social and home life, which they had not been empowered to achieve. The authors proposed schemes may have had greater success if they had been more integrated. They referenced examples including Housing First and Individual Placement Support that offer opportunities in 'ordinary settings'.

Housing First

The focus of Housing First is to move people who are experiencing homelessness into independent and permanent housing quickly, and then provide additional support and services as needed. A key

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[204] Brown, P. (2013); Hough, J. and Rice, B. (2010)
[205] Crisis (2017), *Ending Rough Sleeping…*
[206] *Ibid.*
[207] Crisis (2017), *Ending Rough Sleeping…*
[208] McKenna (2011); Tracey et al. (2011)
[209] Tanekenov et al. (2018), *Empowerment, Capabilities and Homelessness: The Limitations of Employment-focused Social Enterprises in Addressing Complex Needs*, Housing Theory and Society, 35 (1)

aim of the Housing First approach is that people using the service exercise choice and control over their own lives. Freedom and choice have been identified by clients as a key strength of the service, alongside factors including secure accommodation and intensive support. Likewise, research has shown that where the core principles of Housing First are most closely adhered to, there is greater chance of reducing long-term homelessness in England.[210] This includes the level of choice and empowerment that clients are given, which in turn results in personalised support.

Co-production

Other studies have explored the impact of co-design activities within services and research on empowering people with multiple and complex needs, including people experiencing homelessness. Where implemented well, co-production can support positive relationships and help people to feel empowered as they feel they have an input in decisions. For example, Halvorsen (2003) defines empowerment as a concept where people believe decision makers take their comments seriously and that resulting decisions have reflected their concerns.[211] Furthermore, Andrews and Brewer (2013) linked co-production with social capital because individuals can get involved in their community or an organisation, for example through volunteering or involvement in policy campaigns.[212]

There are examples of collaborative projects, where people experiencing homelessness have worked with professionals to develop resources and interventions, resulting in positive outcomes. For example, when young people experiencing homelessness developed a mobile phone application, they had the chance to express their opinions and frustrations, as well as an opportunity to improve the lives of their peers through improved access to support and services.[213] Another project involved young people experiencing homelessness developing an audio documentary. This facilitated the development of interpersonal skills and provided them with opportunities to engage their strengths.[214]

Lastly, there are organisational benefits of involving people with lived experience in service delivery, as also discussed in the peer support section. For example, trainees with lived experience of multiple and complex needs in Manchester were felt to have improved user engagement, and shaped processes which made the organisations where they worked more credible to the individuals they set out to help.[215]

C. Trauma-informed care

Trauma-informed care (TIC) describes a way of working with people. It has been shown to give clients a 'voice', and it is guided by principles of empowerment and choice.

Research has shown that individuals who are homeless are likely to have experienced some form of previous trauma in their past and/or when they were homeless; and being homeless increases the risk of further victimisation and re-traumatisation.[216] Trauma-informed care provides a framework

[210] Bretherton J and Pleace N. (2015), *Housing First in England: An Evaluation of Nine Services*
[211] Halvorsen, K. (2003), Assessing the effects of public participation, Public Administration Review, 63(5), pp.535-543
[212] Andrews, R. and Brewer, G. A. (2013), *Social Capital, Management Capacity and Public Service Performance Evidence from the US States*, Public Management Review, 15(1), pp.19-42.
[213] Buccieri, K. (2015), *Empowering Homeless Youth: Building Capacity through the Development of Mobile Technology*, Journal of Community Practice, 23, pp.238-254
[214] Kelly B. and Hunter M. (2015), *Exploring Group Dynamics in Activity-Based Group Work with Young People Experiencing Homelessness,* Social Work with Groups, 39(4), pp.307-325
[215] Homeless Link (2019), *Co-Production – employing lived experience: Inspiring Change Manchester*
[216] Borysik (2019); Hamilton et al. (2011); Coates et al. (2010); Maguire et al. (2009)

for delivering services to traumatised individuals within a variety of settings, including homelessness services. There is not an agreed definition of TIC, which makes it more difficult to measure whether an organisation or service is trauma informed. Based on existing research and practice, Hopper et al. (2009) described TIC as: *'a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.'* [217]

Research has suggested that individuals and families experiencing homelessness need and want trauma-informed services. They desire autonomy, prevention of further victimisation, and assistance in restoring their devalued sense of identity.[218] Less is known about whether TIC is effective in homelessness service settings. However, research in other fields suggests that trauma-informed services may be effective for people experiencing homelessness, for example initial findings show that it could have a positive effect on housing stability.[219]

Available research suggests that integrating services for traumatic stress, substance misuse, and mental health leads to better outcomes. Numerous studies have shown a reduction of substance misuse and psychiatric symptoms, and some studies have also shown improvements in mental health and daily functioning, as well as reductions in hospitalisation and use of crisis services.[220] Trauma-informed services have also been found to be cost-effective. Organisations taking a trauma-informed approach have reported increased collaboration with clients and external agencies, and improved staff morale.[221]

Studies have shown that training is essential to effectively implement and reinforce TIC. Staff need to feel confident to manage and address trauma reactions, and wider organisational buy-in is considered beneficial in creating this.[222] Assessment and screening have also been found to be important aspects of trauma-informed services. Finally, partnership working is considered necessary to address the needs that are uncovered.[223]

D. Building motivation for change

Homelessness can affect an individual's motivation for change and willingness to engage with treatment.[224] Therefore, homelessness services have the opportunity to work with individuals to increase motivation so that they may accept help, and feel more hopeful about receiving support and improving their situation.

Motivational interviewing

A technique used to increase motivation is motivational interviewing. Motivational interviewing originated in the substance misuse sector. It involves professionals engaging and motivating

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[217] Hopper et al. (2009), Shelter from the Storm: Trauma-Informed Care in Homelessness Services…
[218] Padgett et al. (2009), *In their own words: Trauma and substance abuse in the lives of formerly homeless women with serious mental illness*, American Journal of Orthopsychiatry, (76), pp. 461-467
[219] Kammerer, N. et al. (n.d.), *Project RISE Evaluation Report*, Health and Addictions Research Inc. and Institute for Health and Recovery
[220] Hopper et al., *Shelter from the storm*
[221] *Ibid.*
[222] Community Connections (2003); Moses et al. (2004)
[223] McHugo et al. (2005), *The assessment of trauma history in women with co-occurring substance abuse and mental disorders and a history of interpersonal violence*, Journal of Behavioural Health Service Research, 32, pp.113-27
[224] Local Government Association (2017), *The impact of homelessness on health: A guide for local authorities*

individuals to improve their unhealthy behaviours[225] through clarifying their strengths and aspirations, evoking their own motivations for change and promoting autonomy in decision making.[226] Evidence demonstrates that motivational interviewing improves treatment engagement and outcomes among many different individuals.[227] Factors including age and ethnicity can influence outcomes, as studies have shown greater effectiveness among older clients and minority ethnic groups.[228] However, less is known about the benefits and effectiveness of motivational interviewing among people experiencing homelessness. Lastly, some studies have also shown that the organisational environment may be a critical factor in the effectiveness of motivational interviewing.[229] For example, Berk-Clark et al. (2015) found that organisational boundaries and culture prevented motivational interviewing being implemented effectively in a supported housing organisation.[230]

Royal College of Nursing guidance on motivational interviewing[231]

There are four general principles of motivational interviewing:

- **R** - resist the urge to change the individual's course of action through telling them how to behave.
- **U** - understand it is the individual's reasons for change, not those of the practitioner, that will elicit a change in behaviour.
- **L** - listening is important; the solutions lie within the individual, not the practitioner.
- **E** - empower the individual to understand that they can change their behaviour.

The following techniques can be integrated into motivational interviewing approaches: asking open-ended questions, listening reflectively, affirming and clarifying discussion, summarising feedback and eliciting self-motivational statements.

Inspiring hope in a homelessness context

Studies which have studied hope with individuals experiencing homelessness share the common theme that powerlessness, associated with the experience of homelessness, has a destructive impact on self-esteem and hope.[232] However, understanding of how to inspire hope remains vague, particularly for single adults who experience entrenched homelessness.[233]

A study that explored motivation for change and psychological distress amongst people experiencing homelessness and substance misuse in Canada found that clients had clear goals for recovery; housing was integral to facilitating hope and supporting recovery.[234] Reasons for this included that it was associated with a fresh start and rebuilding their lives, and because it would enable independence and improve wellbeing. Goal setting was a way in which individuals expressed hope,

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[225] Hecht et al. (2005), *Motivational interviewing in community-based research: experiences from the field*, Annals of Behavioural Medicine, 29

[226] Rollnick et al. (2008), *Motivational Interviewing in Health Care: Helping Patients Change Behavior*, American Journal of Pharmaceutical Education, 73(7)

[227] Lundahl et al. (2010), *A meta-analysis of motivational interviewing: Twenty-five years of empirical studies*, Research on Social Work Practice, (20), pp.137–160

[228] *Ibid.*

[229] Helfrich et al. (2012); McGraw et al. (2010)

[230] Berk-Clark et al. (2015), *Motivational Interviewing in permanent supportive housing: The role of organizational culture*, Administration and Policy in Mental Health, 42(4), pp.439-448

[231] https://www.rcn.org.uk/clinical-topics/supporting-behaviour-change/motivational-interviewing

[232] Partis (2003); Williams and Stickley (2011); Hughes et al. (2010)

[233] Kirst et al. (2014), *The promise of recovery: narratives of hope among homeless individuals with mental illness participating in a Housing First randomised controlled trial in Toronto, Canada*, BMJ Open, 4

[234] *Ibid.*

for example, by thinking about employment and training ambitions, and rebuilding relationships. However, some clients had difficulty adjusting to housing, and were concerned about feeling socially isolated, which could have negative implications for hopefulness and recovery. Hence, the authors emphasised the need for follow-on care to support this transition.

