

“What is our actual impact?”: A mixed-method assessment of a Belgian shelter for homeless men

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Abstract

This paper presents an outcomes assessment carried out in an 84-bed long-term shelter for homeless men in Brussels. In the context of increasing Housing First studies, it investigates an instance of the traditional “treatment first” model and provides a new Belgian case study. Adopting a multidimensional approach, it aims to better understand what impact an average stay in a long-term shelter has on its residents. The assessment investigated several outcomes—income and housing, physical and mental health, life skills, social and assistance network—and relied on a participative mixed-method design. Although the shelter mission is broad and ambitious (i.e. autonomy, global well-being and reintegration into society), the assessment results show that the shelter struggles to have positive effects on the residents beyond the provision of basic care (a roof, food, administrative support) and that the stress felt by the residents even tends to increase during their stay. Several recommendations collectively emerged from the assessment: individualizing shelter support and making it evolve during the stay, reducing the size of the shelter while at the same time fostering community living, developing partnerships. At the public policy level, we would recommend revising the mission of long-term shelters in accordance with their means.

Key words: outcomes assessment, long-term shelter, homelessness, mixed methods

1. Introduction

Homelessness remains a persistent social issue around the world. The traditional approach to tackle it is often referred to as the “treatment first” model, also called “staircase”, “linear” or “continuum of care” model. From the streets, homeless people might spend the night in an emergency shelter, then move on to a long-term shelter to work on their issues – e.g. administrative, legal, financial, addiction- and health-related—and only then move to their own place (sometimes after having gone through transitional housing programs). More recently, an innovative approach called Housing First has been gathering increasing attention. The Housing First philosophy reverses the traditional model that aims at gradually building the “housing-readiness” of homeless people by providing them immediate access to housing, which becomes the starting point of the social work instead of the ultimate objective (Busch-Geertsema et al., 2010). This approach has been widely studied in several countries and has already shown some effectiveness, especially in terms of housing stability (Aubry et al., 2014, 2015; Raitakari & Juhila, 2015). The expansion of this innovation does not mean that the traditional model becomes unused or useless (Buxant, 2018b; Lelubre, 2014; Tsai et al., 2010), but it challenges it. In Belgium, an assessment of a Housing First program was conducted from 2013 to 2016 (Buxant, 2018a, 2018b), but, to the best of our knowledge, no specific assessment of the widespread long-term shelters which are based on the “treatment first” model has ever been conducted.

In this context, adopting a participative mixed-method approach, this paper aims to assess the multidimensional outcomes generated by a Belgian long-term shelter representative of the traditional approach. The assessment relies on a quantitative longitudinal analysis looking at several outcomes with the addition of a significant qualitative layer. This study will enrich the literature, as results of homelessness studies cannot be easily generalized across countries due to the influence of the respective national social security and health care systems, as well as the housing and labor markets – and also, because there seems to be a scarcity of European studies, in particular (de Vet et al., 2013).

Our research questions can be summarized as follows:

- (1) What are the multidimensional effects of an average stay in a long-term shelter on its residents?
- (2) Why and how do these effects happen?
- (3) How could the long-term shelters be improved to produce “better effects”?

We structure the paper as follows. Section 2 discusses the assessment of homelessness programs and presents the Belgian context of homelessness as well as the case under study. Section 3 describes the methodology used and the data collection. Section 4 explains the quantitative and qualitative results. Section 5 provides a discussion of results and Section 6 concludes with a discussion of limitations and lessons learned.

2. Background and previous literature

2.1. Assessment of homeless programs

In the traditional “treatment first” model, homeless people enter a shelter to work on their issues and to prepare them to move into their own place. The recent innovation, Housing First, reverses this process by giving homeless people access to housing immediately and unconditionally, as the starting point to work on their issues. It was developed by Dr. Sam Tsemberis in New York in the 1990s and originally targeted homeless people with mental health and addiction problems (Tsemberis, 2011).

Several rigorous empirical studies have demonstrated the effectiveness of the Housing First approach, especially in terms of housing stability (systematic reviews in the US, Canada and Europe are available in Aubry et al., 2014, 2015; Raitakari & Juhila, 2015). However, traditional services remain used and useful for several reasons. First, as Tsai et al. (2010) explain in an exploratory comparative analysis of the two approaches, the reality of the housing market makes the process of finding appropriate single accommodation at affordable prices long and difficult, so that temporary solutions must exist. Housing availability is a key barrier highlighted in many Housing First studies and well summarized by Gaetz (2010) in his question: “how effective can Housing First be if there is no affordable housing to move people into?” (p. 25). Second, as Tsai et al. (2010) further advance, some sub-populations might benefit more from one approach or the other. Indeed, the homeless population is very diverse, so that there can be no “one-size-fits-all” solution—and Housing First was originally designed for a specific and extremely vulnerable sub-population (Buxant, 2018b). Third, implementing a Housing First program with fidelity requires high capacity-building, along with training and technical support (Canham et al., 2019; Hasford et al., 2019; Nelson et al., 2014).

The effectiveness of the traditional “treatment first” model has been studied in various northern countries, including North America and Europe, although less in European countries (de Vet et al., 2013). These studies often looked at the housing situation of the homeless people after their discharge from the program (e.g. Glisson et al., 2001; Nelson et al., 2007). While the housing situation is a key dimension in the fight against homelessness, focusing only on that dimension has been criticized by some authors (Johnstone et al., 2016). Indeed, the interconnection between housing outcomes and multiple life domains such as physical health, mental health, social network, employment, substance use, and self-esteem has been documented (Barber et al., 2005; Gaetz et al., 2019; Pollio et al., 2006; Powell et al., 2016). Still, few studies adopt such a multidimensional perspective. Conversely, studies evaluating the impact of the Housing First approach tend to include multiple life domains, in order to evaluate the full potential benefits of the innovation (Buxant, 2018a).

