# UNDERSTANDING PATHWAYS IN AND OUT OF HOMELESSNESS

CHH | Collaborative for Health and Home

*A literature review focussing on understanding the risk and protective factors around entry into and continuing homelessness and the interventions to end episodic and chronic homelessness. A special focus is made to explore these aspects of homelessness for women and children.*

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## Executive Summary

Women and children experience many risk and protective factors affecting their entry into and experiences in homelessness. As such, they may require unique interventions to promote sustainable exits from homelessness and to address negative outcomes associated with homelessness. In pursuit of their mission to affect multi-sectoral change and system transformation to achieve better health and housing outcomes for homeless individuals in Calgary, the Collaborative for Health and Home has conducted a literature review to investigate the lifetime risk and protective factors affecting women and children experiencing homelessness as well as interventions that can promote exits from homelessness.

Women and children are a unique population among those experiencing homelessness. Overall, women make up a smaller proportion of the overall homeless population as compared to men but are more likely to have children with them as men (i.e., experiencing family homelessness). Evidence indicates that homelessness has multiple adverse effects on women, including higher rates of mental health issues such as depression and post-traumatic stress disorder, substance use, and higher risk of domestic violence. These issues may, in turn, affect the children in their care. Children experiencing homelessness, although powerless to prevent their own homelessness, are still impacted by their experiences in residential instability and homelessness; these experiences may put them at higher risk for adverse outcomes, including poor mental health, socio-emotional problems, behavioral issues, cognitive delays, academic underachievement, and poorer physical health.

Our review of the literature identified several risk factors affecting women and children's trajectories into homelessness. These risk factors may occur during an individual's childhood or adolescence or may be more proximal to the homelessness experience. These risk factors are also interconnected with the experience of homelessness, such that many of the risk factors for homelessness are also caused by homelessness, leading to increasing complexity with increasing time in homelessness. For example, mental health issues may lead to homelessness and experiencing homelessness may increase risk of mental health issues.

Individual-level risk factors for homelessness include mental health issues, substance use, and physical health issues or disabilities (e.g., traumatic brain injuries). Interpersonal level risk factors for homelessness, which involve interaction between two or more people and may not be completely within the control of the individual, include domestic violence, childhood adversity (e.g., experiences of childhood abuse, parental separation or divorce, mental health or substance use in the household, or incarceration of a family member), trauma, and childhood maltreatment and child welfare involvement. Family homelessness has also been linked to being in a single parent home and a lack of social support. Finally, structural risk factors are those linked to issues that are beyond an individual's control and reflect policies, procedures, or legislation of a system that may impact an individual. These may include a lack of employment options or economic growth, a lack of affordable or subsidized housing, a lack of access to economic resources and/or subsidies, low rates of rental vacancies, and increases

in market rent. Overall, these risk factors are not unique to women and children; however, they may affect women and children differently than other populations.

Furthermore, these risk factors may interact with each other and act as either a precipitating factor or a trigger for homelessness. Many women and children experience these risk factors without entering homelessness, but once they experience a triggering event, they will enter into homelessness. For example, any women who enter homelessness with their families are fleeing domestic violence; domestic violence is the underlying factor that causes a woman and her children to leave stable housing, but financial insecurities are the triggering factor that causes them to enter into homelessness. This economic insecurity may be due to women earning less than her partner, not having financial independence, or being unable to earn enough (e.g., because of lack of education, literacy, childcare, etc.).

The literature review also identified protective factors against homelessness. These factors can prevent entry into homelessness or support sustainable exits from homelessness. Individual-level protective factors include healthy coping mechanisms, resilience, optimism, and high self-esteem. Interpersonal-level protective factors include strong social support and low levels of isolation, living with a partner (i.e., not being a single parent), and living in a stable neighborhood. Finally, structural level protective factors that promote housing stability include access to subsidized housing, higher income levels, and employment and employment-related supports (including job training or job readiness).

Interventions to address risk factors for homelessness and promote protective factors against homelessness are broad. Many focus specifically on providing housing (with or without supports) based on several different models, based on the individual or family's needs (e.g., Housing First, Permanent Supportive Housing, Assertive Community Outreach). More broadly, interventions to prevent homelessness can focus on providing access to affordable housing or preventing evictions. Other interventions focus on preventing or addressing specific risk factors for homelessness, including substance use interventions (e.g., rehab programs, managed alcohol programs), mental health supports (e.g., counselling, Critical Time Interventions), and addressing underlying poverty through improved employment or income assistance. Other interventions focus on promoting overall wellbeing for the individual or family, including addressing trauma, promoting mindfulness, social support, and education and supports for healthy parenting.

Based on the evidence from the literature review, the CHH recommends the following actions:

1) When designing interventions to prevent or address homelessness for women and children, there is a need to consider the complexities of their unique needs and experiences.
2) Beyond addressing the risk factors for homelessness, there is a need to promote strength-based approaches to prevention and intervention. In this way, we can empower women, create healthier families, and prevent homelessness.
3) Structural interventions are necessary as many of the risk and protective factors for homelessness are beyond the control of individuals.

4) Housing that meets the unique needs of women and children need to be prioritized, in terms of affordability, availability, and access.
5) Housing is only a part of the solution for addressing homelessness. Additional supports are needed to address underlying risk factors and to promote protective factors for women and children.
6) Further research is required to better understand the unique pathways in and out of homelessness and to promote sustainable exits from homelessness for sub-populations of women and children

## Introduction

As an offspring of the Calgary Recovery Services Task Force, the Collaborative for Health and Home (CHH) aims to affect multi-sectoral change and system transformation to achieve better health and housing outcomes for homeless individuals in Calgary, especially for those facing chronic homelessness. The CHH has several working groups to focus on addressing homelessness and health for specific populations, including the Women & Child Working Group which responds directly to one of the recommendations of the Task Force, to develop specialized responses for homeless women and children.

One of CHH's guiding principles in achieving their goals of improving health and housing outcomes for those experiencing homelessness is to adopt an upstream focus on prevention and early intervention. In order to better inform this work, this literature review was conducted to better understand the factors that put individuals at risk for becoming chronically homeless and protective factors that keep at-risk individuals from becoming chronically homeless. This research is focused on identifying factors that prevent or protect individuals from becoming 'trapped' in homelessness. While there is significant research that speaks broadly to the risk and protective factors for homelessness, we aimed to investigate risk and resiliency in relation to experiences of long-term, chronic homelessness.

Thus, this literature review discusses risks and protective factors for entry into and continuing homelessness as well as interventions for ending homelessness. With better knowledge of factors that lead to or protect individuals from chronic homelessness, informed by an overview of best practice models, the collaborative can work to inform, create and strengthen policies and early intervention programs that help reduce chronic homelessness in Calgary, AB.
Using the results of the literature review, a model of the pathways in and out of homelessness has been developed which identifies high-risk periods for homelessness and chronic homelessness such that interventions can be targeted to impact on risk factors and promote protective factors.

## Methods

We conducted a systematic search to inform this narrative literature review, with the aim of providing the best level of evidence to inform practices and decision-making for the Collaborative for Health & Home in Calgary, AB.

The goal of this literature review was threefold:

- To understand the risks throughout the lifespan for homelessness and the critical period(s) for these risks.
- To understand the protective, early intervention, and resiliency factors that prevent or reduce risks of homelessness or chronic homelessness
- To identify interventions for reducing risk/promoting resilience around chronic homelessness throughout the lifespan

Given the complex nature of the relationship between risk and protective factors for homelessness, we included search terms for some of the known risk and protective factors for homelessness such that we could identify early intervention activities that might help to address these issues throughout the lifespan. For example, knowing that childhood adversity is a risk factor for homelessness, we looked for interventions that might help to prevent or address the harms of childhood adversity, without fully addressing homelessness. However, given that exploring each of these risk or protective factors is beyond the scope of a single literature review, we have chosen to focus specifically on these factors in terms of their relationship with homelessness and homelessness prevention. More specifically, we were interested in gathering information on the risk and protective factors for chronic homelessness throughout the lifespan.

Thus, we conducted three systematic searches of the academic literature using Medline, PsycInfo, SocINDEX, and CINAHL:

1) Risk factors for homelessness and chronic homelessness
2) Protective factors for homelessness and chronic homelessness
3) Interventions to address homelessness and chronic homelessness

Search terms for each search are available in Table 1. Each search was combined with the "homelessness" search terms using the Boolean operator "AND".

Table 1: Search Terms

| | |
|---|---|
| Homelessness | Homeless* OR housing OR chronic homeless* or unstably housed/unstable housing OR rough sleeping OR couch surfing |
| Search 1: Risks | Risk OR cause OR risk factor |
| Search 2: Prevention | Prevention OR resilienc* OR early intervention OR diversion OR protective |
| Search 3: Interventions | Intervention OR best practice OR model OR program |

As this was not a fully systematic review, the inclusion and exclusion criteria were meant to guide the search and to decide which articles were most relevant for the Calgary context and the goals of this literature review. Inclusion criteria was broad, meant to include: any age and sex of the individuals (including families); individuals and/or families who are at-risk of homelessness, those who are experiencing homelessness, or those who have experienced homelessness; articles in English; and studies focusing on urban homelessness. Exclusion criteria included: studies examining specific disease risk within populations experiencing homelessness; studies focusing specifically on mental health or substance use treatment; research published before 2000; research on low- or middle-income countries; and cost-effectiveness or case studies.