Evidence about inspiring hope from mental health services

Within a review of strategies and interventions used to increase hope in mental health settings, Schrank et al. (2012) described hope as a central component of mental health recovery.[235] Although the review found that increasing hope was a secondary outcome, rather than the main aim of interventions themselves, the authors identified five promising ways of working to increase hope. This included: collaborative strategies for illness management; a focus on fostering relationships both with staff and people outside the mental health system; facilitating connections with peers, particularly peer support; helping clients to assume control and to develop and pursue realistic goals; and specific interventions to support numerous positive factors such as self-esteem, self-efficacy and wellbeing.

E. Provision of structure and routine

Many of the people that homeless and rough sleeper services work with may lack structure and daily routine. Reasons for this include that they have been focusing on surviving on the streets and/or because they are excluded from productive activities such as work, activities of daily living, socialisation and leisure.[236] Furthermore, routines for people experiencing homelessness can be imposed, for example, by rules and structures in hostels, and therefore may lack meaning.[237] Hence, services often aim to support people who are homeless to gain independent living skills and use their time in a rewarding way, which can in turn improve their overall wellbeing.

As with coping and resilience, we identified very few sources that explicitly focused on the themes of structure and routine amongst homeless populations. Where it has been covered, the benefits of supporting people experiencing homelessness to develop structure and routine included improvements to confidence and reduction in unhealthy behaviours, often because individuals realised that they could participate in, and enjoy, meaningful activity.

Occupational therapy

There are examples of occupational therapists working with people experiencing homelessness to assist them to establish routines and find satisfaction in carrying out daily activities. This includes an occupational therapy intervention within homelessness services in Bristol that involved staff working with clients to increase activity levels and develop more structured and productive routines.[238] There were sessions such as cooking and gardening groups to enable clients to have a positive experience from a legitimate activity, and the chance to 'experience themselves differently'. A strength of this approach was that it could address one of the key causes of negative behaviours – an individual's lack of occupation and their unstructured use of time – rather than focusing on the

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[235] Schrank et al. (2012), *Determinants, self-management strategies and interventions for hope in people with mental disorders: Systematic search and narrative review, Social Science and Medicine*, 74(4), pp.554-564

[236] Lloyd C. and Basset H. (2012), *The role of occupational therapy in working with the homeless population: An assertive outreach approach*, New Zealand Journal of Occupational Therapy, 59(1)

[237] Chard et al. (2009), *Exploring occupation and its meaning among homeless men*, British Journal of Occupational Therapy, 72(3)

[238] Fieldhouse et al. (2011), *Evaluation of an Occupational Therapy Intervention Service within Homeless Services in Bristol*, University of West England

negative behaviours themselves. Short-term outcomes included clients successfully engaging in new routines and reporting growing confidence.

Another example identified was a study that explored the impact of occupational therapists joining the Homeless Health Outreach Team in New Zealand.[239] It concluded that occupational therapy lends itself well to the homelessness field because of the focus on function, purposeful activity, life roles and the development of individual capacity. The authors believed that occupational therapists could play a key role in addressing the functional needs of people experiencing homelessness and assisting them to take up meaningful roles. Both studies highlighted the challenges of embedding occupational staff into homeless teams, due to the flexible ways of working and delivery across numerous locations.

The benefits of structure and routine

Those experiencing addiction may find their time structured around addressing this. A study of women's experiences of homelessness services in Ireland found that those who were trying to curb their use of alcohol and/or drugs often sought a greater degree of structure within accommodation settings, and preferred stricter settings.[240] The structures and rules in certain services, particularly domestic violence refuges and transitional housing, had also helped them to re-establish a structured routine to support day-to-day living and their ability to source more stable housing. However, several service providers highlighted the implications of women becoming 'too comfortable' in residential service settings, which increased the risk of them becoming over-reliant and dependent upon service providers and staff to provide structure and routine in their lives.[241]

Research also has shown the value people who are experiencing homelessness place on roles and routines that some might take for granted. For example, Finlayson et al. (2002) and Chard et al. (2009) found that lack of control, especially over small things such as the type of food served at meals and the hour of bedtime in hostels, proved problematic.[242] Likewise, a study that explored the serious losses associated with homelessness found that societal expectations, such as finding somewhere to live and securing employment, were not always identified as most meaningful.[243] The smallest losses often had the greatest impact. Hence, co-produced processes and rules could have benefits, as clients will have the opportunity to inform decisions linked to routine and structure.

F. Preparing clients psychologically for move-on

Homeless Link's 2016 research[244] about moving on from homelessness provides a useful definition of move-on:

'Move on was variously seen as about becoming independent, moving away from a former life or lifestyle, feeling safe, secure and calm, and offering hope. An important element of move on is seen to be the ability of individuals to sustain their accommodation and ensuring they are supported appropriately to avoid repeat homelessness. Many service providers felt that move on was, at its core, about moving to accommodation that better suits an individual's needs and circumstances.'

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[239] Lloyd C. and Basset H. *The role of occupational therapy in working with the homeless population…*

[240] Mayock et al. (2015), *Women, Homelessness and Service Provision*, Simon Communities in Ireland

[241] *Ibid.*

[242] Chard et al. (2009), and Finlayson et al. (2002) *The process and outcomes of a multimethod needs assessment at a homeless shelter…*

[243] Boydell et al. (2000), *Narratives of identity: representation of self in people who are homeless, Qualitative Health Research,* 10(1), pp.26-38

[244] Homeless Link (2018), *Moving on from homelessness: how services support people to move on*

Move-on often involves supporting clients so that they feel prepared to live independently, increasing access to accommodation and providing continued support in independent accommodation. Support provided may include pre-tenancy training, support with benefits and budgeting, and support into education, training and employment.

The need for holistic support to enable move-on

It has long been recognised that *'simply putting a roof over someone's head does not always solve his or her homelessness.'*[245] Hence, sustainable solutions to homelessness require a range of housing support services to prevent tenancy breakdown and a return to the streets.[246] Several studies have emphasised a range of changes that need to occur to enable people experiencing homelessness to successfully move on, beyond securing a tenancy and basic 'housekeeping skills'. For example, Seal (2005) discussed resettlement as a process of change, arguing that housing is unlikely to be sustainable unless cognitive, emotional and/or practical changes occurred.[247] Reflecting previous findings about the importance of individual choice, Seal outlined the importance of individuals being able to make rational choices, such as about where to live; of developing positive feelings about themselves, other people and their circumstances; and of reviving old skills and learning new ones. Similarly, Neale and Kennedy (2002) concluded that good practice is not simply about providing permanent accommodation or ensuring abstinence from drugs. It is also about helping those who experience homelessness and use drugs to achieve stability, feel safe and secure, meet new friends, and grow in confidence and self-respect.[248] More recently, Homeless Link also emphasised that move-on is seen as far more than acquiring a tenancy or other form of accommodation because there is often a need for ongoing support and continued positive relationships.[249]

The FOR-HOME study surveyed 400 single people experiencing homelessness aged 16+ who were resettled from hostels and other temporary accommodation into independent tenancies in England.[250] It found that many respondents had low morale, anxiety, and the sense of social loneliness after resettlement. Before moving, many respondents believed that it would be easy to settle down and that they would cope, which is why some then refused tenancy support services. However, several individuals found the transition daunting and felt ill-prepared psychologically for what was ahead. Low morale resulted from no longer having the support of hostel staff and residents, and sometimes family and friends. Motivational interviewing (discussed on pages 38-39) and Cognitive Behavioural Therapy have been suggested as methods to support clients to think about potential areas of difficulty in order to plan coping strategies to successfully move on.[251]

The importance of partnership working

Homelessness services often work with a diverse group who present a range of complex problems. Therefore, as Hurtubise et al. (2009) state, it is necessary for staff to collaborate with external organisations and deliver a range of support interventions.[252] Snyder and Weyer (2002) describe the