Adopting a participative, multidimensional and mixed-method approach, this paper investigates the impact of a Belgian homeless long-term shelter on its residents, cross-checking outcomes identified

by its own stakeholders (residents, social workers and management team) against those investigated in the literature.

2.2. Homelessness in Belgium

Obtaining official figures regarding the number of homeless people is a complex process and one must often rely on estimations. In Belgium, overnight censuses of homeless people are organized on a regular basis in several cities with the help of foundations, research centers and associations. The latest census in the capital city, Brussels, was carried out in November 2020 and results showed that 4380 adults and 933 children were estimated to be homeless. This is a 27.7 % increase compared to 2018 results (Horvat & Striano, 2020). Unfortunately, the homeless population in Brussels has been increasing for some time and statistics from 2017 showed that it had nearly doubled in 8 years (+96 % between 2008 and 2016) (Mondelaers, 2017).

The Brussels homelessness sector involves many private and public actors and is characterized by a high institutional complexity that some deplore (Lelubre, 2014; Malherbe et al., 2019). Several studies have also stressed the growing disproportion of resources devoted to emergency homeless services in Brussels, such as emergency shelters or winter plans, to the detriment of more long-term solutions (Rea et al., 2001; Liagre, 2011; Lelubre, 2014). Consequently, long-term shelters, supported or transitional housing programs, and Housing First approaches are chronically saturated and some of them are tending to tighten up their entry requirements.

Developed in Brussels, and in four other major Belgian cities, the Belgian Housing First program was implemented and assessed from 2013 to 2016. Buxant (2018b) explains: “Because of the support provided to the 11 Housing First teams in Belgium over nearly five years, more than 400 long-term homeless people with very significant needs in terms of physical health, mental health or addiction, are no longer living on the streets and have successfully started their recovery and social integration process” (p. 234).

There are 17 accredited long-term shelters in Brussels, and these are members of a federation called AMA (*Fédération des maison d'accueil et des services d'aide aux sans-abri*), that collects data about their activities, including sociodemographic statistics on their residents (gathered in a database called AMAstat, that we used in our quantitative analysis). According to the decree granting the accreditation and subsidies to long-term shelters (May 27, 1999): “The mission of the long-term shelter is to provide reception, accommodation and psychosocial assistance adapted to the residents in order to promote their autonomy, their global well-being and their reintegration into society” (art. 2, our translation). The 17 Brussels shelters translated this statement into their own mission statements. In particular, the shelter under study states its mission in its annual reports as follows: “The objective of our shelter is to welcome and accommodate homeless men aged between 20 and 60 years old, who are

in material and moral difficulty and who wish to regain their autonomy and reintegrate into society” (our translation). This is very similar to the missions stated on the websites of the other Brussels shelters—autonomy and social reintegration are their overarching goals too. The statements are sometimes broken down into the primary or explicit objective of securing permanent housing and the secondary or implicit objectives of employment, relationships, health as well as a positive experience in the shelter as such.

2.3. The case: an emblematic Belgian long-term shelter

With a capacity of 84 beds for single homeless men, the long-term shelter under study is one of the largest in Brussels. This shelter is part of the social program of a social enterprise that works towards helping people living in precarious situations to become more autonomous. More precisely, the social enterprise combines the economic activities of collecting, sorting and selling second-hand items with social activities at two levels: (1) it employs people far from the job market in its economic activities (2) the profits from those activities are used to partly finance several social activities, the main one being the shelter.

The shelter offers an integrated approach. For a daily fee, it provides many services such as accommodation, meals, laundry, help with administrative paperwork, psychosocial support, health management, etc. Each resident has his individual room but they all share common facilities (showers, toilets, living rooms, smoking rooms) and eat every meal in a social restaurant on the top floor of the building. The shelter welcomes very diverse profiles—but the average resident is a single Belgian quadragenarian who stays for 6 months. Ten social workers are there during the day, and each has a caseload of 8 or 9.

The objective of the outcomes assessment was to evaluate the actual impact the shelter had on its residents in a participative approach. More precisely, it aimed to (quantitatively) measure and (qualitatively) understand the multidimensional effects of an average stay in the shelter on its residents. Eager to improve the effectiveness of the shelter, the board members and the directors of the social enterprise were largely supportive of the assessment.

3. Data and methods

The assessment was initiated in 2016. Formally, it relied on an embedded mixed method design where secondary (qualitative) data complement a primary (quantitative) research design (Creswell & Plano Clark, 2018). Mixed-method approaches are particularly relevant when studying homelessness, to provide a comprehensive view of the underlying mechanisms of an intervention (Meschede & Chaganti, 2015; Nelson et al., 2014). Here, the main methodology was quantitative, based on a before-

after econometric design, but with the valuable support of qualitative data and with the collaboration of several stakeholders.

3.1. The primary research design: a quantitative multidimensional approach

To develop the quantitative study, we first set up a collective mapping of all the potential, multidimensional effects that the shelter could have on its residents. The list of effects was gradually expanded thanks to the inputs from the shelter management team, social workers and residents. The most relevant outcomes were selected for data collection based on discussions with the stakeholders. We also compared and augmented the selection with the outcomes generally included in Housing First assessments, from our literature review.