Approximately 35,000 titles and abstracts were screened for relevance to the current literature review. Relevant articles were retrieved for full-text review. Articles were then themed to establish the main areas for discussion in the categories of risk factors, protective factors, and interventions addressing homelessness. Articles were then selected within each theme that provided unique and relevant information for the Calgary context.

# Findings

Individuals experiencing homelessness are not a homogenous group. Individuals will vary on their risk and protective factors, their reasons for entering homelessness, their timing of entry into homelessness, and their length of time in homelessness. All of these factors may affect their experiences of homelessness and their response to interventions to regain housing stability. Furthermore, specific groups may vary based on their needs for support during their time experiencing homelessness. Where possible, the populations (e.g., families, youth, adults, individuals experiencing chronic homelessness) are identified who experience specific risk and protective factors and the interventions that address these factors.

Individuals experiencing homelessness often have multiple complexities leading to their unique risk profiles (e.g., multiple risk exposures or limited supportive resources). This may be part of the reason for their entry into homelessness but also may be affected by their time in homelessness (i.e., their complexities increase with their length of time in homelessness). With increasing complexity often comes increased vulnerability and difficulty in engagement, leading to difficulty in implementing interventions that may help to end the individual's homelessness. For example, mental health issues may increase an individual's risk for homelessness and homelessness may lead to mental health issues for some individuals. As well, many of the risk and protective factors will influence each other. For example, increased social support (a protective factor) may reduce mental health issues; conversely, negative peer influences may affect substance use.

## Homelessness Typology

Homelessness can be defined in many different ways. Thus, it is important to define what is meant by homelessness within this literature review. However, there may be variance in the way that different research evidence has defined homelessness. Where possible, this is discussed in the appropriate sections of the literature review. In the current review, we will use the definitions identified by the Homelessness Partnering Strategy[1].

- **Chronic Homelessness**: individuals who are currently homeless and have been homeless for 6 months or more in the past year.
- **Episodic homelessness**: individuals who are currently homeless and have experienced three or more episodes of homelessness in the past year, where episodes are defined as periods when a person is in shelter or a place not fit for human habitation.

## Heterogenous Groups within Homelessness

As identified above, individuals experiencing homelessness are not homogenous. The following section outlines some of the primary groups who experience homelessness and some of the unique factors that define these populations, including unique risk and protective factors. Throughout the rest of the document, evidence that is specific to these groups is identified, where possible.

## Youth and LGBTQ2S Youth

Because adolescence is an important period for social, emotional, physiological, cognitive, and psychological development, the stresses of homelessness can affect youth differently than adults[2]. Homelessness can alter development of children and youth and lead to more extreme responses to the stresses and trauma of living in shelter or on the streets[3]. Youth experiencing homelessness have increased risk of experiencing violence, victimization, self-harm, sexual risk behaviors, and decreased mental health functioning[4-6]. These experiences during homelessness can exacerbate the effects of previous trauma and lead to further complexities[7]. Youth may lack social and financial resources and might try to cope independently, therefore isolating themselves. They also may lack knowledge of supports or have had previous negative experiences with service providers that may affect their desire to engage with formal or informal supports.

In addition to the issues experienced by youth experiencing homelessness, homeless youth who identify as LGBTQ2S may experience additional and unique issues. Gattis and colleagues[8] found that homeless sexual minority youths and homeless heterosexual youths had statistical significant differences in terms of family, peer behaviors, experiences of stigma and discrimination, mental health and substance use, and sexual risk behaviors. Compared to heterosexual youth, LGBTQ2S (Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirited) youth are more likely to experience homelessness and are over-represented among homeless populations. Kidd and colleagues[9] found that these youth may experience a high prevalence of mental health concerns, including suicide attempts, psychological distress, and mental health diagnoses. LGBTQ2S youth who experience mental health issues may also have an earlier age at their first episode of homelessness. In a 2016 ethnographic study of LGBT youth in New York, Castellanos and colleagues[10] found three distinct pathways for this population, which included: homelessness after placement into state systems (e.g., the child welfare system); homelessness due to extreme family conflict over the youth's sexual orientation; and homelessness as a result of family disintegration due to pre-existing conflict that was exacerbated through the disclosure over the youth's LGBT status as well as normative adolescent development.

## Women

In their 2016 analysis on pathways into homelessness, Aubry and colleagues[11] noted the relationship between gender and homelessness – both becoming homeless and time to leave homelessness. In general, women make up a smaller proportion of the homeless population than men[12] and experience shorter episodes of homelessness. However, women may exit to less stable housing[13,14]. Women also have specific risk factors for homelessness, depending on the presence of children. Children may be a protective factor, given that having dependent children reduces the odds of experiencing homeless[12]. However, for women who are experiencing homelessness with their children, there may be unique barriers to reaching stable housing (e.g., finding affordable childcare during employment). Experiences of women and families experiencing homelessness are discussed in more detail below.

### Children Experiencing Homelessness

Children experiencing homelessness, although generally powerless to prevent their homelessness and may not fully understand the factors affecting their homelessness, are still impacted by their experiences in residential instability and in homelessness. Children experiencing homelessness are typically exposed to multiple stressors (e.g., interpersonal and community violence, exposure to higher rates of maternal depression and other psychiatric disorders, parental substance use, and fewer educational/social resources)[15].

Most of the research examining the effects of homelessness on children have reported on the increased risk of adverse effects, including poor mental health, socio-emotional problems, behavioral issues, and cognitive delays[16-18]. Compared to housed children, children experiencing homelessness have significantly higher rates of certain mental health and behavior problems, academic underachievement, and psychosocial stressors, including violence or a major loss [19-22]. Several research studies have indicated that mental health problems in pre-school and school-aged children who experience homelessness are 2 to 4 times higher than in other children, with up to 40% of children having mental health issues that required clinical evaluation[23]. However, one study that focused on children under three years of age found no significant differences in developmental status between homeless and low-income housed children[18]. Other studies have focused on the adverse physical effects in children experiencing homelessness, including increased rates of hospitalizations, decreased likelihood of being up-to-date on immunizations, and higher rates of asthma[24-29].

### Pregnancy, Motherhood, and Family in the Context of Homelessness

Evidence indicates that women experiencing homelessness have significant adverse impacts, including physical and mental health outcomes such as: higher rates of depression, other mental health issues, domestic violence, post-traumatic stress disorder, and substance use[30-33]. Mothers experiencing homelessness may be struggling with past traumas, broken-down family relationships, and fractured social support systems[25,34-37]. Maternal mental health may also influence child behavioral issues. In a 2018 study of 119 homeless mothers and their children, Wu and colleagues[38] found that maternal depressive systems were positively associated with child behavior problems through increased parenting stress.

Research regarding homelessness and pregnancy has often focused on the adverse health outcomes related to pregnancy for homeless women and their infants. Little has been published regarding the additional hardships that pregnant women may face when trying to navigate single vs. family homeless-serving systems or how women may experience homelessness while pregnant, with or without other children in their care.

Early studies of family homelessness identified several triggering events or precursors of family homelessness. These include both individual-level and community-level factors[25]. Individual-level factors include: being a female-headed households, unwed child-rearing, economic hardships of single mothers, domestic violence, drug use, mental illness, and social support. Community-level factors include a lack of affordable housing, welfare reform, limited availability of public or subsidized housing[39,40]. Other factors have been identified, such as:

domestic violence, access to economic resources and subsidies, family structure and size, and educational attainment. In a multinomial statistical analysis of multiple individual-level and community-level factors, Fertig and Reingold[41] found that the likelihood of family homelessness increases with the age of the mother, domestic violence experiences, and health issues. This risk decreases with immigrant status, living with the father, having strong social support, and neighborhood stability. At the community-level, homelessness risk was increased with an increase in fair market rent, scarcity of affordable housing units, and the rate of rental vacancies. As well, public housing and rental subsidies have been found to be protective against homelessness[32,42]. Similarly, a 2018 study of the pathways into homelessness for families, Sylvestre and colleagues found several key factors that led families into homelessness, including instability (e.g., partner status, housing instability), financial difficulties, limited social networks, and migration (including immigration[43].

Another factor that may affect family homelessness is a failure to sustain doubled up housing with friends or extended family[44], meaning that families would often try to avoid homelessness by staying with friends or family after the loss of their own housing. The breakdown of these living situations would lead families into homelessness. Female heads of families experiencing homelessness may have weaker social networks or levels of social support, as well as higher experiences of substance use and mental health issues, which may affect their ability to find places to stay other than shelter. For many women and families who experience homelessness, the time period before homelessness is generally characterized by residential instability, which can subsequently affect mental health issues[45].

Many women who enter homelessness with their families are fleeing domestic violence; domestic violence is the underlying factor that causes a woman and her children to leave stable housing, but financial insecurities are the triggering factor that causes them to enter into homelessness. This economic insecurity may be due to women earning less than her partner, not having financial independence, or being unable to earn enough (e.g., because of lack of education, literacy, childcare, etc.)[43,44].