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245 Department for Transport, Local Government & the Regions (2002); National Audit Office (2005)
246 Bowpitt and Harding (2009), *Not going it alone…*
247 Seal, M. (2005), *Resettling Homeless People: Theory and Practice*, Russell House Publishing
248 Neale, J. and Kennedy, C. (2002), *Good practice towards homeless drug users: research evidence from Scotland*, Health and Social Care in the Community, 10, 3, pp.196–205.
249 Homeless Link, *Moving on from homelessness…*
250 Crane et al. (2011), *Moves to independent living: Single homeless people's experiences and outcomes of resettlement*, Sheffield Institute for Studies on Ageing, University of Sheffield
251 Homeless Link (2013), *Effective Action: Resettlement from homelessness services*
252 Hutubise, et al. (2009), Shelters for the Homeless: Learning from Research, in Hulchanski, J. D. et al. (eds) *Finding home: policy options for addressing homelessness in Canada*, Cities Centre Press, pp. 43–60

stages of successful partnership working as relationship building, clarifying expectations, identifying needs, sharing expertise, and evaluating the collaboration.[253]

The benefits of partnership working in homelessness services has been discussed in range of national and international studies, but greater research is needed to understand how this can effectively support move-on. For example, a report exploring how homelessness services in England support people to move on from homelessness concluded that better outcomes can be achieved by working in partnership at a local level with other voluntary agencies, the local authority, and statutory services such as adult and children's social care, and health services.[254] Partnerships can be beneficial to maximise resources, knowledge and skills. They may also provide an opportunity to deliver an integrated service for clients, establish joint responsibility for outcomes, and facilitate access to move-on accommodation.[255] However, a review of the evidence base on the effectiveness of services for people experiencing homelessness in supporting move-on concluded that a lack of evaluative evidence on interprofessional and partnership working was a key gap in understanding how services might better support pathways out of homelessness.[256] Case studies of good practice are, however, available, and an example from a Homeless Link report[257] is summarised below.

Promising practice: Pathways Move-on Scheme (PMOT) – Camden Council
Camden PMOT is a centralised team within Camden Council, which has supported single people experiencing homelessness across the borough to move on since 2007. It receives long-term funding through the commissioning of the Camden Hostels Pathway. PMOT works closely with supported housing providers in the borough to build capacity to assist them with resident move-on. A small team of advisors are co-located in Camden Council offices and within hostels. PMOT works with individuals one-to-one to assist them with move-on and provides support to ensure tenancies are sustainable. The team also has a wider role in supporting move-on, including by providing pre-tenancy training and increasing access to affordable accommodation, through relationships with housing associations and council housing teams.

Principles underlying service delivery include partnership working with supported housing providers and other council teams to deliver services; managing expectations so that residents are prepared for and realistic about their most likely move-on options, and are therefore ready to move on from services rather than disappointed by their options, which could cause delays; and focusing on achieving a sustainable move-on, guided by a thorough assessment with multi-agency input to inform the preferred move-on option for each individual. Finally, floating support is provided for three to six months to support sustainability. Between April 2014 and March 2015, 76 people were placed into private rented sector accommodation with support and 67% had sustained their tenancies.

[253] Snyder M. and Weyer M. (2002), *Facilitating a collaborative partnership with a homeless shelter*, Journal of Nursing Education, 41(12), pp. 547-549
[254] Homeless Link (2018), *Moving on from homelessness*
[255] Fraser et al. (2017) *Building Bridges: A guide to better partnership working between local authorities and housing associations,* The Chartered Institute of Housing
[256] Anderson, I. (2010), *Services for Homeless People in Europe: Supporting Pathways out of Homelessness?,* Homelessness Research in Europe
[257] Homeless Link (2018), *Moving on from homelessness*

Experiences of move-on support in England

A review of how services support people experiencing homelessness to move on found that a move-on plan is often used to organise and review support for independent living.[258] Move-on plans are often flexible, led by the client and with services taking a strengths-based and person-centred approach (the benefits of which are discussed in this section and elsewhere). Lastly, services often maintain support well beyond the point of move-on, for example when a client starts a new tenancy, largely through informal ad hoc support or continued access to services based at the organisation, such as drop-in sessions. This reflects wider points made in this review around benefits of continued care and positive relationships.

Existing research into the effectiveness of shelters has shown that the level of support provided to help individuals access permanent accommodation appears vital to their move-on.[259] However, a Crisis review into what works to end people sleeping rough outlined that move-on from hostels and shelters is a chronically underexplored issue – particularly in the long-term and in assessing who does and does not move on.[260]

Move-on support guidance

Homeless Link guidance[261] suggests that services consider the following areas when developing move-on support:

- What resettlement options are available
- Whether support from external agencies is required
- How to decide whether a client is ready for move-on.

The guidance goes on to suggest preparing for resettlement with a client by:

- Managing expectations
- Discussing aspirations
- Providing social and emotional preparation
- Considering mentoring and befriending schemes that offer informal support
- Providing practical preparation (e.g. budgeting and cooking skills)
- Supporting the client to become familiar with the local area, to reduce isolation.

Barriers to successful move-on

There are systematic barriers preventing people experiencing homelessness from transitioning away from their situation. Regardless of support provided and context, the lack of affordable housing options often blocks a successful move-on for many experiencing homelessness. A Homeless Link report that used data from 2017 in England, showed that 30% of accommodation providers thought a lack of affordable housing was the main barrier preventing people moving on from homelessness services.[262] Accommodation providers reported that 18% of clients were ready to move on but were unable to. Of this total, 40% had been waiting six months or longer. Local Housing Allowance rates have also recently been identified as a barrier to reducing homelessness. These were introduced to help people on low incomes pay their rent, however Crisis research showed that

[258] *Ibid.*
[259] Hutubise, et al. (2009), Shelters for the Homeless…
[260] Crisis, *Ending rough sleeping what works…*
[261] Homeless Link, *Effective Action: Resettlement from homelessness services*
[262] Homeless Link, *Moving on from homelessness…*

underinvestment has meant that people have not been supported to afford the cheapest rents across the UK.[263]

Additionally, St Mungo's research suggested specific shortages of small units providing intensive support for those with serious mental health problems, as well as units for women and people with continuing substance use issues.[264] The Homeless Link move-on report also highlighted the need for greater access to mental health services as they play a vital role in supporting many people to move on from homelessness. Services reported a reduction in the availability of and access to these services, which was a key factor affecting move-on.[265]

There are also individual barriers. Peer research into Camden's hostel pathway conducted in 2015, found a sense of hopelessness amongst residents who sometimes felt that they had become institutionalised in a system that there was no escape from.[266] Therefore, the report recommended that there was a need to address this to raise aspirations and encourage residents to engage in support that could change their situation. This links back to the evidence on resilience, which showed that overwhelming self-doubt can lead to people giving up and feeling unable to progress and succeed.

G. Relationships and recovery

People experiencing homelessness can maintain a range of helpful relationships including with family, friends, professionals and partners. Table 3 below builds on available research to show the benefits of different types of positive relationship that have been identified in the literature.

Table 3: Benefits of different types of positive relationship

Type of positive relationship	Benefits identified through research
Intimate partner	Reduced drug use, improved self-esteem and wellbeing; motivation to move away from a street-based lifestyle.[267]
Family, partners and friends	Valuable financial and emotional support. [268]
Hostel staff	Encouragement, improved social capital and overall wellbeing amongst people experiencing homelessness alongside drug and alcohol misuse.[269]
Supportive relationships	Discourage drug use and enable better management of addictions.[270]

Importance of positive relationships and social networks

The literature highlights the establishment of supportive social networks as a component of effective recovery. As outlined by Terry and Cardwell (2015), social networks provide emotional support,

[263] Basran, J. (2019), *Cover the Cost: How gaps in Local Housing Allowance are impacting homelessness*, Crisis
[264] St Mungo's (2009), *Down and Out? The Final Report of St Mungo's Call 4 Evidence: Mental Health and Street Homelessness*
[265] Homeless Link, *Moving on from homelessness…*
[266] Voiceability (2015), *Peer research into Camden's hostel pathway*
[267] Nyamathi et al. (1999); Stevenson & Neale, (2012)
[268] Hawkins R.L. and Abrams C. (2007), *Disappearing Acts: The social networks of formerly homeless individuals with co-occurring disorders*, Social Science & Medicine, 65, pp.2031-2042
[269] Stevenson, C., *A qualitative exploration of relations and interactions between people who are homeless…*
[270] Alverson et al. (2000); Laudet et al. (2000)

empathy, inspiration, encouragement, opportunities, roles, practical help, a chance to give help as well as receive, and motivation to change.[271] Lemos (2000) highlighted that people experiencing homelessness, like everyone else, want love and friendship and, if the only place they get it is on the streets, then that is where they will return.[272] This is reflected in St Mungo's research into why people returned to rough sleeping after time away from the streets. It found that the impact of social and geographical isolation following move-on resulted in loneliness and worsening mental health.[273] More broadly, there is considerable research demonstrating that good relationships are central to both physical and mental wellbeing. Good quality relationships reduce a range of health risks, whilst being associated with enhanced happiness, quality of life, resilience and cognitive capacity.[274]

Research has also shown the role of relationships in creating positive outcomes for different groups of people experiencing homelessness. For example, Tavecchio and Thomeer (1999) showed the importance of alternative social networks in supporting young people who were homeless after leaving abusive families.[275] Crane and Warnes (2007) found that older people taking on independent tenancies after experiencing homelessness had a better chance of successful resettlement if they were in regular contact with family or housed friends.[276] Furthermore, Bowpitt and Harding (2009) discussed the correlation between a positive relationship with a tenancy support worker and increased self-esteem.[277] The authors found that people who had previously experienced homelessness and substance misuse had started viewing themselves differently because of how staff treated them. For example, clients described how their support workers '*make you feel human and worth something*', because they were non-judgemental and did not treat them differently.