Together with the stakeholders, we then co-created two questionnaires approaching those effects with indicators from the scientific literature – adapted to the context where necessary. One questionnaire was developed for the residents and one for the social workers. The questions were generally answerable on 5-point or 7-point Likert scales and there was always a choice not to respond (for ethical reasons). We opted for a before-after econometric design, collecting answers at the beginning of the resident's stay (T1) and after 5 months (T2) – the average duration of stay being 6 months¹. To ensure confidentiality, residents and social workers answered the questionnaires separately and in private. The questionnaires were loaded onto touch tablets with audio support available if the residents had difficulties reading the questions². Data were collected between December 2016 and April 2019.

The residents' questionnaire included questions on the following dimensions:

(1) Physical and mental health. For physical health, we used an indicator on general health from the Copenhagen Psychosocial Questionnaire (COPSOQ) (Pejtersen et al., 2010; Dupret et al., 2012), that asks the respondent how he would describe his health status (on a scale from “very poor” to “very good”). Studies have shown that people generally rate their health status correctly (Wu et al., 2013) and this indicator had already been used in homeless studies (e.g. Wojtusik & White, 1998). For mental health, we also used an indicator from the COPSOQ questionnaire, approaching the mental health dimension by combining questions related to trouble sleeping, stress and depression.

¹ Unfortunately, it was impossible to administer the questionnaire at the end of the residents' stay, for several reasons. Sometimes the residents just disappear. Sometimes they are expelled and that makes it awkward to ask them to fill in a questionnaire before they leave. And when they leave to take up a housing solution, they usually have a lot to do to prepare for the move, so they are not physically and mentally available to engage with such a questionnaire.

² Residents could ask the social worker for help with the questionnaire if needed, and a question on the social workers' questionnaire asked if they had often had to provide help, but usually, this was not necessary. Also, the questionnaire was introduced by a video from one of the researchers explaining the purpose of the study and clarifying how confidentiality would be ensured (the data from the questionnaires was sent directly to the university servers and only aggregated data would be communicated to the shelter).

(2) Life skills. We used the concept of life mastery (Pearlin & Schooler, 1978) – which is a psychological scale determining the extent to which the respondent believes he can influence the course of his life.

(3) Two types of social network: family and friends. We used items from the "family and social relationship" section of the Addiction Severity Index (McLellan et al., 1992). The questions were: "How many friends/family members can you count on?" Similar indicators have been used in other studies on homelessness (e.g. Wagener et al., 2022).

(4) Access to services (housing, psychological assistance, employment): this we call "assistance network". We used items specially developed for that particular questionnaire, i.e. we asked the residents to indicate how many housing / employment / psychological services they knew.

The social workers' questionnaire included questions related to the residents' autonomy skills (complementing the 'Life skills' dimension (2) listed in the residents' questionnaire) and two aspects that were considered too sensitive to ask to the residents directly: hygiene and addiction (complementing the 'Physical and mental health' dimension (1) listed in the residents' questionnaire). More specifically, it approached the aspect of the residents' autonomy through one question (created for the questionnaire), asking social workers to estimate the level of autonomy of the residents in daily life. The hygiene aspect was evaluated through four items developed by Blankertz & Cnaan (1994): shower/bath, change clothes, clean personal area and take mental health medication. Social workers were also asked to estimate the frequency of substance use (alcohol and cannabis) of the residents³.

Housing and income information was not included in the questionnaires since, together with other sociodemographic data, the shelter already records those data for all the residents in AMAstat⁴.

We conducted paired sample t-tests on the panel data to test if changes between T1 and T2 were significant⁵. Since our data did not respect the assumptions made for t-tests (notably the normality assumption), we conducted the equivalent non-parametric tests, i.e. Wilcoxon matched-pairs signed-rank test (Wilcoxon, 1945). Although they generally have lower statistical power than parametric tests, nonparametric tests permit statistical tests without any hypothesis on the data distribution and are thus

³ We tried to gather information from the residents using the 4 items of the CAGE questionnaire (Mayfield et al., 1974) but the majority of the residents chose to skip that section.

⁴ As explained, AMAstat is a database used in many shelters and managed by the AMA federation. For each stay, AMAstat records the start and end date of the stay and several items of information about the resident (age, education level, income at entry and exit, nationality, where the beneficiary spent the night before coming to the shelter, where he went when he left the shelter, if departure was arranged with the shelter or whether the decision was made unilaterally, etc.).

⁵ Given the small size of the panel sample and the small expected size effect, it was not possible to adjust the significance level (type I error rate) for multiple testing using the Bonferroni correction, so as to avoid further reducing the statistical power.

more accurate in our case. Consequently, in the results section, we report on the Wilcoxon tests, which gave very similar results to the t-tests⁶.

3.2. The secondary research design: a qualitative approach

The assessment also aimed to uncover the processes underlying the effects measured in the quantitative study. Consequently, we conducted interviews and set up focus groups with the social workers and the residents (that we recorded and transcribed) at two different times.

First, during the quantitative data collection, the goal was to discuss the assessment process and determine whether any adjustments needed to be made to the questionnaire, but it was also an opportunity for discussing the social work at the shelter, the challenges, and the results expected from the study. More precisely, we set up four focus groups with social workers and three focus groups with residents, and we conducted thirteen individual interviews with social workers and four with residents.

Second, after the data collection, we presented the results of the quantitative analysis to the social workers through an interactive gathering, and we conducted six workshops with them to capitalize on their expertise and gather their insights on those quantitative results⁷. We also conducted one workshop with the residents to discuss the results with them.

In parallel and during the whole assessment, we conducted participatory observation, spending full days at the shelter so as to observe the social work in context, participating in numerous meetings with social workers, members of the management team and the board, and having many informal discussions with the residents as well. Our observations were logged in a field journal.

