kunnskapssenteret
Nasjonalt kunnskapssenter for helsetjenesten

Prosjektplan for Effekt av tiltak for å redusere bostedsløshet og øke bolig stabilitet blant personer uten fast bosted

Effect of interventions to reduce homelessness and increase residential stability for people who are homeless

Prosjektnummer:	1024
Plan utarbeidet (dd.mm.åååå):	03.09.2014

Kort beskrivelse/sammendrag

Bostedsløshet er resultat av faktorer på individuelt nivå slik som fattigdom, dårlig psykisk helse, rusavhengighet, eller på samfunnsnivå. Resultatet er negative konsekvenser på en persons velferd og fysisk og psykisk helse. Målet med denne systematiske oversikten er å identifisere, vurdere, og oppsummere forskning på effekt av boligsosialt arbeid for å redusere bostedsløshet og øke boligstabilitet blant bostedsløse personer.

Short description/summary in English

Homelessness can be caused by a number of individual level factors including poverty, mental illness, or substance abuse, or society level factors. The result is negative effects on an individual's well-being and physical and mental health. The aim of this systematic review is to identify, evaluate and synthesize research on the effect of housing programs and case management interventions to reduce and increase residential stability for homeless people.

Project category and commissioner	
Produkt (programområde):	Systematisk oversikt
Tematisk område:	Velferdstjenester
Oppdragsgiver/bestiller. (med navn på kontaktperson for eksterne prosjekter):	Ingrid Fosse Husbanken Ingrid.fosse@husbanken.no
Project leadership and review team	
Prosjektleder:	Heather Menzies Munthe-Kaas
Prosjektansvarlig (gruppeleder):	Karianne Thune Hammerstrøm
Interne medarbeidere:	Sissel Johansen

Eksterne medarbeidere:	
Plan for erstatning ved prosjektdeltakeres fravær:	Erstatte med en av interne medarbeiderne

Objective

The aim of this systematic review is to identify, evaluate and synthesize research on the effect of housing programs and case management interventions to reduce and combat homelessness.

Background

Preventing homelessness has been a priority for the Norwegian State Housing Bank (*Husbanken*) since 1999 (1) p. 18). Despite work to prevent and reduce homelessness over the last 15 years, the number of homeless persons has remained between 5000 and 6500 since the first mapping of the homelessness problem was done in 1997. "Project homeless" was carried out from 2001 until 2004 with the aim of developing methods and models for the organization of housing and services to homeless persons. The project acted as the foundation for the national strategy to prevent and combat homelessness as outlined in St. melding 23 2003-2004 (2). Husbanken has called on local municipalities that are dealing with homelessness to cooperate on social housing development. The goal of this long-term cooperation is to increase efforts to prevent and combat homelessness, increase social housing activities in the municipalities, and to increase social housing competence in municipalities (3). These activities are directed at citizens who are not participating in the housing market or who need assistance to achieve satisfactory living conditions. Specifically prioritized groups include disadvantaged youth, young families, former psychiatric patients and former prison inmates (3).

Substance abuse and homelessness

The majority presence (54% in 2012), of individuals with substance abuse problems in the homeless population in Norway has remained constant since the first mapping in 1997. Most of these individuals struggle with drugs, but many also have problems with alcohol addiction(3). Men make up the majority of homeless persons with substance addictions. Substance abuse is also related to length of homelessness; four of five long term (many years) homeless persons have addiction problems compared to only two of five who have short periods of homelessness. The majority of individuals are born in Norway (3).

Mental illness and homelessness

One of three homeless individuals in Norway has a known or visible mental illness (3). Mental illness is more common among those who have been homeless for long periods of time: 40% of people who are homeless for many years (or back and forth between shelter and homelessness) have mental illness compared to only 29% of those who have short periods of homelessness (3). Almost half of the homeless individuals in Norway who have problems with substance abuse also struggle with mental illness (3).

Methods

The search strategy will be developed by a research librarian in cooperation with topical experts and the project leader.

We will systematically search for literature in the following databases:

- PsycINFO
- ASSIA (2014, 2010)
- Campbell Library (2016)
- Cochrane Library (including CENTRAL)
- PsychInfo (2016, 2014)
- PubMed
- Social Services Abstracts
- Sociological Abstracts
- ERIC (2016, 2014)
- CINAHL
- ISI Web of Science (2016, 2014)

We will also search through Google, Google Scholar and relevant websites for grey literature.

Population:

People who are homeless or at risk of becoming homeless. A homeless person is defined as a person living in the streets without a shelter that could be classified as "living quarters» with no place of usual residence who moves frequently between various types of accommodation (including dwellings, shelters, institutions for the homeless or other living quarters) which may include living in private dwellings but reporting "no usual/permanent address" on their census form.