Establishing positive relationships and social networks

As there is a strong association between healthy relationships and recovery,[278] support services can help people who are or were homeless to develop and maintain positive relationships.

A study into supporting the social networks of people experiencing homelessness found that multiple factors had led to the loss of social networks, but that practitioners had the potential to strengthen social networks to achieve positive outcomes for people with experience of multiple exclusion homelessness.[279] This could be through promoting existing social networks, such as partnerships, helping to develop new ones, and supporting people withdraw from less positive relationships. The authors concluded that practitioners should be alert to structural changes that threaten social networks, and may need to enhance their skills to create opportunities to foster existing positive relationships when working with clients and collaborating with other professionals.

Promising practice: Social Behaviour Network Therapy

Another method that has been considered beneficial in the development of positive relationships is Social Behaviour Network Therapy. This is based on the idea that people with serious drinking problems need to develop positive social networks to support change. It has been found to be a

[271] Terry, L. & Cardwell, V., *Understanding the Whole Person…*
[272] Lemos, G. (2000), *Homelessness and Loneliness: the Want of Conviviality*, Crisis
[273] St Mungos, *On my own two feet*
[274] J. H. Fowler & Christakis, (2008); Haslam, & Branscombe, (2009)
[275] Tavecchio, L. and Thomeer, M. (1999), *Attachment, social network and homelessness in young people*, Social Behavior and Personality, 27 (3), pp.247–62.
[276] Crane and Warnes, *The outcomes of rehousing older homeless people…*
[277] Bowpitt and Harding, *Not going it alone…*
[278] Best and Lubman, (2012); Laub and Sampson, (2001)
[279] Joly et al. (2014*), Supporting the social networks of homeless people*, Housing, Care and Support, 17(4)

feasible and consistent treatment approach that can be delivered by a range of therapists in the alcohol field.[280] Research with hostel residents who use drugs and alcohol found that social network focused therapies can potentially assist people experiencing homelessness to build social and recovery capital.[281] However, it emphasised that this would be more likely to be successful if hostel management and staff are supportive of, and actively engage with, therapy delivery. The findings reflect wider research into developmental assets, which has consistently found that factors such as support from family and other adults reduces high-risk behaviours such as substance misuse.[282]

However, Joly et al. (2014) highlighted the need to be careful about blurring professional boundaries, as staff sometimes replace absent social networks. Relationships may become more akin to friendship, rather than remaining professional.[283] This issue may be particularly problematic in the context of move-on when there could be a sense of reliance, but no obligation to provide support. In addition, McGrath and Pistrang (2007) discussed the tensions where staff are required to both provide support and enforce rules,[284] and Tabner (2013) acknowledged the positive and negative associations support staff have within the social networks of people experiencing homelessness.[285] This was reflected in Neale and Stevenson's study, which showed that hostel residents were bitter about the no visitor policy. They felt this reinforced their loneliness and made it hard for them to maintain relationships with people in the community – negative feeling which sometimes extended towards the staff.[286] Hence, factors such as hostel rules and wider social circumstances can limit the social networks available to people experiencing homelessness. Although choice is central to the concept of recovery,[287] Padgett et al.(2008) found people who had experienced homelessness, serious mental ill-health and substance misuse were not always able to exercise choice about who they socialised with and how they went about this.[288]

Finally, the research acknowledges that relationships amongst people experiencing homelessness are not uniformly positive. For example, peers can be a bad influence, and clients may feel let down by staff if the support does not meet their needs. As Neale and Stevenson (2015) explain, access to social capital can be frequently undermined by difficult family backgrounds, relationship breakdowns, bereavements, substance misuse, mental health problems and dishonesty.[289] Such experiences can result in a lack of trust, negative emotions and concerns about abuse of power, which require time to overcome. This was reflected in Revolving Doors research into victimisation in supported accommodation in London, which found the separation between 'rough sleepers' and 'others' resulted in many victims of violent crime suffering in silence, rather than risk losing their identity as well as support networks.[290]

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[280] Copello et al. (2006), *Implementing and evaluating Social Behaviour and Network Therapy in drug treatment practice in the UK: A feasibility study*, Addictive Behaviours 31(5), pp.802-810

[281] Neale J and Stevensen C. (2015), *Social and recovery capital amongst homeless hostel residents who use drugs and alcohol*, International Journal of Drug Policy, 26

[282] Fulkerson et al. (2006); Valois et al. (2009); Schwartz et al. (2013)

[283] Joly et al., *Supporting the social networks of homeless people*

[284] McGrath, L. and Pistrang, N. (2007), *Policeman or friend? Dilemmas in working with homeless young people in the United Kingdom*, Journal of Social Issues, 63 (3), pp. 589-606.

[285] Tabner, K. (2013), *Beyond Homelessness Final Report 2013*, The Rock Trust

[286] Neale and Stevenson, *Social and recovery capital…*

[287] Deegan and Drake, (2006); Farkas et al. (2005)

[288] Padgett et al (2008), *Social Relationships Among Persons Who Have Experienced Serious Mental Illness, Substance Abuse, and Homelessness: Implications for Recovery*, American Journal of Orthopsychiatry, 78(3), pp.333-339

[289] Neale and Stevensen, *Social and recovery capital…*

[290] Borysik, B. (2019), *We are victims too: A peer study into repeat victimisation among people who moved from the streets into supported accommodation in London*, Revolving Doors Agency

Social integration and feeling part of a community

Lastly, research has also discussed the benefits of social integration on positive outcomes for people with multiple and complex needs, including those experiencing homelessness. As Terry and Cardwell outline, it is not enough to have some good friends or supportive relatives; people need to believe in their role in the wider community and society.[291] Similarly, Farrall et al. (2014) explain that success often looks like feeling 'normal', defined as buying into mainstream citizenship values,[292] while White (2010) describes social integration as positive participation and contribution to communal life.[293]

There is overlap with other themes in this review, such as peer support, coping skills and structure and routine. For example, as previously referenced, a study of homelessness services in Bristol showed that encouraging clients to use their time constructively through communal activity had the potential to positively influence relationships.[294] Research conducted by Rethink found that peers with similar experiences provide empathy, a living reminder of the possibility of change, relevant advice, and reassurance that you are 'not alone'.[295] Likewise, Tracy et al. (2010) found that interpersonal networks provide practical help and resources to help people with their recovery, including accommodation, childcare support, tips and coping skills, and information or signposting to a job.[296] Furthermore, as social connections bring roles such as caring, story-telling, activism, supporting and creating, they can also alter how someone views themselves and their abilities. There is a transition from a care recipient to provider, enhancing wellbeing and resilience.[297]

H. Psychologically Informed Environments

Psychologically Informed Environments (PIEs) are about setting the conditions or environments that support delivery. PIEs were originally described as offering a way to recognise good practice that 'reflects the true complexity and emotional nature of the issues to be tackled'.[298] They do this by acknowledging the emotional and psychological needs of clients and consciously using features of their managed environment. When the concept was further developed specifically for homelessness services, the purpose of PIEs was described as enabling clients to make changes in their lives which can be expressed in different ways but will 'usually be changes in behaviours and/or emotions'.[299]

PIEs link with the other areas covered in this section. For example, where homelessness services have embedded a PIE there is often a focus on creating a safe and private environment, to enable people to take risks and progress.[300] Additionally, a PIE service will have a commitment to prioritising relationships between frontline staff and clients, and view these relationships as the most valuable tool for facilitating positive behaviour change.[301] Training is also provided to staff, so that