We analyzed the qualitative data using Nvivo software by categorizing them according to the variables of the quantitative analysis. All the quotes of this paper are translated from French and are our own translations.

3.3. Variables on outcomes

The quantitative results are based on 128 observations from the 64 residents who answered the questionnaire in T1 and in T2. Table 1 presents the main variables we used in our analysis.

⁶ We also tried resampling techniques, i.e. permutation tests with Monte Carlo simulations – which also gave very similar results. Resampling is another way of statistical testing without assuming a specific data distribution. It is based on a large number of random permutations of the sample data to “create” a distribution for comparison with the observed test statistic.

⁷ The topics of the six focus groups were: “good departure” from the shelter, addiction, recurrence (when residents stay at the shelter more than once)] health, occupation and autonomy.

Table 1 – Description of the main variables used from the questionnaires

Variable	Description	References	Questionnaire	Range
<i>Physical and mental health</i>				
Stress	Indicates the resident's level of stress computed as the mean of 7 items (Cronbach's alpha: 0.8541)	COPSOQ	Residents	1-7
Addiction	Indicates the frequency of alcohol and cannabis use by the resident	Purpose built	Social workers	1-7
Health	Indicates the resident's general health condition (from bad to good)	COPSOQ	Residents	1-7
Hygiene	Indicates the resident's hygiene computed as the mean of 4 items (Cronbach's alpha: 0.8166)	Blankertz & Cnaan, 1994	Social workers	1-7
<i>Life skills</i>				
Life mastery	Indicates the feeling of control the resident has over his own life computed as the mean of 4 items (Cronbach's alpha: 0.7355) ⁸	Pearlin & Schooler, 1978	Residents	1-7
Autonomy	Indicates the level of the resident's skills for an autonomous daily life	Purpose built	Social workers	1-7
<i>Social and assistance network</i>				
Family network	Indicates how many family members the resident can count on	Addiction Severity Index (ASI)	Residents	0-6+
Friends network	Indicates how many friends the resident can count on	ASI	Residents	0-6+
Housing services	Indicates how many housing services the resident knows of	Purpose built	Residents	0-4+
Employment services	Indicates how many employment services the resident knows of	Purpose built	Residents	0-4+
Psychological services	Indicates how many psychological services the resident knows of	Purpose built	Residents	0-4+

3.4. Sample bias investigation

Our goal was to collect data on all of the residents staying at the shelter during the data collection period. In the end, we managed to collect data on half the residents, which creates potential biases. The main reasons for missing questionnaires were: short stay, inability to understand French, mental health problems, and refusal to complete the questionnaire. Using the AMAstat database, which covers the whole population, we were able to assess sociodemographic biases, which appear to be limited. Data on the whole population are rarely available but they allow investigating several biases – not only the common attrition bias of respondents leaving the sample between T1 and T2. Below, we present the two biases we think are the most important.

We collected 212 questionnaires in T1 and 64 corresponding questionnaires in T2. The results of the quantitative analysis are based on 128 observations corresponding to the 64 pairs of questionnaires in T1 and T2 (we also report descriptive statistics from the 212 answers in T1 to give a broader picture

⁸ The original scale includes seven items. Six were included in the questionnaire but we had to remove two items in the analysis to ensure a proper internal consistency of the scale (Cronbach's alpha > 0.7).

of the residents' situation when they arrive at the shelter). During that same period of those 64 stays, 294 other stays began at the shelter – of these, 56 lasted for at least 5 months⁹. Using AMAstat, we quantified biases between those subpopulations thanks to Pearson's Chi-squared tests, when the variables were categorical, and Student's tests, when the variables were continuous, with a significance level of 5 %. Table 2 displays the average characteristics in the sample, the overall population and the sub-population of residents staying at least 5 months, as well as the p-value of the tests.

Bias 1: is the panel representative of the whole shelter population? We compared the administrative characteristics of the 64 panel residents (who answered the questionnaires in T1 and T2) with those of the 358 stays (including the 64 panel residents) that started at the shelter in the same period as the panel. As indicated in column (3) of Table 2, we found no significant difference in terms of education, recurrence, nationality, income and accommodation at entry. Only the average age of the residents in the panel is slightly higher.

Bias 2: is the panel representative of the population that stays at the shelter for at least 5 months? We compared the administrative characteristics of the 64 panel residents (who answered the questionnaires in T1 and T2) with those of the 120 residents (including the 64 panel residents) who entered the shelter during the same period and who all stayed at the shelter for at least 5 months (i.e. who should ideally have answered the questionnaire in T1 and T2). As indicated in column (5) of Table 2, we found no significant difference in terms of age, recurrence, nationality, income and accommodation at entry. Only the level of education of the residents in the panel is slightly lower.

⁹ The mean stay duration is 6 months and the median stay duration is 3.5 months.

Table 2 – Sample description and biases

	(1)	(2)	(3)	(4)	(5)
	Sample (64 panel data)	Overall population (358 stays)	<i>Test for bias 1</i> (<i>p-value of the test</i>)	5 month population (120 stays)	<i>Test for bias 2</i> (<i>p-value of the test</i>)
Age (in years)	42.5	39.5	(0.03)*	42.7	(0.92)
Age categories			(0.18)		(0.90)
18-29 years	12.5 %	18.7 %		12.5 %	
30-49 years	62.5 %	62.8 %		61 %	
50+ years	25.0 %	18.4 %		26,5 %	
Recurrence (% of first stays)	32.8 %	32.4 %	(1.00)	28,3 %	(0.34)
Nationality (% non- Belgian)	32.8 %	34.9 %	(0.81)	40 %	(0.13)
Education ^a			(0.13)		(0.05)*
Lower	62.5 %	55.3 %		55.8 %	
Higher	28.1 %	38.3 %		37.5 %	
Other	9.4 %	6.4 %		6.7 %	
Income (% having a source of income at entry)	43.75 %	35.6 %	(0.18)	37.5 %	(0.19)
Housing the night before ^b (% who slept in an accommodation the night before entering the shelter)	39.7 %	34.9 %	(0.46)	38.3 %	(0.88)

Notes: ^a Lower = primary school or first 3 years of secondary school; Higher = 6 full years of secondary school or higher education. Other = unknown, specialized education, none. ^b Accommodation includes the resident's own accommodation or a friend/relative's accommodation. No accommodation includes on the street, an emergency shelter, jail, or hospital.