A person at risk of becoming homeless is someone who will be released from prisons, institutions (e.g. for psychiatric or rehabilitative care), or other accommodations within two months without having any housing arranged for them in the near future (3). A person at risk can also be a person who lives temporarily with relatives or friends, or a person with short-term subletting contracts who has applied to the social services or other organizations for assistance in solving their housing situation.

There will be no population restrictions regarding mental illness, addiction problems, age, gender, ethnicity, race, national contexts, etc. However, distinct subgroups will be separated in our analyses provided there is sufficient information in included studies.

Intervention:

Housing programs or case management or a combination of the two types of interventions.

Qualified housing programs and forms of case management must meet the criteria defined by the Society for Prevention Research (4). To meet this standard a detailed description of the programme or policy must be available (p.4):

> An adequate description of a program or policy includes a clear statement of the population for which it is intended; the theoretical basis or a logic model describing the expected causal mechanisms by which the intervention should work; and a detailed description of its content and organization, its duration, the amount of training required, intervention procedures, etc. The level of detail needs to be sufficient so that others would be able to replicate the programme or policy. With regard to policy interventions, the description must include information on relevant variations in policy definition and related mechanisms for implementation and enforcement.

Outcomes:
Primary outcomes: homelessness and residential stability.
The minimum follow up is 12 months after intake. Continuous data should describe the housing situation during specific periods, for instance, past 30, 60, or 90 nights. This could be the mean number of nights, or the mean proportion of nights in a particular housing situation. Dichotomous data should involve the number of persons or the proportion of persons in different housing situations. Housing situations should be at least one of the following: homeless, unstable housing, or stable housing. Our goals is to use standardized definitions. Whether this is possible or not depends on the information given in included primary studies. For a study to be included in the meta-analysis, necessary statistical information for calculating effect sizes or relative risks must be available. If such information is not available in identified documents or provided by authors when contacted, these studies will be included in a narrative summary.

Secondary outcomes: (only included if primary outcomes are available), health-related outcomes including presence/severity of mental illness or substance abuse, quality of life, marginalization, employment, criminal behaviour, school attendance.

Study design:
Randomized controlled trials. Studies must include data on individuals or nuclear families to be eligible for inclusion. Evaluations based on ecological data and qualitative studies were not eligible.

Inclusion/exclusion of studies
Two researchers will independently of one another go through all titles and abstracts which result from the systematic literature search, and include/exclude references according to the inclusion criteria and discuss their assessments to decide whether the reference should be included. In the case of disagreement, the reference will be retrieved in full-text. References meeting the inclusion criteria will be ordered and read in full-text. Two researchers will independently of one another read the full-text articles and assess them for inclusion/exclusion based on a pre-defined inclusion form (see Appendix 1 attached).

Assessment of methodological quality of included studies

Two researchers will assess the methodological quality of the included studies independently of one another using the Cochrane risk of bias tool, which is based on an assessment of selection bias, performance bias, detection bias, attrition bias, and reporting bias (5). In cases of disagreement, the assessment will be discussed until consensus is reached.

Data extraction

One researcher will extract data from the included studies and another researcher will double check extraction. Data will be extracted concerning: author, title, date and country of publication, study design, number and characteristics of participants, dropout, type of intervention, type of control group/intervention, length of follow-up, and relevant outcome measures. When data is missing, we will contact authors, and if sufficient data is not provided we will exclude the studies from the analysis, or we will recalculate the data and employ extrapolations.

For a detailed description of the Norwegian Knowledge Centre's procedures, visit www.kunnskapssenteret.no to access our Handbook.

Assessment of heterogeneity

We will assess the clinical heterogeneity of the included primary studies based on the intervention, comparator, setting, population, and follow-up. Where clinical heterogeneity is deemed to be too great in a potential comparison, studies will not be pooled in a meta-analysis. Where heterogeneity is present but assessed to make meta-analysis inappropriate we will combine the results using a random effects model. We will assess statistical heterogeneity using the $\chi 2$-test and I^2 when results from more than three studies can be pooled in order to ascertain to which the degree the observed variation in study outcomes between included primary study is larger than can be expected by change. The statistical heterogeneity will be interpreted in light of the magnitude and directions of the observed study outcomes, as well as the results from the the $\chi 2$-test and I^2.

Data synthesis

If possible, a meta-analysis will be done using RevMan 5. If comparisons, populations, or reported outcomes are considered too diverse for a synthesis to be conducted, we will summarize the included studies using descriptive analysis based on data extracted from the original studies.

We will conduct a subgroup analysis on populations (persons with mental illness and/or addiction problems), and on programme delivery (e.g. programmes conducted in a Scandinavian context) and programme provider if possible (e.g. national, district or private programmes).