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291 Terry and Cardwell, *Understanding the whole person…*
292 Farrall et al. (2014), *Careers in Transition: The Social Context of Desistance from Crime*, Oxford University Press
293 Best et al. (2008), *Breaking the habit: a retrospective analysis of desistance factors among formerly problematic heroin users*, Drug and alcohol review,27(6), pp.619-624.
294 Fieldhouse et al., *Evaluation of an Occupational Therapy Intervention Service…*
295 Rethink, (2009) *Getting back into the world: Reflections on lived experiences of recovery*, Rethink recovery series
296 Tracy et al. (2010), Social support: A mixed blessing for women in substance abuse treatment. Journal of social work practice in the addictions, 10(3), pp.257-282.
297 Rethink, (2009); Jacobson and Greenley, (2001)
298 Haigh et al. (2012), *Psychologically informed environments and the "Enabling Environments" initiative*, Housing, Care and Support, 15(1), pp.34-42
299 Keats et al., *Psychologically informed services for homeless people: Good practice guide*
300 *Ibid.*
301 Johnson R. and Haigh R. (2010), *Social psychiatry and social policy for the 21st century: new concepts for new needs: the 'psychologically-informed environment',* Mental Health and Social Inclusion, 14 (4), pp.30–35

they feel able to maintain compassionate and therapeutic-like relationships with clients and meet their emotional and psychological needs.[302]

Research has shown that PIEs achieve significant positive change for people experiencing multiple exclusion/deprivation and with histories of compound trauma. This includes improved housing outcomes, improved behaviours, improved use of services and improved mental health.[303] Data also suggests that PIEs achieve more positive outcomes than services not run in this way, and that staff benefit alongside clients.[304] Furthermore, UK government best practice recommendations for working with people experiencing homelessness suggest creating PIEs, where approaches and interventions '*recognise and work with the levels of emotional trauma that accompany, and in many cases precede, an individual becoming homeless'*.[305]

Reflective practice is a key principle of PIEs. This involves staff considering their own emotional responses to the challenges of relationships through one-to-one supervision and group discussion. It provides staff with protected time to discuss, consider and learn from their personal experiences, thus supporting personal learning and development. It can also be used to plan an approach to supporting individuals and to develop a shared model of working, creating an organisational culture. Research has shown that reflective practice is valued by staff because they benefit from a space to process the emotions created by their work.[306] There is robust evidence that teams who regularly meet to reflect on their practice are more effective than those who do not.[307]

Another core element of PIEs is the focus on the physical environment, with the aim to create a service with a sense of warmth, safety and wellbeing so that clients feel welcome and valued.[308] PIEs recognise that factors such as light, open or closed spaces, and noise levels impact on psychological wellbeing[309] and show that the shared space, and those living within it, are valued.[310] For example, services often remove physical barriers between staff and clients to prevent a sense of 'them and us' and/or involve clients in co-creating spaces that reflect their preferences. However, meeting the psychological and emotional needs of clients is resource intensive. Phipps et al. (2017) concluded that PIEs must be sufficiently resourced to ensure that gains to both resident and staff wellbeing are maintained.[311]

Promising practice: St Basils experience of implementing a PIE

St Basils provides supported accommodation and a range of services to young people who are homeless across the West Midlands. They developed a PIE approach in 2011 and quickly learnt that the quality of relationships matters. They found that to break through any history of adversity and abandonment, and develop genuine trust and rapport, there was a need for consistent and stable contact between staff and young people. This type of relationship had to be nurtured with time and

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[302] Cumming et al. (2017), *St Basils Psychologically Informed Environments – meeting the emotional and psychological needs of young homeless people*, Housing Learning & Improvement Network
[303] Cockersell P. (2016), *PIEs five years on*, Mental health and social inclusion, 20 (4)
[304] *Ibid.*
[305] Johnson and Haigh, *Social Psychiatry and Social Policy…*
[306] Phipps et al., *Psychologically informed environments for homeless people…*
[307] West M. and Markiewicz L. (2004), *Building Team-based Working: A Practical Guide to Organisational Transformation*, Blackwell
[308] Ritchie, C. (2015*), Prevent rough sleeping; create a psychologically informed environment, Therapeutic Communities,* The International Journal of Therapeutic Communities, 36 (1)
[309] Mazuch, R. and Stephen, R. (2008), *Creating healing environments: humanistic architecture and therapeutic design*, Journal of Public Mental Health, 4(4), pp. 48-52.
[310] Keats et al., *Psychologically informed services for homeless people: Good practice guide*
[311] Phipps et al. *Psychologically informed environments for homeless people…*

attention, which had practical implications for both staff workload and the length of time young people stay at St Basils.[312] Using the PIE tools and approaches also took time and required confidence, hence PIE is an ongoing commitment. Reflective practice sessions have been part of continuing development opportunities for staff, but this was sometimes hard to maintain. It was therefore important that staff led the agenda for these sessions so that they were meaningful and relevant. Lastly, St Basils found that a large part of a successful PIE involves managers 'buying-in' to the concept and promoting the benefits to staff.

Promising practice: The Psychology in Hostels Project

The Psychology in Hostels Project operates in the Lambeth homeless hostel network. The service, which provides a PIE for residents and staff, is delivered by psychologists based across three Thames Reach hostels.

Between 2016 and 2018, over 200 residents engaged with the team, and 1,650 therapy sessions were offered, with a 78% attendance rate.[313] 2017 evaluation findings showed that participation had resulted in individuals accessing mental health services, and that there had been a 62% reduction in people sleeping rough.[314] Key reasons underlying success were felt to be understanding resident needs and contact at a pace that suited the individual, using informal outreach activities to develop trust.[315]

This project is also provides a good example of how partnership working between commissioners, an NHS trust and a homeless service can lead to positive outcomes for people with multiple and complex needs.

Summary – provide support that enables and empowers

This final section has covered the fourth building block of the Recovery Approach: providing support that enables and empowers. It has considered evidence on how people can be supported, both practically and psychologically, to move on from homelessness, beyond addressing basic accommodation needs. It has also discussed the outcomes and limitations of different approaches. A key theme has been the principle of choice and control. Delivering a psychologically informed service also enables some of the wider themes to be addressed, and PIEs have been found to lead to positive outcomes for clients both in homeless settings and more widely.

Move-on is about providing a range of tailored support so that people feel able to live safe and secure lives once they enter their accommodation. Partnership working can be beneficial in enabling people to access different types of support to meet their needs; but more evidence is needed to demonstrate how organisations can effectively work together to support individuals to transition away from homelessness. The evidence from the Psychology in Hostels Project, which is delivered in partnership between health, the homeless sector and local authority partners, is promising. More

[312] Cumming et al. (2017), *St Basils Psychologically Informed Environments*
[313] London Housing Foundation (2018), *Press release: South London and Maudsley NHS Foundation Trust win London homelessness award!*
[314] Peddie J. (2017), *Psychology in Hostels*, King's Health Partners
[315] *Ibid.*

research into move-on from hostels and shelters would enable better understanding of success, and how to effectively target support.

Increased resilience and coping skills are important in enabling those experiencing homelessness to move on. However, structural barriers around a lack of affordable housing remain a significant barrier to positive outcomes being achieved.

For positive risk-taking (PRT) to be applied successfully, research has shown that factors including positive relationships, which foster trust and respect, person-centred approaches and focusing on individual experiences of risk (rather than staff perceptions), are key. Clear guidance would help staff to apply PRT consistently and confidently.

There are links with research into PRT and the findings on empowering clients. For example, strengths-based approaches, which involve collaborating with individuals to design support, can improve wellbeing and promote capability. Other interventions covered included Housing First, Personalised Budgets, co-production and employment interventions through social enterprises, of which the last has had mixed results. Personalised Budgets is an emerging intervention that has promising results, but this is costly and resource intensive. Greater understanding of the impact of Personalised Budgets, beyond housing outcomes, would be beneficial to assess effectiveness. Trauma-informed care has also been shown to empower individuals. This approach has been shown to result in various positive outcomes for people experiencing homelessness, but less is known about its effectiveness in homelessness services. Likewise, motivational interviewing has been shown to improve mental and physical health outcomes, but there is less research about this in a homelessness context.

Few studies explicitly covered developing structure and routine among the homeless population. Available research has shown that factors including occupational therapy, meaningful activities and structure within hostel settings provide people experiencing homelessness with routine as well as demonstrating that they can use their time effectively.

Different types of positive professional and personal relationships can have many practical and emotional benefits for people experiencing homelessness. Social networks can provide support, motivation for change, and reduce health risks and the likelihood of someone returning to the street. Feeling part of a community can enhance resilience and bring positive relationships. Relationships, social networks and social integration can change how individuals see themselves, as they are no longer simply a 'care recipient'. Staff can help to facilitate positive relationships, for example through delivering communal activities and providing support; but they should be aware of professional boundaries and potential tensions linked to service rules and processes.

6. Comparing the Recovery Approach with other models

Much of the evidence on what works in the homelessness sector is in relation to specific interventions rather than models of support. For example, the Centre for Homelessness Impact has an intervention tool that shows the strength of evidence, cost effectiveness and impact that different interventions have.[316] We have covered interventions implemented as part of the Recovery Approach in this review, including Street Outreach and Psychologically Informed Environments. Furthermore, where homelessness organisations do have defined models of support these are not available publicly, for example because they are copyrighted.

Nonetheless, we are aware of some more general models that may be of interest. These are discussed below.