We are aware that some inevitable biases might remain, in line with the main reasons for missing questionnaires and the ethical concerns that such assessments raise. In particular, we could expect some restraint from the residents in terms of (negative) answers and comments or the non-participation of the most dissatisfied residents, resulting in an overestimated (positive) impact of the shelter. Nonetheless, as the findings will show, criticisms were still widely expressed and several areas for improvement were identified.

4. Findings

This section presents the main results of the outcomes assessment. It is organized into four main subsections corresponding to the selected outcomes. For each subsection, we begin by referring to Table 3, which summarizes the quantitative results, and we then interpret those results with the qualitative data. The first two columns of Table 3 are descriptive. Column (1) displays the average value in T1 for all the variables based on the 212 questionnaires collected in T1 to give a broader picture of the residents' situation when they enter the shelter. Column (2) displays the range of each variable. The last two columns report on the Wilcoxon paired tests, based on 128 observations corresponding to the 64 pairs of questionnaires. Column (3) displays the size effect (the average difference between T1 and T2) and

column (4) displays the p-value of the test. Wherever possible, we discuss those quantitative results, referring first to the residents' qualitative inputs and then to those of the social workers.

Table 3 – Effects of a stay at the shelter

Variables	(1) average in T1 (n = 212)	(2) Range	(3) Size effect (n = 64)	(4) Wilcoxon tests (Prob > z for H ₀ : Δ _{T2-T1} = 0)
Income and housing				
			<i>(n = 212 here)</i>	
Income	0.60	0-1	+0.38^a	-
Housing	0	0-1	+0.32^b	-
Physical and mental health				
Stress	3.42	1-7	+0.31	0.0351*
Addiction	3.04	1-7	+0.47	0.0411*
Health	5.03	1-7	-0.13	0.5416
Hygiene	5.59	1-7	-0.08	0.5722
Life skills				
Life mastery	4.05	1-7	+0.26	0.1148
Autonomy	5.19	1-7	-0.11	0.4112
Social and assistance network				
Family network	1.58	0-6+	+0.13	0.5598
Friends network	1.44	0-6+	+0.02	0.8092
Housing services	2.05	0-4+	+0.52	0.0125*
Employment services	2.13	0-4+	-0.06	0.7977
Psychological services	1.45	0-4+	0	0.9307

Notes: ^a Of the 212 residents who entered the shelter, 60 % already had a source of income, while 98 % of residents left the shelter with a source of income. ^b And although, obviously, no resident entered the shelter when they had a housing solution, 32 % left the shelter with a housing solution.

4.1. Income and housing

This section discusses the evolution of the residents' income and housing situation¹⁰.

Income. When a homeless person enters the shelter, the priority, with the help of their social worker, is to sort out their administrative situation. This paperwork includes regaining access to an income (e.g. through having an official address or through applying for unemployment benefit). We can generally say that, under Belgian legislation, every citizen has a right to a minimum (though not always adequate) income, for all citizens whose administrative affairs are in order. Income information is included in the AMAstat database. Using this database, we see that 60 % of the residents who answered in T1 had an income when they entered the shelter and 98 % left the shelter with an income. (Only residents who are at the shelter for a very short time will remain without any income.)

Housing. Housing information is also included in the AMAstat database. Twenty-seven percent of the residents who answered in T1 moved out of the shelter and into accommodation on their own and

¹⁰ While we present the proportions for the 212 beneficiaries who answered in T1, AMAstat covers the whole population and the proportions appear quite stable over the years. Between 2014 and 2018, of the 947 beneficiaries who left the shelter, 92 % left the shelter with an income, 29 % moved to a housing solution and 6 % went to hospital.

5 % went to hospital for medical treatment. The others left to go to a precarious solution (e.g. temporarily to a relative's house) or to no solution at all, or to a destination that is unknown to the social workers inputting the data in the database.

Some residents complained that they did not get enough support from the shelter to find accommodation. For their part, social workers explained how “complicated” the housing market is in Brussels: social housing has endless waitlists and private housing is generally too expensive for the residents' small income.

4.2. Physical and mental health

This section discusses the physical and mental health dimensions, i.e. the stress felt by the residents, their addiction issues, their general health and their hygiene.

Stress. Table 3 shows an increase in the stress felt by the residents between T1 and T2. Although residents are stressed by their precarious situation, one would have expected that their stress would decrease as they settled in during their stay. However, in the interviews and focus groups, social workers and residents explain that the shelter itself generates stress. One stressor frequently mentioned is the community life with 84 different personalities.

Resident 1: "We can be stressed 24 hours a day if we want to, here". [...] Resident 2: "Yeah, it's not easy because we're not really made for communal living."

"We don't all get along here. There are sometimes tensions between residents." (Resident)

Residents and social workers also explained that the restrictive environment of the shelter with its heavy rules becomes more and more of a burden during the residents' stay. As an emblematic example, residents are stressed by the nightly patrol of the rooms (for safety and control purposes) as it disturbs their sleep.