## Risks for Entry into or Continuation of Homelessness

Many factors have been identified that increase an individual's risk for entering homelessness. As with protective factors from homelessness, these risk factors may be at the individual, interpersonal, community, or systemic levels. All of these risk factors interact to establish an individual's or family's context for homelessness[46,47], Specific groups may have similar profiles of risk and protective factors.

Homelessness is, in itself, a risk factor for continuing or chronic homelessness. Homelessness itself has been associated with increasing substance use or the developmental health issues, necessitating a nuanced understanding of the cyclical nature of these risk factors and the increasing complexity over time with continued homelessness. Over time, risk factors may grow and individuals may have cumulative risks built over a lifetime. In general, increasing time in

homelessness leads to an increase in the risk factors for homelessness and a decrease in protective factors.

### Individual-level Risk Factors

Much of the research on risk factors for homelessness focus on those pertaining to the individual. Some of these are modifiable, such as substance use or mental health issues; others are non-modifiable, such as age, gender, or ethnicity. For the purposes of this literature review, there will be a focus on modifiable risk factors as those are the ones which can be addressed through service delivery and interventions.

#### *Mental Health*

Mental health conditions are common in those experiencing homelessness. It is likely that homelessness both precipitates and causes mental health issues; however, research in this area has produced mixed results. Most studies examining this relationship have found that mental health issues are associated with longer periods of homelessness or a greater likelihood of returning to homelessness. Other studies of those experiencing homelessness have found no differences in the rates of mental health issues in those who remained homeless and those who attained housing[48,49].

Mental health conditions may be the reason for individuals becoming homelessness. For example, a 2018 study by Barile and colleagues[50] found that 30% of the participants in their study on adults who experienced homelessness reported that substance abuse or mental health issues were the cause of their homelessness. Another longitudinal study from the UK found that persistent housing problems led to an increase in mental health issues[51].

Many studies have found that youth experiencing homelessness are more likely to have diagnosed mental health conditions[52,53]. For example, Merscham and colleagues[54] reported that 66% of homeless youth have experienced suicidal ideation. Another study found that 40% of homeless youth had been diagnosed with bipolar disorder or major depressive disorder[55].

Women experiencing homelessness have also been found to have higher rates of mental health issues that women who are housed. Evidence from the At Home/Chez Soi project (n=713) found that parenting women who had been homeless for 2 or more years had 2.05 times the odds of depression than women who were not parenting and had been homeless for more than 2 years[56]. As well, maternal postpartum depression has been associated with a higher risk of homelessness, even for mothers who had no history of mental illness, depressive systems, or housing instability[57].

#### *Substance Use*

Similar to mental health, substance use issues are both a precipitating cause of homelessness for many individuals as well as an outcome of homelessness, which may in turn lead to chronic homelessness. Substance use issues have been consistently identified as a risk factor for entering homelessness for many sub-populations including youth, women, and adults[58,59] and

are the most common mental health issue among persons experiencing homelessness[60]. Estimates of substance use in homeless populations are high (e.g., a study by Spinelli and colleagues, reporting 64.6% for illicit drugs and 25.8% for alcohol[59]). Furthermore, substance use contributes to longer stays in homelessness, chronic homelessness and lower levels of housing stability after an exit from homelessness[14,61-64]. Substance use has also been associated with first-time homelessness. Thompson and colleagues found that alcohol use disorders and drug-use disorders increased prospective risk for first-time homelessness[65].

Compared to housed individuals, individuals experiencing homelessness are more likely to use substances[11,66-68]. A variety of substance use has been reported in the homeless population, as in the general population; however, the homeless population tends to use at higher rates than the general population. Alcohol use and marijuana use may have different risk factors and outcomes in the context of homelessness compared to illicit drug use (e.g., fentanyl, heroin, cocaine). For example, Booth and colleagues[69] found that homeless populations with alcohol dependence were distinct from those with drug dependence or both alcohol and drug dependence.

Parenting status can also affect substance use during homelessness. An analysis of the At Home/Chez Soi cohort found that parenting women had 2.6 times greater odds of substance dependence compared to other women; however, there was no relationship found between parenting status and alcohol dependence[56].

Substance use in those experiencing homelessness can be influenced by other factors, including social support[70]. A 2010 study of homeless youth by Gomez and colleagues[71] found that those individuals who had street friends who abstained from alcohol use also drank less frequently; similarly, those who had friends who abused or were dependent on drugs were more likely to be substance dependent. These results indicated that substance use is especially susceptible to peer influences and that peers have marked influence on homeless youth. As well, for many individuals, substance use is related to experiences of childhood and adult experiences of trauma, family dysfunction, and family substance abuse[72-74]. DeBoer and colleagues[75] found that many traumatic events, including exposure to residential schools, mental health and physical health issues, were associated with volatile substance use in homeless adults.

Substance use can also have negative outcomes on other life factors, such as mental health. Spinelli and colleagues[59] found that a history of psychiatric hospitalization and major depressive symptoms were associated with greater illicit drug or alcohol symptoms, respectively, in older adults.

### *Physical Health or Disability*

Physical health issues or disability have also been reported as a primary cause of homelessness. In a 2018 study of 577 adults experiencing homelessness[50], several discussed disability or physical health issues as their reason for entering homelessness. Physical health issues and disabilities, including cognitive disabilities (e.g., FASD or Traumatic Brain Injury (TBI)), are

common in homeless populations. Studies are not always clear about whether these issues occurred before homelessness or if they came about during the individual's stay in homelessness.

Traumatic Brain Injury (TBI) is common in homeless populations and can affect an individual's decision-making as well as their vulnerability to victimization, substance use issues, and mental health issues[76]. A 2012 systematic review of TBI in homeless populations[77] revealed that the lifetime prevalence of TBI in the 8 included study was between 8-53%. Hwang and colleagues[76] and Oddy and colleagues[78] found that TBIs tend to occur in late adolescence and usually occurs prior to the onset of homelessness (70% or more). A study of 2732 homeless adolescents and young adults in Minnesota found that 43% reported a history of TBI and that TBI was associated with homelessness at a younger age, increased likelihood of a mental health diagnosis, substance use, suicidality, victimization, and difficulties with activities of daily life[79]. This study also noted that 51% of participants reported sustaining their first TBI prior to becoming homeless. Cognitive impairment in general has also been commonly reported in populations experiencing homelessness. One meta-analysis of cognition among homeless populations found that, in 24 unique studies with 2969 subjects, 25% of the participants had cognitive impairment[80].

### Interpersonal Level Risk Factors

Interpersonal risk factors are those that involve interaction between two or more people and may not be completely within the control of the individual. Within this review, these include: domestic violence, childhood adversity, child maltreatment, and trauma.

#### *Domestic Violence*

In general, violence has been associated with entry into homelessness. Domestic violence has often been identified as a precipitating factor for homelessness, especially for women and families. Research has also identified the presence of domestic violence as a contributing factor for many homeless families. In a study of 220 homeless mothers, Browne and Bassuk found that more than 60% of participants had been physically assaulted by male partners[81]. A small, qualitative study also identified family violence as a key pathway into homelessness that the majority of participants had experienced[82]. Furthermore, after families exit homelessness, those that experience subsequent partner violence are three times more likely to experience another episode of homelessness in the future[83].

#### *Childhood Adversity*

Over the past two decades, understanding of the impact of childhood adversity has increased significantly. Childhood adversity may include experiences of childhood abuse (including physical abuse, sexual abuse, emotional abuse, and/or neglect), parental separation or divorce, mental health or substance use in the household, and the incarceration of a family member. Research using the Adverse Childhood Experiences Survey (or ACEs)[84] has linked childhood adversity to a myriad of adverse mental and physical health outcomes, including physical and

mental health disorders, risk-taking behavior, and morbidity[84,85]. Higher ACEs are linked with higher risk of adverse outcomes.

Childhood adversity has been linked to homelessness in many populations. Youth experiencing homelessness are more likely to have experienced childhood abuse[52,86-88]. Experiences of childhood neglect have been linked to higher odds of unstable housing in sexual minority young adult men[89]. A 2010 study on runaway adolescent girls by Saewyc and Edinburg found that almost 70% reported abuse as a key reason for leaving home[3]. Montgomery and colleagues[90] found that childhood adversity scores independently predicted adult homelessness, as well as adverse mental and physical health outcomes. In a 2017 study of 1888 adults with mental health issues in a Housing First program[91], Edalati and colleagues found that 88% of participants reported at least one exposure to childhood adversity and 50% of participants reported more than four exposures. Childhood adversity was associated with higher risks of criminal justice system involvement and victimization. Similarly, a study of 224 adults experiencing homelessness found that over half of the participants had experienced at least 4 ACEs[92]. Experiences in foster care have also been linked to an increased risk for homelessness[93].

Furthermore, research has identified the intergenerational transmission of risks for adults who have experienced childhood adversity. A 2017 study by Cutuli and colleagues found that increasing levels of childhood adversity were linked to higher levels of adult homelessness (both single and multiple episodes) and that childhood adversity for those experiencing homelessness also affected the current cumulative developmental risk of their household[94]. Another study of ACEs in homeless families also found that higher parental ACEs in either maltreatment or family dysfunction predicted higher child ACEs[95].