Nesta: Good and bad help

Research conducted by Nesta identified seven common characteristics of 'good help'.[317] These are:

- **Power sharing:** recognising and building upon the influence and control that each person brings.
- **Enabling language:** Having conversations that enable people to feel safe and ready to take action for themselves.
- **Tailoring:** Helping people define their own purpose and plans, and responding to their individual needs.
- **Scaffolding:** Offering practical and emotional support that helps people take and sustain action, then stepping back as they build confidence to take action alone
- **Role models and peer support:** Helping people connect with and take action with other people they identify with.
- **Opportunity making:** Expanding opportunities for people to take action.
- **Transparency:** Sharing information between practitioners and the people being supported.

There are some clear similarities with the Recovery Approach and findings in the evidence review. For example, in this review we have discussed the benefits of taking a person-centred approach and tailoring support to individual needs. We have also discussed the value of peer support and positive relationships. The Recovery Approach aims to build resilience amongst clients and empower them to take positive action – described above as 'enabling language' and 'scaffolding'. Furthermore, the third and fourth building blocks of the Recovery Approach aim to provide clients with opportunities to act and progress. Both power-sharing and transparency arose in the discussion about positive-risk management and co-production but were not factors that this review has covered in detail.

There are also links with the characteristics of 'good help' and Bandura's self-efficacy theory: that in order to pursue any goal we must have some confidence that we can achieve that goal.[318] Bandura identified four sources of confidence to help people achieve their goals:

1. **Achieving**: personally experiencing some success related to the goal in question.
2. **Witnessing**: seeing or hearing about others, especially 'people like you', achieving a similar goal.
3. **Encouragement**: being supported by people to believe you can achieve your goal.
4. **Positive association:** experiencing a positive emotional or physiological state when seeking to achieve your goal.

[316] https://www.homelessnessimpact.org/intervention-tool
[317] Wilson et al. (2018), *Good and bad help: How purpose and confidence transform lives*, Nesta
[318] Bandura, A. (1977), *Self-efficacy: Toward a Unifying Theory of Behavioral Change*, Psychological Review, 84(2)

This in particular links back to the second building block which covers peer support and advocacy, and the fourth building block which includes relationships and recovery, methods for empowering clients and building motivation for change.

Health Foundation: Person-centred care

The Health Foundation has identified a framework[319] that comprises four principles of person-centred care, which reflect the different elements of the Recovery Approach:

1. Affording people dignity, compassion and respect.
2. Offering coordinated care, support or treatment.
3. Offering personalised care, support or treatment.
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

These principles are supported by evidence. For example, when people play a more collaborative role in managing their health and care, they are less likely to use emergency hospital services[320] and are more likely to stick to their treatment plans.[321] Furthermore, patients who have the opportunity and support to make decisions about their care and treatment in partnership with health professionals are more satisfied with their care.[322] The framework and related evidence also supports the discussion in this review about the benefits of co-production, tailoring support to individual needs and circumstances and taking a strengths-based approach.

Local approaches to addressing homelessness

Lastly, it has also been possible to identify local approaches to addressing homelessness. These tend to focus on partnership working between organisations. For example, this review has referenced evidence in relation to the MEAM Approach, a framework adopted by local areas in England to tackling multiple disadvantage. The MEAM Approach is more about how local organisations should work together to deliver coordinated interventions, rather than how a specific organisation supports clients. This may be of relevance when St Mungo's think about their approach to partnership working, but does not have obvious links to this review because it is focuses on how to successfully coordinate support rather than how one organisation can effectively support its clients.

Of particular relevance, is Birmingham City Council's Homelessness Prevention Strategy that outlines their whole-system approach: Positive Pathway.[323] The approach was first developed by St Basil's in their work with young people and therefore is an example of an organisation's model being adapted more widely. It sets out five key areas that can be used flexibly to ensure that people will be supported as early and as effectively as possible. The five key areas are: Universal Prevention, Targeted Prevention, Crisis Prevention and Relief, Homeless Recovery and Sustainable Housing. Like the Recovery Approach, the Positive Pathway includes street outreach to identify and support people sleeping rough and therapeutic models such as Psychologically Informed Environments.

[319] https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple_0.pdf
[320] De Silva D. (2011), Helping people help themselves, The Health Foundation
[321] De Silva D. (2012), Helping people share decision making, The Health Foundation
[322] *Ibid.*
[323] Birmingham City Council (2017), *Birmingham Homelessness Prevention Strategy 2017+*

7. Conclusion

St Mungo's Recovery Approach is a wide-ranging framework, encompassing both principles and activities, which guides all aspects of the charity's work with its clients.

This rapid evidence review has aimed to identify effective methods of supporting people experiencing homelessness to re-build their lives and/or recover. In doing so, we have sought to validate and challenge different elements of the Recovery Approach, identify gaps in practice and/or the evidence base, and support St Mungo's to influence the wider sector and policy. This process was also intended to support St Mungo's to better embed the Recovery Approach across their systems and processes. To do this, available evidence, including academic studies, journal articles, resources and toolkits, evaluations and other literature reviews, have been reviewed to identify key pieces of evidence and demonstrate where evidence is limited or unavailable.

A. Summary of the evidence base

This review has shown that there are some elements of the Recovery Approach that are supported by a strong evidence base of research conducted in the homelessness sector.

As with the elements within the Recovery Approach, there is overlap between these different elements, and applying a combination of these principles is likely to prove more effective than viewing them isolation.

Positive relationships are vital to encouraging and maintaining engagement with support, and to individuals' ability to successfully transition away from homelessness. Positive relationships increase empowerment and wellbeing, for example through encouraging healthy behaviours and increasing self-esteem. Furthermore, positive relationships with staff in homelessness services enable clients to disclose sensitive information. Factors that enable positive relationships between staff and clients include informal activities to build rapport, staff being non-judgemental and individuals having the opportunity to share problems and concerns. Similarly, informal, communal activities can help clients develop positive relationships with their peers, and co-production and/or employment and training opportunities can help people to develop new positive relationships.

Psychologically Informed Environments (PIEs) aim to account for individual thoughts and feelings and the fact that past trauma can affect individual behaviour and coping strategies in the present. Services that are delivered as PIEs have resulted in a range of positive housing and health outcomes and have helped to engage individuals considered 'difficult to reach' in services.

Approaches that involve collaborating with people experiencing homelessness to design and deliver support have been found to help staff to better understand individual views and experiences. There are also wider benefits: for example, strengths-based approaches, where staff collaborated with individuals to design support, have been found to improve wellbeing and promote capability. **Co-production in services** can also result in people feeling empowered and develop positive relationships, whilst also improving the quality and relevance of support.

Strengths-based approaches help individuals to identify their abilities and skills, which they can then build on to achieve positive outcomes, such as improved wellbeing. In addition, interventions such as creative arts and learning opportunities have been found to enhance resilience, which in turn helped people to realise their capability. Research has also suggested that when targeting services,

individual strengths should be considered, not just needs. Enabling people to realise that they do have assets and transferable skills can lead to increased confidence.

As the homeless population is not a homogenous group, both in terms of their experiences and needs but also because of their different identities, there is a need for services to be tailored to reflect this diversity. Where **person-centred approaches** are implemented and services work together with individuals to understand their past and current circumstances, support is more appropriate and better received. Person-centred support has been effective in supporting people who were entrenched in rough sleeping into accommodation

Wellbeing is a common theme in the literature. Through the review, it has been possible to identify interventions that can improve the wellbeing of people experiencing homelessness, show the importance of improved wellbeing in creating additional outcomes, and understand the systematic barriers preventing further wellbeing improvements.

Other elements of the Recovery Approach are supported by research which demonstrates their effectiveness, but in different contexts and/or with different population groups.

Research on **trauma-informed care (TIC)** has demonstrated cost-effectiveness and a range of positive individual and service outcomes. Existing research has indicated benefits for people experiencing homelessness, but less is known about the effectiveness of TIC in homelessness services. Secondly, **positive-risk management approaches** are regularly covered in the literature and resources in sectors including mental health, support for people with learning disabilities and/or difficulties, substance misuse and dementia care. Lessons can be learnt from this, especially as people who experience homelessness often have mental health needs and/or experience addiction, but a better understanding of how this can be applied successfully in a homelessness context would be beneficial. Likewise, **motivational interviewing** has proved successful in supporting people with different health needs, but there is less research on its use with people experiencing homelessness.

Advocacy support can help people to access services, and therefore change how services work with individuals and ensure that assistance is provided prior to issues reaching crisis point. Advocacy roles are currently common in services for people with multiple and complex needs (which includes homelessness) in the UK. Unfortunately, there is less research outlining specifically how advocates can support people experiencing homelessness and what works in a homelessness context. Likewise, there is less evidence about **peer support** from the UK homelessness sector, especially in comparison to the mental health field.

Finally, the review identified some gaps in the evidence.