"It's very unpleasant to be woken up [during the night because of the patrols], so you have to wait until 1 a.m. to fall asleep." (Resident)

"I think that the constraints of the shelter become very heavy as time goes by. And particularly, really that aspect of sleep. [...] [And] the fact that they become more aware of [the reality of] their situation as they go along." (Social worker)

The increase in stress can also be explained by the residents' gradual awareness of their issues—issues they might have been in denial about. Typically, during administrative resolution, problems catch up with them, and it is important to deal with them one by one.

"We're under a lot of pressure here, it's terrible. We're under pressure to get administrative things done." (Resident)

"There are also people who set themselves unrealistic goals, you see – like "I'm going to pay off my debts within three months." [...] so sometimes you have to go through their problems with them and together look at how they can solve their problems, how long it's going to take and also to try and 'compartmentalise' the actions. Because if you see your whole situation like

that, you run the risk of just packing up your stuff and leaving, and going off to who knows where." (Social worker)

Addiction. Table 3 shows an increase in the frequency of alcohol and cannabis use. Since this variable is based on the social workers' questionnaire, this increase may also reflect the social workers' increased awareness, over time, of the residents' substance use. Residents often hide these issues to increase their chances of getting into the shelter (and some residents are not aware of them), but may recognize their addiction problem later. For example, residents explained:

"Being homeless makes you see the ugliness of the world. So we drink to cope with it all." (Resident)

"I'm currently going through alcohol withdrawal but it's rather complicated." (Resident)

For their part, social workers explained in interviews and focus groups that consumption is facilitated and there is greater temptation in the shelter because it brings together many substance users under one roof. Drug dealing is a regular occurrence.

"These are not really times that are conducive to a reduction [of substance use] and in the end, isolation and anxiety cause consumption to increase in general." (Social worker)

"Then there's also the group effect. The number of young people who started smoking [cannabis] when they were staying at the shelter, even though they had never touched it before..." (Social worker)

General health. As shown in Table 3, we found no significant evolution in the residents' perceived health status. In the interviews and focus groups, this result surprised the social workers, because for some residents, the stay in the shelter is a major opportunity to set up a specific medical treatment to improve their health. At the same time, as the social workers also explained, a serious health issue can't usually be cured in 5 months and a chronic disease (e.g. diabetes, hypertension) will never be cured. However, at least the medical checkup on arrival and the medical service available in the shelter throughout the stay means that a medical file is set up for each resident, where important health information is logged.

Hygiene. Table 3 shows that residents have a high level of hygiene on average when they arrive at the shelter and that is maintained throughout their stay. Although this aspect was not widely discussed in interviews and focus groups, social workers explained how delicate and difficult it was to bring up this subject with residents when necessary.

4.3. Life skills

This section discusses what we called "life skills" and looks at life mastery and autonomy, respectively.

Life mastery. Table 3 shows that life mastery—i.e. the feeling of control over one's life—increases during the stay, but not significantly. The shelter's management team hoped to impact that

dimension during the stay but the data could not confirm this. Residents shared with us the difficulty of admitting that they can't cope with their lives by themselves and need the shelter to help them sort their problems out.

"We're not able to pick ourselves up by ourselves, so thankfully the shelter is there." (Resident)

"It's the fact of admitting that 'shit, I need this'. It's not easy. We have our stupid little pride." (Resident)

Social workers also explained how residents "carry the burden of poverty" and have to "live in a game (i.e. society) whose rules are against them", which could explain why their mastery does not increase.

"It's very violent to put the responsibility of finding accommodation on someone who has neither the income nor the CV to seduce a private landlord who has a huge choice [of tenants]. It's very violent. The responsibility should not be on him. Systematically speaking, the guy is trapped." (Social worker)

Furthermore, life mastery might not significantly increase because of the perceived infantilization of the residents in the shelter. This idea is developed in the next paragraph.

Autonomy. Table 3 shows no significant increase in the autonomy (as assessed by the social workers) between T1 and T2. This finding is reinforced by a specific, only ex-post (T2) question – "To what extent did the resident develop new skills that will serve him in his future life?"—to which social workers answered on average "moderately" (3/5) (not reported in Table 3). While autonomy is one of the shelter's core objectives, focus groups revealed that this result was paradoxically not surprising for the residents and the social workers. Indeed, residents complained that the shelter infantilized them. They also explained that disciplinary meetings with their reference social worker could be humiliating.

"We're children here, we're infantilized. They manage our money, they manage our whole life." (Resident)

"[about disciplinary meetings] I call it a council of war. We get told off, like children." (Resident)

Social workers also expressed substantial criticism of the way the shelter functioned: they consider it infantilizing or dehumanizing for the residents, in part because of its big size.

"To make it work for 85 residents, you need a big set of rules." (Social worker)

"When they come into the shelter, we kind of break their autonomy because we do everything for them. We manage their money. We remind them when they have to do the cleaning [...]. Dinner is cooked for them [...]. And so, in the end [...], they unlearn how to organize themselves because we're really behind them." (Social worker)

The level of autonomy is already quite high when residents arrive at the shelter—because they "had a life" before entering the shelter, as some social workers put it. At the same time, this aspect is not explicitly worked on during the stay. On the contrary, residents and social workers even perceived

the shelter as a barrier to the development of the residents' autonomy. A symbolic example of this is the transfer of the management of the residents' financial affairs to the shelter.

Resident 1: "Indeed, it's frustrating. Now you're thinking, "Shit, I can't manage my money any more"". Resident 2: "It's true that you feel like a kid coming to get his pocket money."