Childhood adversity is also linked to other risk factors for homelessness, including mental health issues and substance use. A study examining this link in older homeless adults (n=350) found that exposure to one childhood adversity (i.e., physical neglect, verbal abuse, physical abuse, sexual abuse, parental death, parental incarceration, and child welfare system involvement) was associated with two times higher odds of reporting moderate to severe depressive symptoms and 4.6 times the likelihood of a lifetime suicide attempt, with odds increasing with exposure to additional childhood adversities. As well, individuals with four or more childhood adversities had 7.1 times the odds of a lifetime history of psychiatric hospitalization compare to those without childhood adversity exposures [96]. Larkin and colleagues found that childhood adversity was also linked with substance use in a study of low-income adults (n=250) living in public housing. In this study, 31% of the individuals had experienced four or more adverse childhood experiences (ACEs). These individuals were significantly more likely to have experienced substance use problems[97]. Another study of individuals experiencing homelessness (n=224) indicated that over half had 4 or more ACEs[92].

### *Trauma*

Similar to the association between childhood adversity and homelessness, trauma has also been linked to homelessness in multiple populations, with 69-99% of individuals experiencing

homelessness reporting experiences of trauma[98,99]. Multiple research studies have shown an association between trauma in childhood, adolescence, or adulthood and multiple episodes of homelessness or chronic homelessness[100-102] and may also be linked to early age at entry into homelessness[103]. In a 2018 study by Woodhall-Melnik and colleagues[104], all 25 men interviewed had experienced complex psychological trauma in childhood, including physical, sexual, or emotional abuse; neglect; poverty; parental substance use or mental illness; early substance use; or early involvement with systems (e.g., the child welfare system). These participants had several pathways into homelessness which were grouped by their ability to deal with or address childhood traumas such that they could remain in their home. Trauma is also associated with other risk factors for homelessness, including poor mental health and substance use[101,102].

### *Child Maltreatment and Child Welfare Involvement*

Similar to trauma and childhood adversity, involvement with the child welfare system (including foster care) and/or child maltreatment have also been associated with homelessness. As well, similar to other risk factors for homelessness, there may be a cyclical relationship where child maltreatment may increase a person's risk for homelessness but housing stability or homelessness may also increase the risk for child maltreatment[105]. In a sample of At Home/Chez Soi participants at the Winnipeg site (n=504), 50% of the homeless sample reported a history in-care; these individuals were significantly more likely to female, young, married or cohabitating, of Aboriginal heritage, have less education, and have longer lifetime history of homelessness compared to those without a history in-care. Individuals with experiences in-care reported significantly more traumatic events[106].

## Structural Level Risk Factors

In a 2018 study of 577 adults experiencing homelessness, Barile and colleagues[50] found that many self-reported reasons for homelessness were clustered around employment difficulties or financial crises. These can also be related to a lack of affordable housing and to changes in welfare and subsidy legislation. Gaetz notes the importance of addressing these structural issues as they are linked to homelessness and are beyond individual control. They indicate that the structural conditions that create conditions for entry into and continuing homelessness must be addressed; the interventions and programs that address homelessness will have only limited success for ending homelessness without structural interventions to address these underlying causes[107].

## Protective Factors for Entry into or Continuation of Homelessness

Protective factors are those that can buffer against risk factors to promote health and well-being for individuals and their families. Research on protective factors for homelessness (i.e., the factors that prevent homelessness or promote exits from homelessness) have focused on several domains, including coping, resilience, self-esteem and confidence, spirituality, and social support. Compared to the sections on risk factors and interventions, protective factors for homelessness have received relatively less attention. Ideally, interventions should aim to both promote protective factors and reduce risk behaviors; however, much of the literature in the area of homelessness has focused more on addressing risk factors than on promoting protective factors.

Protective factors for homelessness may differ by population. Where these differences are identified in the available research evidence, they will be noted. As well, protective factors may have a direct or indirect effect on homelessness. For example, the protective factor (e.g., social support) may prevent individuals from becoming homeless (a direct effect) or may promote individuals mental health which may, in turn, promote exit from homelessness (an indirect effect). These factors may be at the individual-level (e.g., coping, self-esteem), the interpersonal level (e.g., resilience, social support), or at the community-level (e.g., income or employment support).

### Individual Level Protective Factors

#### *Coping*

Coping refers to adaptive cognitive and behavioral efforts to manage a person's external and internal stressors[108]. Coping mechanisms (i.e., the means by which an individual exhibits coping) may be positive or negative. Often, individuals experiencing homelessness or early trauma may have more avoidant coping and poor resilience[109,110] which may lead to adverse outcomes (e.g., poor mental health[111]; substance use[112]). For example, a recent study by Bender and colleagues[113] found that homeless youth tend to isolate themselves, trying to cope on their own rather than seeking support from others. This may be due to trust issues, a developed sense of self-reliance and independence, wanting to avoid pity, shame and embarrassment, and feeling like it is pointless to ask for help because no one will listen. However, there is also research indicating coping among homeless populations can be protective.

In 2018, Paul and colleagues[114] conducted a qualitative study of personal perceived strengths, attitudes, and coping behaviors of adults experiencing homelessness which found that minority groups experiencing homelessness have similar personal strengths as the general homeless population. These strengths were sources of coping and resilience and allowed them to manage and overcome challenges during their experience of homelessness. Participants' coping strategies included seeking 'instrumental' support via formal or informal service providers (e.g., income or health support, housing), social support (seeking support from family members and friends and focusing on community and relationship building through socializing), engagement in meaningful activities (e.g., physical or creative pursuits, education, training, or employment),

distancing themselves from overwhelming challenges through avoiding stressful situations, and finding an "anchor" to motivate them to stay strong (e.g., children, social supports).

### *Resilience*

Resilience is an individual's capacity to overcome adversity to achieve positive outcomes[115] and should be viewed not as a characteristic but rather a process or mechanism that underlies positive adaptation in the face of hardship[116]. Resiliency requires both that an individual faces current or past adversity that could compromise normative development and that they also achieve positive outcomes despite these adversities[116]. Resilient development involves an interactive process between risk factors, protective factors, and promotive factors in an individual's life[117]. These include self-esteem[118], self-efficacy[119,120], coping skills[121], relationships with peers[122], emotional closeness and bonding with family (including positive parent-child relationships)[123,124] .

Individuals experiencing homelessness, despite facing many challenges and barriers to stability, are often highly resilient as they are able to survive with minimal supports, and can endure a lack of housing and food, the loss of family or friends, victimization, physical discomfort, physical health issues, and mental health impacts[125]. Thompson and colleagues[126] found that homeless youth are capable of using resiliency through positive life perspectives, focusing on own strengths, external social supports, and healthy coping strategies. The authors noted that, although this group is at risk of negative outcomes, building resiliency can encourage positive choices and increase the likelihood of exiting homelessness.

### *Optimism*

In Paul and colleagues' 2018 study on personal strengths and attitudes of adults experiencing homelessness, participants described a strength as hope and optimism, which helped them endure the stresses of homelessness and manage difficulties[114]. Optimism has also been linked to improved mental health in homeless populations. A study of 168 adults experiencing homelessness in the United States by Fitzpatrick[127] found that social support and optimism were protective against the negative effects of adverse childhood experiences on depressive symptoms as adults, with participants with higher levels of optimism and social support reporting lower depression and anxiety symptoms.

### *Self-Esteem*

Self-esteem has been investigated within homeless populations to investigate its relationship with housing stability, resiliency during homelessness, and exiting homelessness. In a qualitative study of 10 participants, Paul and colleagues found that even with multiple challenges, self-esteem was associated with participants' perseverance and confidence in their ability to succeed (e.g., through finding housing, completing training or employment, or survival on the streets)[114]. Self-esteem is also linked to other protective factors, with Dang and colleagues[128] finding that higher self-esteem was associated with better mental health in homeless youth.

## Interpersonal Level Protective Factors

### *Social Support*

Social support is an important factor for both the prevention of and ending of homelessness. In general, stronger social supports with both family and friends are related to success in leaving homelessness. Caton and colleagues[129] found that higher levels of family support were associated with shorter episodes of homelessness. Similarly, multiple studies have found that having access to social support from family and friends is associated with an increased likelihood of exiting homelessness and housing stability[130]. Greater perceived social support is also a predictor of housing sustainability[131].

Social support is also linked to other protective factors of homelessness. For example, Dang and colleagues[132] found that youth with higher levels of social connectedness and self-esteem had lower levels of psychological distress. Strong social networks can help to prevent homelessness[133]. As well, Gattis[134] found that, among youth experiencing homelessness, higher family communication and school engagement were associated with lower levels of depression. McCarthy and Casey[135] also note that because resilience does not develop in isolation, relationships and social interactions can facilitate the development of resilience. Youth who are homeless with higher levels of connectedness (i.e., close connections with their families, schools, etc.) have better outcomes than youth who are less connected[136,137] and can be protective against other behaviors, including substance use, sexual risk-taking, violence, and emotional distress[138].