This is not to say that the evidence demonstrates that these approaches are ineffective, but rather that there is a limited number of research studies and/or evaluations, especially in the UK homelessness context, on these subjects. As such, it is more difficult to understand the effectiveness of these interventions and how they would work best with people experiencing homelessness. For example, although peer support is highly valued by clients and professionals, the evidence base on the impact of **intentional peer support schemes** is particularly limited. There are also gaps in practice and evidence in relation to **homelessness prevention activity in health services** and what works in **supporting people to move on from hostels and shelters**. It is accepted that partnership working can help to address the range of multiple and complex needs that people

experiencing homelessness require support with, especially when they would benefit from specialist services. However, less is known about how **interprofessional and partnership working** can effectively support people experiencing homelessness. Furthermore, we identified very little specific research on **enhancing the resilience and problem-solving skills** of people who have experienced homelessness.

Lastly, although certain interventions covered in this review have been able to demonstrate impact on housing outcomes, less is known about **wider impacts, such as health and wellbeing outcomes**. This is particularly the case for different types of **street outreach interventions** as research has focused on the short-term, housing impact. However, it is often challenging to decipher the impact of outreach interventions alone, because these usually form part of a wider programme of support.

Table 4, below, provides a summary of the evidence base across the four building blocks of the Recovery Approach. As this table shows, no single building block is entirely supported or unsupported by evidence. However, the elements covered in the second building block, securing resources and opportunities, are the least well-supported by evidence from the homelessness field. There is also a noticeable gap in the evidence about effective move-on, which is fundamental to service delivery and people experiencing homelessness achieving sustainable outcomes. Nonetheless, gaps in the evidence do not mean that something does 'not work'.

Table 4: Summary of the evidence base across the different elements of the Recovery Approach

STRONG EVIDENCE BASE IN RELATION TO SUPPORT FOR PEOPLE EXPERIENCING HOMELESSNESS	STRONG EVIDENCE BASE – BUT IN WIDER SECTORS RATHER THAN HOMELESSNESS CONTEXT	GAPS IN EVIDENCE
• The importance of positive relationships and how these can be facilitated • Psychologically Informed Environments (when initial model is adhered to) • Links between improved wellbeing and wider outcomes • Understanding of how wellbeing can be improved and barriers preventing this • Strengths-based approaches • Person-centred approaches and tailoring support • Collaboration with service users when designing and delivering support	• Trauma-informed care (mental health, substance misuse, family services) • Positive risk management (mental health, learning disabilities, dementia care) • The benefits and outcomes of advocacy (for people with multiple and complex needs more broadly) • Peer support (mental health services) • Motivational Interviewing (substance misuse, physical and mental health)	• Intentional peer support programmes (particularly in the homelessness context) • How partnership approaches and interagency working can be effectively implemented to support people experiencing homelessness • Effective move on from hostels and shelters, the importance of preparing someone psychologically for move-on and how to support sustainable transitions • How resilience and problem-solving skills can be enhanced for people experiencing homelessness • Limited evidence of non-housing outcomes from street outreach interventions

Key: Build initial relationships and trust; Secure resources and opportunities; Develop client skills; Provide support that enables and empowers

B. Limitations

As discussed in the introduction, this review could not achieve all of its initial aims. We were limited by available resource and available evidence, both of which limited our ability to achieve the first research aim – validating and challenging the Recovery Approach, including through comparison with other models.

To limit the scope of the research to a manageable size, it was agreed that the review would focus on specific elements of the Recovery Approach and the evidence in relation to these. Therefore, the review explored different elements of the Recovery Approach in isolation, and highlighted crossover and relationships between these different elements where relevant. However, it did not cover the evidence in relation to completing all the of the different activities together, or the evidence about how certain types of support should be sequenced. As a result, we cannot look at the model as a whole and make an overall judgement about its success.

Furthermore, we initially intended to compare the Recovery Approach with other models in the homelessness sector, and evidence in relation to these. We aimed to identify similarities and differences in how other organisations are supporting people who have experienced homelessness to lead fulfilling lives, to add to the evidence base. However, we found that such models were copyrighted and therefore not available publicly. To address this, we have highlighted relevant good

practice throughout the review and have referenced general models and local approaches that might be of interest in Chapter 6.

Finally, the nature of the research – secondary research only – meant that we could not address the fourth aim – to support St Mungo's to better embed the Recovery Approach across its systems and processes. We have suggested follow-up research to achieve this aim.

C. Next steps

Based on the findings outlined above, we suggest the following actions for the homelessness research community **to address the gaps in evidence** and improve support for people experiencing homelessness.

1. There is a need for greater research to support some elements of the Recovery Approach, particularly intentional peer support schemes, enhancing resilience and problem-solving skills and psychological preparation for move-on. There would also be benefits of learning more about how positive risk management, advocacy and trauma-informed approaches can be successfully implemented in a homelessness setting.

2. Research undertaken needs to go beyond housing outcomes to explore factors that look at a wider variety of outcomes, particularly impact on client wellbeing and quality of life, in order to gain a better understanding of good quality support and to improve sustainability of approaches.

3. There would be benefits of identifying and/or conducting further research to learn more about how different approaches work for different sub-groups of people experiencing homelessness. These include women, immigrants, LGBTQ+ people, ethnic minorities and younger/older people. This would enable approaches to be increasingly person-centred, and account for differences in experiences and views amongst different disadvantaged groups.

4. Such research should focus on the views and experiences of clients, rather than just staff and stakeholders. In line with the aim of providing person-centred support, it is vital that the perspectives and experiences of clients are considered. Building on what we know about co-production, this could also lead to clients feeling empowered and services being more able to meet individual needs.

5. Revolving Doors advocates a peer research approach. Trained and supported peer researchers offer unique perspectives and insights, improve understanding of the complex issues being explored, and support engagement with research participants.

We also recommend the following actions for St Mungo's to **better validate and embed the Recovery Approach**:

6. If there is a desire to learn more about what works and what could be improved within the Recovery Approach, or how the model can be better embedded across the organisation, there needs to be specific research with St Mungo's clients, staff and partners. This will help St Mungo's to learn more about whether the Recovery Approach is or is not meeting client needs.

7. A Theory of Change approach could be a useful way to conduct that internal research and find out more about how St Mungo's clients' experiences and outcomes relate to the building blocks of the Recovery Approach. The current Recovery Approach Theory of Change outlines how activities are intended to lead to goals and outcomes. There could be benefits to reviewing the Theory of Change to shape future research activity. This review process may also support further adaptation and/or innovation of activities related to the Recovery Approach.

Finally, we recommend the following action for St Mungo's to **positively influence the homelessness sector and its stakeholders**:

8. As we were unable to find detailed information about models used by other organisations working with people experiencing homelessness, sharing lessons from this review with the sector could be a useful way for St Mungo's to take the lead in opening dialogue about support models and good practice. The roundtable that St Mungo's is planning for Autumn 2020 is a good first step.

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Annex 1: Detailed methodology

As mentioned in the Introduction we began this review by agreeing search methods and search terms. We decided to search databases such as Wiley Online, Open Grey and the British Library as well as the Google Scholar search engine. We also put out a call for evidence to our research network on severe and multiple disadvantage, made up of over 90 multidisciplinary researchers, with the aim of identifying relevant grey literature.

We identified a range of terms that cut across the different themes underlying the Recovery Approach (the secondary search terms). We then searched for sources related to these, across the three principle stages of support provided by homelessness service: outreach, engagement and move-on (the primary search terms).

To further refine our search and identify the most relevant sources we added in additional search terms. On Google Scholar, 'homeless' and 'homelessness' led to different results, hence the use of both terms alternately. We also added 'complex needs' and 'England' to find sources most suitable to St Mungo's and their client group. Finally, we included 'BAME' to see if we could identify literature about addressing a specific sub-groups' support needs. However, to limit the scope of the study and concentrate our resources, it was agreed with St Mungo's that we would not explicitly review the evidence across a range of sub-groups. Furthermore, the Recovery Approach is designed to work across all St Mungo's services and with all their clients, rather than a specific group of people.

Table A1: Rapid evidence review search terms

Primary search terms	Secondary search terms	Additional terms for refinement
• Outreach • Engagement • Move-on	• Choice and control • Empowerment • Personalisation • Peer support • Positive risk • Recovery • Relationships • Strengths and assets • Service-user involvement • Service-user voice	• Homeless • Homelessness • England • Complex needs • BAME

To limit the scope to a manageable quantity of the most relevant evidence, we concentrated on English-language sources from the last 20 years (from 1999 as we began the review process in 2019). We also reviewed international English-language literature to uncover innovative models from outside the UK. We uncovered several relevant studies from countries including Canada, the US and Australia.

Table A2 shows the initial results from inputting the terms above on Google Scholar, while Table A3 shows the initial results from using these search strings on Wiley Online Library.