GRADE

We assessed the certainty of the synthesized evidence for each main outcome using GRADE (Grading of Recommendations, Assessment, Development, and Evaluation). GRADE is a

method for assessing the certainty of the evidence in systematic reviews, or the strength of recommendations in guidelines. GRADE has four levels of certainty:

High quality: Further research is very unlikely to change our confidence in the estimate of effect.

Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Very low quality: We are very uncertain about the estimate.

Assessments are done for each outcome and are based on evidence coming from the individual primary studies contributing to the outcome. For more information on GRADE visit www.gradeworkinggroup.org, or see Balshem and colleagues 2011 (6).

For a detailed description of the Norwegian Knowledge Centre's procedures, visit www.kunnskapssenteret.no to access our Handbook.

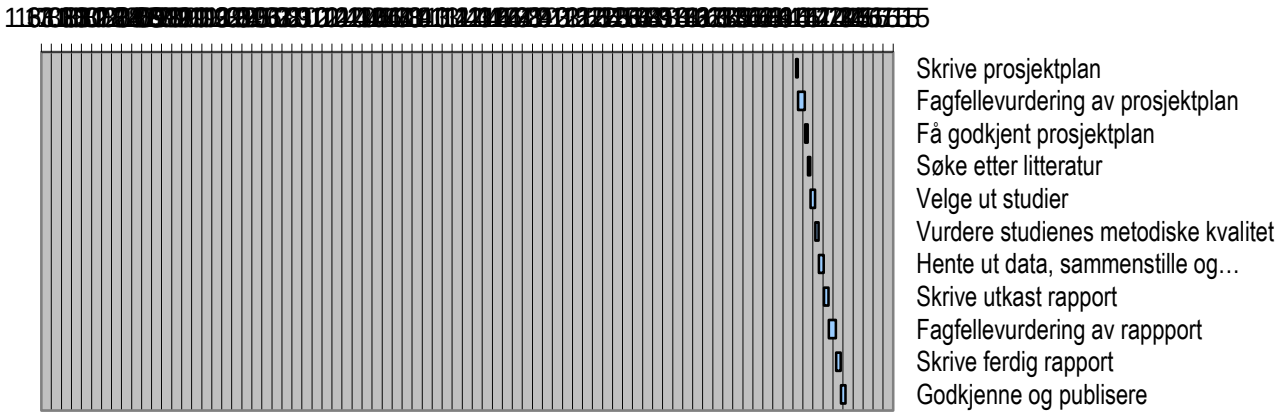
Peer review process

The project plan and the final report will be peer reviewed by one internal reviewer from the Norwegian Knowledge Centre for the Health Services and by one external reviewer. The normal process is to have two internal and two external peer reviewers. However, this project plan is based on a previously accepted and reviewed protocol from The Campbell Collaboration. It was therefore deemed unnecessary to have more than one internal and one external reviewer.

Activities, milestones and schedule

Gantt diagram:

Fagfellevurdering av rappport		24.12.2014	21	14.01.2015	
Skrive ferdig rapport		15.01.2015	14	29.01.2015	
Godkjenne og publisere		30.01.2015	14	13.02.2015	



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Publication/Dissemination

The final product will be a systematic review which will be delivered electronically to Husbanken (probably in January 2015), and thereafter published on the Knowledge Centre's website. This will also be published as Campbell Collaboration review in *Campbell Systematic Reviews*.

The target group for this report is the welfare directorates, including the Norwegian State Housing Bank, the Health Directorate, The Directorate of Integration and Diversity and the Norwegian Correctional Services

Risk Analysis

RISK ELEMENT	PROBABILITY	CONSEQUENCE	RISK FACTOR
Project team becomes ill/unavailable	Unlikely	Shift of tasks to other project team members	Low
Project leader becomes ill/unavailable	Likely	Project team will complete the process	Moderate

References

1. NOU 2011:15 Rom for alle: En sosial boligpolitikk for framtiden.

2. St. meld. nr. 23 Om boligpolitikken.

3. Dyb E, Johannessen K. Bostedsløse i Norge 2012 - en kartlegging. Oslo: Norsk Institutt for by- og regionforskning; 2013. (NIBR-rapport 2013:5).

4. Flay B, Biglan A, Boruch R, Castro F, Goffredson D, Kellam S, et al. Standards of evidence: Criteria for efficacy, effectiveness and dissemination. Prevention Science 2005;6(3):151-175.

5. Cochrane Handbook for Systematic Reviews of Interventions 5.1.0 [Updated March 2011]. Available from www.cochrane-handbook.org: The Cochrane Collaboration; 2011.

6. Balshem H, Helfand M, Schunemann H, Oxman A, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. Journal of Clinical Epidemiology 2011;64(4):401-406.