Homeless individuals, especially women, may stay in close contact with housed family members. These housed individuals can provide social, material, and economic support to the homeless individual[133]; however, supporting a homeless individual can cause stress and over time can strain the relationship. Thus, increasing length of time in homelessness can weaken the strength of social networks and available social supports[133]. Similarly, in a study of 643 adult men participating in transitional housing in Montreal[139], 38% of the sample returned to shelter within a year of departing the program. The authors found that poor social support was linked with a return to shelter and a faster time to returning to shelter. Thus, social support can be an effective strategy for preventing entry into and return to homelessness.

## Structural Level Protective Factors

Resources at the interpersonal and community levels have been predictive of housing stability. Many such protective factors operate at the structural level. In a study of adults experiencing homelessness, Aubry and colleagues[11] found that factors such as access to subsidized housing and higher income levels are positively associated with housing stability.

### *Job Training or Readiness*

Just as unemployment can be a risk factor for homelessness, having a job or promoting job readiness and training can be effective in addressing homelessness. Evidence from Caton and colleagues[63] and Piliavin and colleagues[140] indicate that being currently or recently employed, having earned income, and/or job training is associated with a shorter duration of

homelessness and the absence of such job-related factors is associated with returning to homelessness.

### *Income Support and Other Financial Assistance*

Receiving income supports, such as social benefits or accessing subsidized housing has been found to be one of the strongest predictors of sustained exits from homelessness[13,14]. Others have suggested that one of the mechanisms by which Housing First participants have success in housing is due to the rent supplement that is provided to participants[11,141].

## Interventions

Because of the complexity of homelessness and the fact that homelessness is more than just a lack of housing, there is a need for interventions addressing homelessness to target more than just stable housing[142]. In order to facilitate exits from homelessness, many factors specific to the individual or family unit need to be considered, such as gender, life experiences, personal goals, systems involvement, health, and necessary supports[143,144]. Thus, in this section, two main areas of intervention have been identified: 1) housing interventions (e.g., Housing First) which have strong evidence for supporting housing stability and ending homelessness and chronic homelessness; and 2) interventions which address risk factors or promote protective factors for populations experiencing homelessness.

In general, interventions focus on one aspect of homelessness and have specific goals. For example, an intervention may focus on housing stability or ending chronic homelessness or supporting individuals with co-occurring substance use and mental health issues. Both of these types of targeted interventions recognize the complexity of risk and protective factors and the inter-related nature of risk factors on the pathways in and out of homelessness. An intervention may target mental health issues (an identified risk factor for homelessness) as a means of preventing homelessness or promoting exits from homelessness. However, it is not the intention of this review to do a comprehensive examination of all interventions that target a risk factor or promote a protective factor for individuals experiencing homelessness. Rather, it is meant to provide an overview of potential interventions that may be useful for examining pathways in and out of homelessness for women and children within the Calgary context.

As well, because studies evaluating the effectiveness of such interventions are limited to measured variables (e.g., gender, self-reported substance use, income level, etc.) and because of the complexity of homelessness, replicability of findings can be difficult and it is difficult to know the full impact of the intervention. Where possible, these limitations are noted. As well, because interventions may work differently with different populations[50], the generalizability across different populations experiencing homelessness (e.g., single males vs. families) may be limited.

## Housing Interventions

### *Housing First*

Housing First (HF) is an evidence-based intervention that involves the immediate provision of permanent housing and supports for individuals experiencing homelessness who have mental health or substance use issues, with no requirement for abstinence from substance use or involvement with programming or supports[145,146]. Case managers provide support on a continuum, based on clients' needs and desire for support and may involve Assertive Community Treatment (ACT) or intensive case management[147]. Housing First interventions may involve scattered-site housing with a rental subsidy or place-based housing, depending on client needs and preferences. Housing First has been found to have significant improvements on housing stability[148], housing quality[149], decreasing psychiatric symptoms[150], moderate improvements in functioning and quality of life, and reductions in systems interactions[151-155]. Aubry and colleagues found that over 70% of individuals with mental illness participating in Housing First programming with Assertive Community Treatment case management were stably housed after up to 24 months[156,157]; this was significantly higher than for those who received standard care. Kerman and colleagues[147] conducted a randomized controlled trial of Housing First (n=2039) and found that participants in Housing First who had achieved housing stability had decreased use of inpatient psychiatric hospitals, emergency departments, and homeless shelters. Using data from the Vancouver site of the At Home/Chez Soi study, Palepu and colleagues[158] examined the association between substance dependence and residential stability among participants in the HF program (n=497). These individuals had experienced homelessness and had a current mental health disorder. Within the 288 participants who met diagnostic criteria for substance dependence, the authors found that, after 12 months in the HF program, there was no significant association between substance dependence and residential stability, which indicates that those individuals with mental health disorders may achieve similar levels of housing stability within HF regardless of having concurrent substance dependence.

The impact of Housing First on a variety of outcomes have been mixed. In an evaluation of Housing First using scattered-site housing and intensive case management for adults experiencing homelessness with problematic substance use, Cherner and colleagues found that that HF clients moved into housing more quickly, had a greater proportion of time housed, were more likely to spend the last 6 months housed, and had longer housing tenure at 24 months; both groups (HF and treatment-as-usual) improved their substance over time but control group had more rapid improvement on problematic alcohol and drug use. The comparison group also had a greater increase in total quality of life, and greater increase in family relations-related quality of life[148]. O'Campo and colleagues found that in an evaluation of a HF intervention in Toronto with an Assertive Community Treatment Team (compared to a control group who received treatment as usual), after two years of participation, the HF group spent significantly more time stably housed than the treatment-as-usual group; they also showed significant improvements in community functioning, but no differences in health service usage, community integration, and substance use[159]. As part of the At Home/Chez Soi trial in Toronto, Kirst and colleagues[160] examined substance use outcomes for those individuals experiencing homelessness and mental illness who were placed into Housing First compared to

those who received treatment as usual (n=575). After two years, participants in the Housing First intervention reported significantly greater reductions in the number of days experiencing alcohol issues and in the amount of money spent on alcohol, compared to those participants who received treatment as usual. However, no differences were found between the two groups regarding illicit drug use[161]. Another study[162] that evaluated the effects of housing first on employment outcomes found that, in a sample of Housing First recipients who had mental health concerns, Housing First did not increase the likelihood of obtaining employment during the follow-up period compared to those individuals who received treatment as usual (the control group). This was true of both Housing First recipients with high needs who received Assertive Community Treatment (ACT) and those with moderate needs who received Intensive Case Management supports.

As homeless individuals are heterogenous, there is also some evidence that Housing First may have differential impacts on certain groups of individuals, based on their own or external circumstances[163,164] Adair and colleagues[165] conducted a latent class analysis to examine different trajectories for groups in Housing First programs using data from the At Home/Chez Soi trial (n=2140). They describe 6 patterns of movement through Housing First over time. Approximately 28% of the sample (of which 27% were HF participants) found minimal housing stability over the course of the project (Class 1). However, 33% of the sample (77% of whom were in HF) experienced rapid and sustained housing by 6 months, with almost no loss of stability at 24-months. Compared to Class 1, these individuals tended to be older, more likely to be female, less likely to be Aboriginal, were homeless fewer years before study entry, and had more physical comorbidities. Another large group was Class 6, which had rapid gains to housing but returned to homelessness after the first year. Almost 25% of HF participants were in this group. Compared to Class 1, these individuals had a higher monthly income, higher levels of psychiatric symptoms, and were less likely to be Aboriginal.

HF does not lead to housing stability for everyone. Some individuals will leave HF sites, due to interpersonal violence with staff or other residents or may require more intensive clinical care. In a qualitative study of 11 participants, Stahl and colleagues examined the factors that may enhance or endanger housing stability in single-site HF programs[166]. Results showed that community was important for individuals. Many participants talked about the importance of connection and how the resident community increased feelings of acceptance of support; however, within the place-based site, there were also high levels of interpersonal tension. The individuals also noted that HF gave them the opportunity to seek stability, where they had a safe place to sleep at night that was a permanent home. HF also helped to increase their autonomy, which was a contrast from their experience in homelessness, as they could come and go as desired from their new home and could control their daily activities[166].

Although HF has been shown to be cost-effective and effective in improving client quality of life, practical results may vary due to differences in implementation and client demographics. Housing First is not an effective approach to housing stability for all individuals who participate in this type of programming. Although HF has been shown to be effective in increasing housing stability, improving mental health outcomes, and reducing substance use, some individuals who

participate in HF may not achieve such outcomes. Approximately 15-20% of individuals participating in HF (i.e., those with persistent homelessness and mental health issues) continue to experience evictions and have needs that are not met by the HF model[151]. A 2014 study by Stergiopoulous and colleagues examined client outcomes in 301 participants in HF as part of the Toronto site of the At Home/Chez Soi project. The authors found that 60-72% of participants saw improvements. The other participants saw difficulties in community integration, mental health symptom severity, substance use, community functioning, and quality of life[167]. Similarly, Davidson and colleagues[168] investigated program fidelity at nine scattered-site Housing First programs in New York City and compared client outcomes across the sites (n=358). They found that greater program fidelity was associated with a higher likelihood of housing retention and a decreased likelihood of substance use at the 12-month follow-up.