Table A2: Scoping stage - Google Scholar search results

Primary term	Secondary term (s)	General Results	Homeless / homelessness included	England included	Complex needs included	BAME included
Outreach	Peer support	17,700	7,660 / 6,040	2670/ 2180	537/ 508	43/35
Outreach	Positive risk	834	124/ 103	74/ 63	34/ 29	0
Outreach	Choice and control	2854	688/563	372/301	153/ 131	5/8
Outreach	Strengths and assets	1580	403/325	119/86	21/ 19	2/2
Outreach	Personalisation	3060	428/ 373	359/319	174/ 167	10/14
Outreach	Service-user involvement	1450	451/363	350/279	148/ 126	13/ 9
Outreach	Service-user voice	78	25/26	18/19	10 / 13	0
Outreach	Recovery	77,300	17,400/ 16,500	10,600/ 6,490	1130/ 1030	82/59
Outreach	Trauma-informed	6,070	2,610/2,410	640/601	168/ 170	13/9
Outreach	Empowerment	98,500	16,300/15,000	8740/ 5,480	774/ 680	73/ 66
Outreach	Relationships	327,000	27,000/ 18,800	17,400/ 12,900	1910/ 1700	161/ 117
Engagement	Peer support	50,000	11,300/ 8650	4,480/ 3,330	707/ 668	78/63
Engagement	Positive risk	3,170	226/ 178	110/ 115	45/ 46	1/0
Engagement	Choice and control	13,900	1,470/ 1,180	809/ 654	227 / 213	13/16
Engagement	Strengths and assets	3,800	663/ 557	201/ 153	27/ 29	5/2
Engagement	Personalisation	17,200	1,320/ 987	909/ 721	291/ 267	25/ 25
Engagement	Service-user involvement	5,360	824/ 693	625/ 478	200/ 180	24/16
Engagement	Service-user voice	378	75/ 51	56/36	18/ 15	0
Engagement	Recovery	742,000	25,300/ 18,100	17,100/ 13,600	1590/ 1510	172/ 122
Engagement	Trauma-informed	12,700	3,990/ 3,920	1,030, 984	232/ 245	29/ 27
Engagement	Empowerment	544,000	29,400/ 16,900	16,600/ 12,900	1070/ 1100	168/ 120
Engagement	Relationships	1,960,000	61,100/ 35,300	26,400/ 18,300	2,860/ 2,680	383/ 260
Move-on	Peer support	14,200	1,970/ 1,650	841/ 689	226/ 194	21/16
Move-on	Positive risk	668	62/38	39/ 27	18/ 14	1/0
Move-on	Choice and control	2,040	414/ 315	247/ 202	97 / 88	6/6
Move-on	Strengths and assets	551	127/ 103	42/ 36	9/ 9	0
Move-on	Personalisation	3,600	351/289	288/230	108/ 102	10/9
Move-on	Service-user involvement	846	232/ 167	176/127	75/ 59	9/3
Move-on	Service-user voice	61	21/16	18/ 14	8/ 9	0
Move-on	Recovery	80,800	15,700/ 7,440	7,410/ 3,400	482/ 433	42/ 24
Move-on	Trauma-informed	1,790	625/ 556	209/ 183	61/ 52	7/7
Move-on	Empowerment	13,400	11,400/ 6,180	4,810/ 2,700	356/ 310	35/ 15
Move-on	Relationships	269,000	17,900/ 16,300	14,700/ 7,230	897/ 802	91/ 53

Table A3: Scoping stage – Wiley Online Library search results

Primary term	Secondary term (s)	General Results	Homeless / homelessness included	England included	Complex needs included	BAME included
Outreach	Peer support	1,597	341	187	51	6
Outreach	Positive risk	75	20	19	2	0
Outreach	Choice and control	92	39	30	17	0
Outreach	Strengths and assets	29	8	4	0	0
Outreach	Personalisation	362	62	42	19	2
Outreach	Service-user involvement	103	21	17	4	1
Outreach	Service-user voice	4	1	0	0	0
Outreach	Recovery	9,897	1,656	977	86	8
Outreach	Trauma-informed	5,344	1,052	590	15	1
Outreach	Empowerment	8,391	1,235	686	79	7
Outreach	Relationships	30,192	3,295	1,696	125	10
Engagement	Peer support	6,960	691	356	77	7
Engagement	Positive risk	473	29	23	2	0
Engagement	Choice and control	977	75	47	21	0
Engagement	Strengths and assets	181	22	11	1	0
Engagement	Personalisation	4,882	189	113	29	2
Engagement	Service-user involvement	588	52	38	5	1
Engagement	Service-user voice	49	6	4	1	0
Engagement	Recovery	114,086	4,851	2,469	135	13
Engagement	Trauma-informed	49,113	3,786	1,986	21	10
Engagement	Empowerment	76,068	4,292	2,268	126	11
Engagement	Relationships	466,145	14,073	6,373	240	18
Move-on	Peer support	358	39	25	4	3
Move-on	Positive risk	40	2	2	0	0
Move-on	Choice and control	69	6	4	1	0
Move-on	Strengths and assets	9	2	0	0	0
Move-on	Personalisation	1	44	36	17	0
Move-on	Service-user involvement	33	9	8	1	0
Move-on	Service-user voice	2	0	0	0	0
Move-on	Recovery	49	2,087	631	74	5
Move-on	Trauma-informed	10,971	771	305	66	5
Move-on	Empowerment	5	1,365	409	47	6
Move-on	Relationships	170	4,829	1,222	94	6

As outlined in the Introduction the search was documented systematically, to demonstrate sources identified. We created a log to provide a summary of key details that would beneficial when reviewing sources in more detail and writing the report. The information recorded included:

- Year of publication
- Type of study (e.g. systematic review, randomised control trial)
- Summary
- Key messages
- Target group
- Primary area of focus (linking back to the different elements of the Recovery Approach)
- Other areas of focus (x 3)
- RAG - relevance
- RAG - quality

We also recorded whether the source was based on evidence from the UK or abroad.

Tables A4 and A5 demonstrate the RAG rating system that was created to consider the quality and relevance of each source and to facilitate the consultation process. This therefore helped us decide,

in consultation with St Mungo's, what evidence was most suitable for inclusion in the review. The rating for each source was then also included in the log. This process helped us to identify suitable sources to review when it came to collating findings and drafting the report. It also enabled us to identify gaps in evidence and/or types of research.

Table A4: RAG rating used to decide source relevance

	Relevance		
Population	Homeless people/ rough sleepers	Other complex needs that are likely present amongst St Mungos service users e.g. Mental health, LDD, care leavers, substance misuse	Population that do not have complex needs, or with limited overlap to homeless population, and of less relevance to project focus.
Topic	Clear link to Recovery Approach and themes underlying this	Some link to Recovery Approach and themes underlying this. (E.g. discussion about role of support worker - with qualities linked to recovery approach ideas around advocacy and managing risks).	No link to Recovery Approach and themes underlying this.
Year of publication	Published in last 10 years.	Published more than 10 years ago.	Published more than 20 years ago

Table A5: RAG rating used to decide source quality

	Quality		
No. of citations	Source is regularly cited by authors publiishing work on similar topics. (Exception if published very recently)	Source is occasionally cited by authors publishing work on similar topics (less than 10 citations).	Source has not been cited, despite being published for a long time.
Methodology	Source has a clear research questions, methodology and rationale for picking this. Large number, of good quality references to other relevant evidence included. Bonus if RCT/ Systematic Review/ Large-Scale longitudinal research project/ mixed method approach.	Small scale study that covers short time period. Limited reference to wider literature/ evidence.	Unclear how findings were obtained. Limited amount of research completed. Lacking references to wider evidence.
Source	Identified via: academic / scholarly database, search of relevant charities published research, Government Social Research, call for evidence amongst research network, St Mungos list of sources.	Identified via bibliography of previously identified good quality source	Generic online search engine.
Publication type	Published in an academic journal/ by an established charity / in conference papers / in a book on a relevant topic/ on Gov.uk website. Source is academically peer reviewed.	Newspaper / magazine article. Published by think tank with particular objective - risks neutrality.	Online Encyclopedia

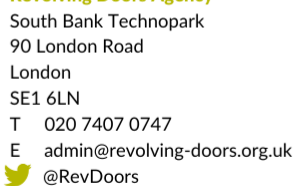
Across the initial 70 sources that were initially reviewed:

- 28 were deemed 'Amber' relevance and 42 were considered 'Green' relevance.
- 11 sources were considered 'Amber' quality and the remaining 59 were considered 'Green'.
- 58 sources were published in the last ten years.
- 49 sources focused on people experiencing homelessness.

Sources that were irrelevant and poor quality were sifted out prior to this stage. Additional sources were then identified during the writing stage, following input from St Mungo's and Revolving Doors staff, and when specific gaps in evidence were explored further.

Testing and confirming findings

Once the report was drafted, key learning was presented to Revolving Doors staff and then St Mungo's staff to share findings and consider next steps. This process helped to ensure that key sources and promising practice had not been excluded whilst providing an opportunity to discuss the implications of the findings.



Revolving Doors Agency
South Bank Technopark
90 London Road
London
SE1 6LN
T 020 7407 0747
E admin@revolving-doors.org.uk
@RevDoors