"It's kind of our mission, to empower people but yes, certainly, there's a lot of stuff that we... Well I don't know how we could have incorporated that into the questionnaire, to measure people's autonomy in a place where, basically, from the moment they arrive, everything is taken care of for them and, so, well, we don't really work on their autonomy, not really, no." (Social worker)

Social workers also said that the support to the residents is too generalized (not tailored to their specificities) and rigid (does not evolve during the stay).

"I think that as residents evolve during their stay at the shelter, the setting should also evolve and become less restrictive. [For example], a guy who's been here for a while and for whom things are going well and all that, why is he still having to go and ask for money every week? [...] Quite a few institutions work in 'phases', depending on where the residents are in their stay and how much headway they're making." (Social worker).

4.4. Social and assistance networks

In this section, we examine two types of networks: the social network (family and friends) and the assistance network (access to support services).

Social network. As reported in Table 3, we did not observe a significant expansion of the residents' (initially very small) network of friends or family during their stay. Residents have usually 'drained' their personal network before coming to the shelter; or they want to break away from their harmful social network.

"I'm realizing that I can't count on many people anymore because I have exhausted them too much on certain points." (Resident, quoted by a social worker)

"I'm trying to get out of the hotel and restaurant business and to break with my social network, which is all about nightlife and partying." (Resident)

For their part, although they believe that the lack of social network is an important part of the residents' precariousness, social workers explained that they do not intervene in the residents' personal relationships out of respect for their privacy.

"Afterwards, re-establishing a network of friends, that's really complicated for us to do. We can set up a professional network [...] but finding friends for them, that's not possible. But yes, they are very isolated, and there's often a fear too, and we do warn them, but when a guy lives here for 18 months, supervised by 10 social workers, and there are 84 people around, to then find himself alone in housing, it's a shock. It can be hard to live with, really." (Social worker)

Surprisingly, the shelter's communal lifestyle does not seem to counteract the residents' feeling of isolation.

"On one occasion, a resident was talking to us about the loneliness he felt here and we told him we were here and he almost shouted 'No, YOU'RE NOT HERE', [meaning that] we aren't present in the way he would want us to be." (Social worker, quoting a resident)

"I think it's a feeling shared by many of the residents; despite everything, they feel alone, even though they're here with 80 other people and even though we're here too." (Social worker)

Assistance network. Table 3 shows an increase in the number of housing services that residents are aware of, but not in the number of employment and psychological services. This finding is reinforced by a specific, only ex-post (T2) question—"To what extent did you learn about new services?"—to which residents answered on average "moderately" (3/5) (not reported in Table 3).

This result illustrates the focus placed on housing in the social work aimed at residents' reintegration into society. Social workers and residents sometimes question the relevance of this focus.

"But, in the end, a lease means nothing. [...] they give up on housing because housing is not everything, it's not everything. There's something else behind that and that 'something else' is very difficult to work on here." (Social worker)

"Psychological work should be a priority, rather than finding housing as quickly as possible." (Social worker)

5. Discussion

This study contributes to the literature by providing a comprehensive outcomes assessment of long-term shelters through a Belgian case study. In short, we find that the shelter struggles to have significant positive effects other than improving their residents' administrative situation (mainly, access to an income). In terms of housing, the results show that 27 % of the residents moved from the shelter into their own accommodation. Other shelters in Brussels show similar results (Mennig & Vanhessen, 2018), illustrating the difficulty of rehousing homeless people. By contrast, maintaining housing obtained in a Housing First model seems effective. Buxant (2018b) explains that for the Belgian experiment: "findings indicated that vulnerable individuals who have experienced long-term homelessness are able to move into houses directly from the street and maintain housing, with 93 % of the participants in the experimental cohort remaining housed after the second year" (p. 232). As the assessment was participative, all the findings were discussed with the shelter stakeholders and integrated into a strategic review to improve shelter effectiveness. The shelter management team was willing to develop more partnerships to increase access to affordable housing.

In terms of physical and mental health, we see that a stay in the shelter tends to be stressful for the residents. The literature partly confirms our results. Indeed, it is recognized that homelessness is stressful in itself, but so is life in the shelter (Rowland, 2020). Klitzing (2004) shows that after moving into a shelter, residents continue to experience difficult situations and chronic stress. The author explains

that the most frequent coping strategy is to spend time with others and he points out that leisure activities tend to decrease the stress. In our case study, though, spending time with other residents does not necessarily lead to a reduction in stress. On the contrary, some residents stated that living in a big community contributed to an increase in their level of stress. Although it might reduce the feeling of loneliness, living in a community can generate many stressors, such as high noise levels and violence (Uribelarrea, 2020). Duperron & Uribelarrea (2021) also underline the tension between the pleasure of ‘being together’ and the tiring aspect or weariness of ‘being with’. Based on these findings, the shelter stakeholders discussed the relevance of reducing the size of the shelter (which is one of the largest in Brussels) and in parallel better expanding the (currently few) leisure activities, notably through partnerships, to create more interactions with people inside and outside the shelter.

With respect to substance use, it is difficult to assess this accurately and it is probably underestimated (Pierre-Marie & Roger, 2014). However, our assessment reveals that substance use tends to increase during residents’ stay, as the presence of many substance users in the same place generates an incentive. Wusinich et al. (2019) also note that sobriety is hard to achieve in shelters. While reducing substance use is challenging for all homeless service providers, the Housing First approach eliminates proximal triggers (from living in a confined space with other substance users) and does not increase problematic substance use (Baxter et al., 2019; Kerman et al., 2021). Furthermore, this approach follows harm reduction principles, which focus less on consumption per se and more on reducing negative impacts of consumption (Kerman et al., 2021; Watson et al., 2017). Similarly, some authors ask themselves whether it might be better to focus on other aspects and hope that this in turn will lead to a decrease in substance use (Adlaf et al., 1996; Sibthorpe et al., 1995). Karabanow & Kidd (2014) explain: “Drug use is likely a symptom of other problems that need to be addressed just as urgently” (p. 25). The same words were said in our interviews. Here again, reducing the size of the shelter might mitigate the incentive effect.