### *Permanent Supportive Housing*

Permanent Supportive Housing (PSH) is a model of housing supports that combines the provision of stable housing and other supportive services (depending on the needs of the clients). PSH programs may include a Housing First approach. Studies evaluating the outcomes of permanent supportive housing have shown mixed results. Outcomes may vary by the type of substance use (e.g., cocaine use compared to alcohol use)[169]. Several studies have found that substance use decreased with the PSH model[170,171], but others found no significant reduction in substance use with PSH[151,159,172].

### *Access to Affordable Housing*

Access to affordable housing is required for both the prevention of homelessness and to facilitate stable exits from homelessness. Although other intervention strategies can help to ameliorate outcomes for individuals at risk of or who experience homelessness, in order to address homelessness on a structural level, an effective affordable housing strategy is needed. Gaetz[107]notes that such a strategy must include a commitment to ongoing reinvestment in subsidized and social housing, including an expansion of supportive housing for those with complex needs (e.g., addictions, mental health issues, physical disabilities), and the development of affordable housing in the private sector.

### *Preventing Evictions*

Evictions can often lead to homelessness. A systematic review of the psychosocial factors[173] associated with evictions (n=10 studies) from rental accommodations found four categories of factors, including financial hardships, sociodemographic characteristics (e.g., larger households, higher number of children in the household), substance use issues (including addictions, heavy drinking, and illicit drug use), and other physical or mental health issues. In a systematic review on the prevention of tenant evictions[174], the authors found that only three of the relevant studies assessed the effect of the intervention on tenant evictions, and one of these studies

was deemed to be of insufficient quality. The other two studies indicated that legal assistance and debt advice were promising interventions to effectively decrease the risk of eviction.

### Interventions Addressing Risk Factors or Promoting Protective Factors in Populations Experiencing Homelessness

Although not necessarily specifically focused on addressing homelessness, interventions which support positive developments in education, housing, health, and employment can address risk factors or promote protective factors for homelessness.

#### *Substance Use/Addictions*

As substance use is a prominent risk factor for entry into homelessness as well as chronic homelessness, addressing substance use can be an important intervention for homelessness. It is not the purpose of this literature review to discuss all of the models for addressing substance use; however, several interventions that are used to address substance use in relation to homelessness are discussed.

In a systematic review of interventions (n=17) to address alcohol use in homeless adults, Adams-Guppy & Guppy[175] found that many different interventions were effective in reducing alcohol abuse, including standard case management and intensive case management, often when integrated with a housing program. Housing as an intervention (non-abstinence based) was present in 6 studies; however only one study found a positive effect for a housing-only approach on alcohol use (in chronically homeless adults)[176]. Other studies found no significant differences in alcohol use between the housing programs' participants. Alcohol abuse counselling and residential treatment were also found to be effective; however, mixed results were found with long-term follow-up in a smaller study of homeless mothers with substance abuse issues[177].

Housing First (as described above) has been shown to have mixed results on the substance use outcomes among its participants. In a 2017 study, Cherner and colleagues[148] found that HF participants reduced their substance use but that the control group had more rapid improvement on problematic alcohol and drug use. Some studies have found that HF can reduce substance use; however, others have found no reduction in substance use.

Lower rates of substance use have been associated with more exits from homelessness in newly homeless youth[178]. As well, difficulty accessing addictions treatment has been linked to continued homelessness in a prospective cohort of 685 street-involved youth (ages 14-26 years) with substance use issues[179]. Although it was not the purpose of this literature review to review treatment options for substance use issues, it is obvious that there is a link between housing stability and substance use, and that structural issues that affect support for substance use issues (e.g., residential treatment programs) must be addressed.

### Assertive Outreach

Assertive Outreach can be an effective complement to Housing First or other housing models. Assertive Outreach is a specialist mental health service which provides intensive, highly coordinated and flexible support and treatment for clients with complex substance use and/or mental health needs. In a 2006 study of 73 homeless clients who had participated in an Assertive Outreach program, 41 successfully entered treatment[180].

### Brief Motivational Interviewing

Brief Motivational Interviewing has also been found to help reduce substance use among homeless populations. In assessing the results of a randomized trial testing a single-session brief motivational intervention for substance use among homeless adolescents (n=285), Peterson and colleagues[181] found that those youth who received the intervention reported reduced illicit drug use (other than marijuana) at the one-month follow-up time, compared to the control group. However, no significant differences were found between groups for alcohol or marijuana use. Another study of 117 homeless adolescents assessed the effect of a brief motivational intervention as a follow-up to the 2006 Peterson study, which was modified to enhance engagement of the youths. During the intervention, service utilization increased for the youth, but returned to baseline levels at follow-up, but substance use decreased over time[182]. Another study of a brief intervention to reduce substance use among homeless adolescents (n=61) compared a two-session brief intervention group with a two-session education group. The authors found that the brief intervention group increased participate readiness to change alcohol use but did not significantly decrease primary alcohol use or sexual risk-taking. A similar intervention design, a Motivational Interviewing Social Network Intervention to reduce high-risk alcohol and drug use among homeless adults transitioning to permanent supportive housing (n=41). The intervention involved four sessions using a computer program to provide personalized social network visualization to help participants understand the people in their social network who triggered their substance use and those who would support abstinence. Then, if they were ready, the participants were encouraged to make changes to their social network to reduce their substance use. Those receiving the intervention reported increased readiness to change, substance use abstinence self-efficacy, and alcohol use compared to controls[183].

### Managed Alcohol Programs

Managed Alcohol Programs (MAPs) are a harm-reduction intervention for individuals experiencing homelessness who have issues with alcohol abuse. Without requirements for sobriety, these programs also generally provide alcohol in regular standardized doses which allow individuals to reduce their consumption of non-beverage alcohol and also to focus on other areas of their life which otherwise may be taken up with sourcing alcohol. In one such intervention, chronically homeless adults (n=17) with a mean duration of alcoholism of 35 years showed a decrease in emergency department visits, police encounters, and alcohol consumption during the program, and the participants reported improved hygiene, compliance with medical care, and health[184]. Similarly, Vallance and colleagues[185] found that a Managed Alcohol Program led to 41% fewer police contacts, 33% fewer police contacts leading to custody

times, 87% fewer detox admissions, and 32% fewer hospital admissions compared to periods of times out of the program. Compared to control participants, those participating in the Managed Alcohol Program had 43% fewer police contacts, 70% fewer detox admissions, and 47% fewer emergency room visits. The MAP participants also had decreased non-beverage alcohol use. Both groups of participants had reduced alcohol-related harms. A 2018 study by Pauly and colleagues[186] reviewed 13 Canadian managed alcohol programs with a variety a programming models, including residential and day programs, the provision of food and accommodation, alcohol dispensing and administration policies, and other supports; these may be important for addressing context-specific needs of communities or sub-populations.

### *Mental Health*

Much of the interventions related to mental health issues among homeless populations focus on providing housing and supports to individuals with mental health issues and not necessarily addressing the mental health issues themselves. This is important as it recognizes that, although some mental health issues may be caused by homelessness, mental health issues may be a non-modifiable risk factor for homelessness that should be addressed through psychological or clinical care. As specific "treatment" was excluded from this literature review, these interventions will not be discussed in this section. As well, much of the literature does not differentiate between types of mental health issues among homeless populations and therefore it is difficult to separate the effects of interventions. For example, the results of an intervention for someone who has depression compared to someone with bipolar disorder may be very different; however, most studies just refer to participants as having a "mental illness" or "psychiatric disability".

#### Critical Time Interventions (CTI)

Critical Time Interventions are designed to prevent recurrent homelessness among persons with severe mental illness by enhancing continuity of care during the transition from institutional to community living[187]. Some studies have found positive results for CTI, others have found no differences between CTI and treatment as usual. In an evaluation of a Family Critical Time Intervention for mothers with children as they transition from shelter into affordable housing, Samuels and colleagues (2015) used a case management team to encourage mothers to create and maintain necessary community connections. Those mothers who participated in the intervention (n=210) had declines in mental distress and psychopathology; however, these treatment effects did not differ by those who participated in the intervention and those who received treatment as usual.

#### Assertive Community Treatment (ACT)

Assertive Community Treatment is meant to serve individuals with serious and persistent mental illness to ensure that mental health treatment can continue for individuals who are experiencing homelessness as they move through the continuum of care. However, the effectiveness of ACT in homeless populations is mixed. Rosenheck[188] found that participants in ACT who continued in the program for longer did not have better outcomes in substance abuse, housing, employment, or mental health status compared to those who were selectively discharged or who left the program. However, Neumiller and colleagues[189] found that ACT led

to a reduction in hospitalizations, psychiatric systems, substance abuse, and stabilization. These positive outcomes were largely attributed to housing assistance and maintenance, medication adherence, and the delivery of intensive and multi-disciplinary services.

### *Employment*

An underlying feature of homelessness and chronic homelessness is a lack of sustainable and stable income that is sufficient for meeting the necessities of daily living. Unemployment is a key risk factor for homelessness that may trigger homelessness on its own or be a precipitating factor to homelessness. Once homeless, individuals and families may experience many barriers that affect their ability to obtain and sustain steady and sufficient employment. As such, interventions in this area can be vital to promoting sustained exits from homelessness.