In terms of general health and hygiene, our quantitative results show that there is no significant evolution in this area, whereas other studies showed an improvement in the long run (Hwang et al., 2005; Schanzer et al., 2007). Health recovery is a long-term process that cannot be achieved in 5 months. Therefore, using the stay in the shelter to open a medical file and secure an access to medical care seems to be the most important step here.

Concerning life skills, although autonomy is key in the shelters’ mission, we did not find any significant increase in this dimension. Other authors have highlighted this paradox before (Graham & Stokkink, 2016; Maes, 2011). For example, Levy (2015) explained: “Entry [of homeless people] into a social service [such as shelters] can thus be described as a loss of autonomy, even though the promotion of autonomy is often the watchword in this sector” (p. 10). This is an important difference with the Housing First program, where residents must take care of themselves in their own accommodation with

a one-off support from social workers (Buxant, 2018b; Tsai et al., 2010). When discussing this autonomy paradox with the shelter stakeholders, the social workers highlighted the fact that autonomy can ultimately become a kind of “social injunction” (Foray, 2017; Lelubre, 2014), while at the same time expressing the need to reduce the infantilizing processes and dependency on the shelter. In particular, they said that shelter support should evolve during the residents’ stay, to improve residents’ independence and life mastery (e.g. more autonomy in their budget management). Individualized support instead of the current generic one should progressively give greater autonomy to residents—and it might also reduce the stress to conform to the many heavy rules. Reducing the size of the shelter would facilitate the implementation of this individualized support.

Finally, regarding networks, we did not observe a significant expansion of the residents’ friends or family network during their stay. Although recreating strong social links (that were sometimes “strained”) has been stressed as crucial to exit homelessness (Thompson et al., 2004), this is a very long process (Wagener et al., 2022). The suggestion to develop more leisure activities with people inside and outside the shelter should improve this aspect. Regarding the network of support services, our results show that only the number of housing services that the residents are aware of increases during their stay. This illustrates the focus on housing for reintegration into society. However, some authors have emphasized the importance for homeless people to reconnect with a wide range of support services (social, psychological, health, etc.) so that they know where to go when they encounter the next significant difficulty (Council to Homeless Persons, 2021; Thompson et al., 2004; Wagener et al., 2022). The results might also be linked to the tendency of the shelter to develop all the services in-house instead of building partnerships with external services—which the shelter stakeholders would like to increase in the future.

6. Conclusion: limitations and lessons learned

To our knowledge, this paper presents the first study using mixed methods that investigates the multidimensional effects generated by a Belgian long-term homeless shelter on its residents. We investigated several outcomes: income and housing, physical and mental health, life skills, social and assistance network.

The mission of long-term shelters is broad and ambitious, i.e. their aim is to achieve residents’ autonomy, global well-being and reintegration into society. However, our assessment shows that the shelter we studied struggles to have positive effects beyond the immediate effects of providing basic care (a roof, food and administrative support) and that the stress felt by the residents even tends to increase during their stay. Of course, one limitation of our study is that we only studied one long-term shelter in-depth. Having said that, we did have the opportunity to present and discuss our results at a

workshop organized by the AMA federation with several shelters: they were not surprised by the findings, and these were supported by their own experiences. And although our assessment also suffers from the typical longitudinal studies biases (i.e. selection and attrition) and the impact might be overestimated because of self-censorship from some residents, we think the triangulation with qualitative data offers valuable insights for improving the effectiveness of long-term shelters. Another limitation was the relatively short time-span between T1 and T2 (i.e. 5 months) for observing significant changes; or it can be seen as public policy being unrealistic regarding the mission of long-term shelters—we will end this section on this.

From our findings and collectively with the shelter stakeholders, we draw several recommendations. First, shelter support can be more effective if it is less generic, more individualized, and if it evolves during their stay. This can help residents regain the autonomy that is at risk in the long-term shelters (even though it is a key objective). This in turn can reduce residents' stress.

Second, reducing the size of the shelter while at the same time fostering community living could help reduce the seemingly undesirable effects of 'large-community' living and still retain the positive aspects. This can help reduce the residents' stress induced by the size of the community, limit the negative influence of others in terms of substance use, and improve the limitations on residents' autonomy which are a by-product of the (many) rules which are necessary to make such a big place work. At the same time, residents also suffer from loneliness, and studies on Housing First have shown that when they are in their own accommodation, being alone within those four walls is also a major difficulty. This is why generating more leisure activities with people outside and inside the shelter is also important.

Third, developing more partnerships within the ecosystem is likely to broaden the residents' social and assistance networks. It should also contribute towards tackling well-known housing market complexities.

We might add a fourth recommendation at a public policy level. Indeed, the expectations of the public authorities which translated into public policies—such as the decree granting the accreditation and subsidies to long-term shelters and defining their mission—are very high, asking the shelters to achieve residents' autonomy, global well-being and reintegration into society. One might wonder whether this is not too much given the shelter's limited means. In this context, refocusing the mission of long-term shelters towards more realistic objectives might be a useful first step. As one social worker summed it up perfectly: "There is no doubt that this shelter is needed in Brussels. There is even a need for more. But as it is, for it to provide something other than food and lodging is rather a matter of luck."

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