One of the mechanisms that can improve income is through full- or part-time employment or informal employment. Structural-level interventions may be needed to promote employment and/or ensure income assistance as individuals experiencing homelessness may not be able to access these options on their own due to barriers related to their housing status. For example, individuals experiencing homelessness may be unable to work due to childcare responsibilities, immigration status, or disability. Living in shelter can also affect ability to get a job or sustain work. Other complexities related to homelessness (e.g., poor mental health or addictions) may further limit individuals' ability to obtain stable income on their own.

Several studies identified interventions that may help to improve employment for individuals experiencing homelessness. Poremski and colleagues conducted a qualitative study which identified persistent barriers to employment among formerly homeless individuals[190]. The authors found that even when housed, barriers to employment persisted such as worries about disclosing sensitive information, fluctuations in motivation, continued substance use, and fears about re-experiencing homelessness. Discussing these barriers with an employment specialist was a potential strategy for developing strategies to overcome them; however, expertise in homelessness-related barriers are necessary. In a study of 2480 clients experiencing homelessness who participated in a labour market program where personal job coaching support was provided, clients supported by a job coach had significantly higher chances of gaining employment and sustaining employment[191]. As such, job coaching may be an effective intervention for addressing homelessness. The Moving Ahead Program, a vocational rehabilitation program, aims to support adults experiencing homelessness into employment. Gray and colleagues found that this program supported individuals to gain employment while also achieving improvements in housing, health, and decreased substance use after 6 months. However, varying results across groups revealed that this program should be used in conjunction with other supports, with individuals starting the program with a serious mental health issue seeing minimal improvements[192]. In a 2013 study, Koffarnus and colleagues found that monetary incentives increased engagement and achievement in a job-skills training program for unemployed, homeless, and alcohol-dependent adults (n=124)[193]. Overall, these results indicate that job training supports can be effective in overcoming barriers to employment for individuals experiencing homelessness.

### *Income Assistance*

As discussed above, a lack of stable income can affect entry into and sustained homelessness. Income assistance (e.g., rental subsidies, grants, disability income, etc.) can be helpful in reducing homelessness and promoting exists from homelessness. Thus, structural interventions can help to provide financial stability for these individuals through advocacy and interventions that provide income assistance. These interventions can promote stability for individuals experiencing homelessness (both episodic and chronic homelessness) through promoting financial independence, motivation and purpose, and addressing recovery outcomes. Although poverty or lack of financial stability may be a risk or precipitating factor of homelessness, it is not necessarily the only factor for homelessness. Consequently, these interventions should be used in combination with other housing and supportive interventions to provide wrap-around supports for individuals experiencing homelessness. This is especially important for individuals experiencing chronic homelessness whose needs may be more complex and require more support.

In a 2018 qualitative study (n=12) on the impact of a rental assistance program on individuals experiencing chronic homelessness, Pankratz and colleagues found that rental assistance helped participants to move off of the streets and into their own home, promoting their recovery through a sense of ontological security[194]. Participants felt like they had control over their life and living situation as well as improved access to resources. After participants had their own home, they were able to reconnect with their community to re-build social supports and become more engaged and integrated. Rental assistance allowed the participants to access housing that would have been previously unattainable, addressing issues of housing affordability and landlord discrimination. Another study investigating the effectiveness of the addition of rental assistance to existing housing and support services for individuals experiencing chronic homelessness found that receiving rental assistance was associated with greater housing stability, housing quality, community functioning, social support, and quality of life after 6 months[195]. A longitudinal study of homeless women who were becoming rehoused found that financial resources were essential for achieving integration within their community and achieving housing stability [196]. Overall, these results indicate that financial assistance and resources, such as rental assistance) can be an important part of achieving housing stability and can also support community integration (which is important for building up protective factors against (re-)entry into homelessness).

### *Mentoring and Peer Support*

Peer Support Interventions cover a variety of interventions which involve peers, or those who have had similar experiences to those who are experiencing homelessness. Yamin and colleagues note that peer support can be offered in many forms, including self-help groups, drop-in centers, advocacy, in-person or online supports, or through peer-delivered services[197].

A study of 197 homeless youth, Dang and colleagues examined the association between natural mentoring relationships and youth functioning[132]. Natural mentors can have protective effects on adolescent functioning. The authors found that 73.6% of homeless youth had natural mentoring relationships (both family and non-family) and that having a natural mentor was

associated with protective factors for the youth, including social support and decreased sexual risk-taking. Similarly, a qualitative study of 23 youth experiencing homelessness found that natural mentors provided social support and acted as surrogate parents. The authors suggested that mentors could promote resilience for youth experiencing homelessness[198]. Another study of 90 youth experiencing homelessness who were also in substance abuse treatment found limited significant positive results for mentoring[199].

A review of peer support interventions in young adults and adults experiencing homelessness found 10 studies that indicated that peer support could have significant impacts on quality of life, drug and alcohol use, and social supports. The authors suggested that common elements of interventions may be responsible for the positive impacts, including having shared experiences with the individual, role modelling, and social support[200].

### *Addressing Trauma and Promoting Psychosocial Development*

This section highlights a range of interventions that address self-improvement (e.g., self-esteem, coping, resilience), experiences of trauma, and life skills.

Overall, there is a need for trauma-informed care and supports in homeless-serving agencies. Women and mothers who are experiencing homelessness (with or without a family) often have histories of childhood or domestic abuse, other trauma, or childhood adversities. Providing support for these women and their children necessitates taking a trauma-informed approach. A 2015 qualitative study by Osuji and colleagues[201] aimed to explore the lived experiences of women without children who experienced housing instability and homelessness in Calgary. The authors found that lack of stability and trauma in their home life before experiencing homeless could leave a lifelong impact. The authors recommend long-term engagement with women experiencing homelessness, client-centred care with supports tailored to the woman's needs, and strong inter-agency collaboration across systems.

### Mindfulness Interventions

Mindfulness is the "awareness that emerges through paying attention on purpose, in the present, and non-judgementally, to the unfolding of experience, moment by moment"[202]. Mindfulness has been associated with greater self-efficacy, coping, and emotional regulation[203]. The SHINE (Support, Honor, Inspire, Nurture, Evolve) mindfulness program is a 10-session program that teaches evidence-based mindfulness awareness practices to people living with poverty, homelessness, addictions, abuse, and physical and mental health challenges. Another study which aimed to explore the benefits of participation in a mindfulness program in mothers and children receiving services at a nursery serving homeless toddlers (<3 years of age) found that, for the mothers, benefits included having their own time and space (i.e., "me" time), improving maternal self-regulation, connecting more positively with their child, and promoting child well-being. These results may help to support positive and effective parenting even in the context of homelessness[204].

### *Arts-Based Interventions*

Art-based interventions have become more popular, especially due to the belief that this type of programming can promote protective factors for individuals experiencing homelessness, including improve mental wellness, social supports, and life skills. Schwan and colleagues[205] found, in a qualitative study with 23 youth experiencing homelessness, that art creation helped the youth to cope with adversity and create meaning, including managing mental health challenges, coping with stress and homelessness, recovering from trauma, exploring themselves, and developing positive self-esteem and hope for the future. Similarly, an art therapy intervention using quilting[206] was found to foster resilience for older homeless women. Another study focusing on leisure activities (e.g., a structured dance class) for adults experiencing homelessness aimed to decrease stress, increase positivity, and encourage healthy coping and found that participates experienced an increase in positive effects after participating in the class[207].

### *Social Support*

Social support has been seen to be a strong protective factor against homelessness; however, limited studies or interventions have been conducted to promote social supports as a preventative measure against homelessness (i.e., in populations at-risk of homelessness), in homeless individuals, or in individuals who have made recent exits from homelessness. One study by Tsai and colleagues[208] (2012) examined social integration in a group of 550 chronically homeless adults who had recently obtained housing. Results at 6 and 12 months showed that, although the participants' housing situations had improved significantly, they still remained socially isolated and had limited improvements in other areas of social integration, such as community or civic participation, or religiousity[208]. Another study of 544 adults experiencing homelessness by Hwang and colleagues[209] found that positive perceived social supports were related to better physical and mental health status and a lower likelihood of victimization. The authors recommended that services promote integration of social supports and the building of social networks within programming.

### *Parenting and Family Interventions*

Parenting while homeless can be a difficult task, especially if there are complexities such as parental mental health or substance issues. Several parenting and family-related interventions have been identified that may help promote family and child well-being and health outcomes, including the Early Risers Program, the Family Critical Time Intervention, and the Healthy Families Home Visiting Program. In a longitudinal 2-year randomized controlled trial by Gewirtz and colleagues[210], the Early Risers program was implemented for 161 homeless families in a supportive housing program, aimed at improving parenting and child outcomes. The families in the intervention group showed significant improvement in parenting self-efficacy and reductions in children's depression. Shinn and colleagues[16] conducted a randomized controlled trial of a Family Critical Time Intervention (FCTI) for children in newly homeless families where the mother had a diagnosable mental health or substance abuse issue. The FCTI involves housing and structured case management to provide support for families leaving shelter to connect with necessary community services. Families were followed over two years. The

authors found that the intervention led to reduced internalizing and externalizing issues in preschool-aged children, declines in school-related issues for children 6-10 years and 11-16 years, and all children (intervention or control) showed reduction in problem symptoms over time, indicating the FCTI has the potential to improve mental health and school outcomes for children experiencing homelessness.

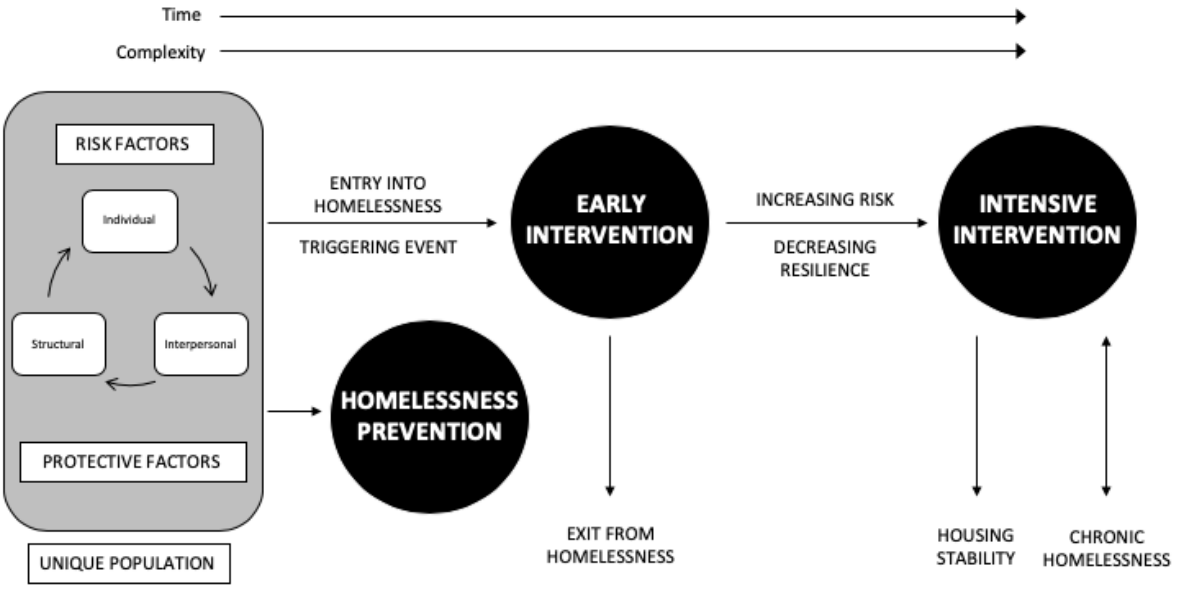
A review of six studies evaluating the effectiveness of housing and service interventions addressing family homelessness[17] found that families showed post-intervention improvement in housing and employment, but did not achieve residential and work stability, indicating that they might be at risk for a return to homelessness. Furthermore, the interventions identified had methodological limitations and poor reporting quality. The effects of the Healthy Families Massachusetts program, a Home Visiting Program, were evaluated using a randomized controlled trial over 7 years with 704 participants[211]. The authors evaluated the effect on young mothers' experiences with homelessness during enrollment and after program completion and found that young mothers who participated in the Home Visiting program were less likely to experience homelessness when their children were preschool-age or older compared to mothers in the control group. The number of home visits was also negatively associated with concurrent homelessness when the children were infants or toddlers, indicating that the intervention may be effective in reducing homelessness for families.

Parenting support programs can help to address the adverse factors that parents and children experience in the context of homelessness. A study by Haskett and colleagues[212] with 80 participants found that the Circle of Parents intervention, a self-help support group that was developed to decrease child maltreatment, found a positive impact of the study on parental effectiveness; however, the findings were not significantly different between the intervention group and those receiving treatment as usual. Other programs have been developed that focus on parenting effectiveness in the context of homelessness but have not been rigourously evaluated. For example, Sheller and colleagues[213] describe the development and implementation of the Family Care Curriculum train-the-trainer parenting support program, which was designed to support parenting in families experiencing homelessness. The program is a 6-week theory-based parenting intervention aimed to make positive changes in parental attitudes to influence the parent-child relationship. Parents are support through self-care, and receive education in emotions, attachment, and developmental needs of their child. However, the program has not been thoroughly evaluated. It is important to note that such programs may be effective; however, as they are an emerging field, limited research is available and even though positive differences between intervention groups may not be evident, further research should be conducted to better understand these effects.

## Proposed Model for Interventions on the Pathway to Homelessness

Given the results of the literature review, it is evident that the relationship between risk and protective factors for homelessness are complex and require special consideration when determining the most appropriate intervention for addressing homelessness. Thus, we propose the following model (Figure 1) to visualize these relationships and outline important timepoints for intervention.

Figure 1: A model for understanding transitions in and out of homelessness




| | | |
|---|---|---|
| Populations experiencing homelessness are not heterogenous. Different groups will have different risk and protective factors, and unique reasons for and timing of entry into homelessness. | **HOMELESSNESS PREVENTION:** If protective factors are greater than risk factors for homelessness, homelessness can be prevented. | **EARLY INTERVENTION:** Focusing on reducing risk factors, increasing protective factors, and addressing triggers can promote housing stability. |
| | **ENTRY INTO HOMELESSNESS:** If risk factors are greater than protective factors for homelessness, the individual may enter homelessness if they experience a triggering event. | **INTENSIVE INTERVENTION:** Prolonged homelessness leads to an increase in risk factors, a decrease in resilience, resulting in the need for complex interventions. |

**INTERVENTION POINTS ALONG PATHWAYS INTO CHRONIC HOMELESSNESS**

## Limitations/Gaps in Research

Several limitations were identified when conducting the literature review. Firstly, because of the volume of information identified during the academic literature search, it was necessary to narrow the research included in this literature review. As such, this is not a systematic review and certain research that has been published in the academic or grey literature may have been missed. As well, relevant evidence available from other countries or locales may have been inadvertently excluded.

Secondly, evidence related to homelessness is limited by methodological issues. Although Housing First and several other interventions have built strong evidence for their effectiveness (i.e., due to a randomized controlled trial study design), many other interventions and studies on homelessness have used weaker study designs, such as cross-sectional or case-studies. These study designs have limited potential for attributing causal relationships (e.g., the causal link between substance use and homelessness) and may fail to properly control for other factors that may affect these relationships. Thus, there is a need for more robust research that adequately controls for potential confounders and takes into account the underlying population characteristics.

Thirdly, there is a need for more research on protective factors related to homelessness. Although several studies were identified that indicated protective factors against entry or re-entry into homelessness, there were often measurement issues in their definition of these protective factors. As well, protective factors were often only identified as part of a larger study examining the factors affecting homelessness. There is a need for more focused research that examines protective factors for homelessness and the potential for interventions that specifically promote protective factors in combination with housing or substance use interventions.

Finally, there is a need for more research on the interaction between factors long-term. Limited research was identified that controlled for risk factors prior to entry into homelessness compared to risk factors during homelessness. For example, if a person had a substance abuse issue before entering homelessness, how did that affect their outcomes compared to a person who started using substances after becoming homelessness; furthermore, how can we prevent substance use after one becomes homeless. It is unclear how the timing of risks affects outcomes and how other factors can interact to affect risk profiles before, during, and after experiences of homelessness.

## Recommendations

Several recommendations for service delivery and implementation of the research evidence emerged from the review of the literature.

1) **Consider the unique, underlying risk and protective factors for each client group**. There is a need to consider the unique set of risk and protective factors that exist for each person who may experience homelessness, as individuals experiencing homelessness are not a homogenous group. Several groups emerged that share similar pathways into homelessness and similar risk and protective factors for homelessness (e.g., youth vs. families). These groups require unique prevention and intervention measures to promote stable exits from homelessness. Designing effective interventions for each population will depend on several factors, including their underlying reason for homelessness and their needs for achieving housing stability, socio-economic stability, and healthy outcomes.
2) **Take strength-based approaches to prevention and intervention**. Although reducing risks and addressing risk-behaviors can be important in promoting homelessness prevention or exits from homelessness, there is a need to focus on strength-based interventions that promote resiliency. Much of the identified research has focused on addressing the risk factors for homelessness (e.g., substance use, mental health issues); however, intervention research has indicated the need for programs and supports that promote protective factors against homelessness, such as social supports. These strength-based approaches can be added into existing housing programming to enhance the positive outcomes for the participants.
3) **Structural interventions that address the underlying causes of homelessness are needed.** Without addressing the underlying issues affecting homelessness (i.e., structural risk factors), it is likely that the cycle of homelessness will continue. Therefore, interventions are needed that collectively promote social and economic policies, strategies, and actions that will reduce homelessness.
4) **Housing is only part of the solution – additional supports are needed**. As a Collective, we have immense capacity for addressing homelessness and its related complexities from a holistic perspective. As housing alone does not provide stability or address underlying risk factors, it is important to continue to partner and collaborate to provide creative and flexible solutions for those experiencing homelessness.

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