SOCIAL PARTICIPATION OF HOMELESS PEOPLE

Evaluation of the Intervention "Growth Through Participation"

Miranda Rutenfrans-Stupar

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*"If you can dream it, you can do it.
Always remember this whole thing was
started with a dream and a mouse".*

Walt Disney (1901 – 1966)

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Chapter 1

General Introduction

INTRODUCTION

Truus is an outspoken but modest woman, past the age of sixty. She has had her share of challenges in life, including a divorce, issues with alcohol, a troubled relationship with her two sons, and many illnesses and deaths among people near and dear to her, as a result of which she has started feeling lonely and no longer takes proper care of herself. In addition, she has trouble meeting all the demands imposed by contemporary society: Her administration is no longer up to date, she has neglected to pay the rent for almost one year, and she has difficulty dealing with all the (electronic) developments. Since she was at risk of being evicted from her dwelling, she was put in touch with a social care organization. This organization has arranged weekly visits by a social worker to help overcome her arrears in rent and to regain control over her life. This worker has also supported Truus in her attempt to re-establish contact with her sons. By acknowledging Truus's talents ("she can make such beautiful clothes, thanks to her years of experience as a seamstress") and by sharing in light-hearted fun, the worker has helped Truus to develop a much more positive mood. She is in touch with her sons again, one of them even helps her with the administration including rent payments, and alcohol has become less of a problematic issue. Truus has also started participating in social activities again, such as a cooking club and handicrafts group. Her presence there is strongly appreciated, because she has such wonderful stories to tell, is open and has a good sense of humor. Truus feels recognized and valued by others. Despite the physical constraints that come with her age, she feels good. She has even found a volunteer who will turn her life story into a book. Truus now radiates happiness and pride; She feels like she can take on the whole world again.

This case illustrates that it is important for (potentially) homeless people to participate in society in order to enhance well-being. It is a challenge for social workers and (mental) health care workers to support their clients by enhancing social participation. Every day social workers contribute to the social and mental functioning of their clients, including potentially and formerly homeless people. This leads to questions such as: What is the best way to improve social participation of homeless people? Which factors play a role in enhancing or impeding social participation? Why is social participation so important? And what is the role of the organization (including management) where they are employed in enhancing clients' social participation and well-being? In this thesis, these complex questions will be answered.

Social participation, which can be defined as "involvement in activities providing interactions with others in society or the community" (Levasseur, Richard, Gauving, & Raymond, 2010, p. 2146), is important for homeless people because they are often

socially isolated (Van Straaten et al., 2016). The majority of the homeless population has to deal with negative life events, such as a loss of their house, their job, and their social ties with family and friends (e.g., Van Doorn, 2005; Wolf, 2016). Additionally, some homeless people have even lost crucial social participation skills because of poor physical and mental health conditions (Gadermann, Hubley, Russell, & Palepu, 2013), substance abuse (Tam, Zlotnick, & Robertson, 2003), and aggressive behaviors (Fazel, Khosla, Doll, & Geddes, 2008). Hence, for homeless people it is particularly difficult to participate in society again. For shelter facilities it is also a challenge to enhance social participation for homeless people, because the contemporary approach is to offer them housing programs. Although these kinds of programs lead to good results, there are also negative side-effects such as loneliness (Busch-Geersema, 2013) because of a lack of social participation. Therefore, shelter facilities should focus on enhancing social participation aside from offering housing programs.

The current thesis attempts to contribute to our understanding of social participation of homeless people in the Netherlands. It especially focuses on the evaluation of a participation-based intervention with the aim to enhance well-being of (formerly) homeless people: Growth Through Participation (GTP – in Dutch "Verder Door Doen") (SMO Breda, 2014a). The present chapter first defines "(formerly) homeless people" and describes the size and other characteristics of the Dutch homeless population. Second, the concept of social participation is discussed, including its relevance, predictors, and outcomes. Third, information on strength-based and recovery-oriented approaches in relation to social participation and GTP is provided, followed by a brief description of GTP. Finally, this chapter ends with the aim and outline of the current thesis.

HOMELESSNESS IN THE NETHERLANDS

Definition
Similarly to many other countries (Demaerschalk et al., 2018), the Netherlands employs various definitions of homelessness (Van Doorn, 2005). The first definition is frequently used in practice and defines homeless persons as "all people who receive support from an organization providing shelter and ambulatory care" (e.g., Planije, Tuynman, & Hulsbosch, 2014). This definition includes people who are living in their own dwelling and receive ambulatory care from a shelter facility. People who have their own dwelling are often still at risk of homelessness, largely due to financial problems and/or (mental) health conditions. For example, research showed that 17 to 25% of people relapse in homelessness after they obtained housing (Mayock, O'Sullivan, & Corr, 2011; Tuynman & Planije, 2012). To prevent possible relapses, people who are at risk of relapsing into homelessness can receive support from a shelter facility. The second definition distin-

guishes two categories, namely literal and residential homeless people. Literal homeless people refers to persons who do not have their own living residence, do not have a fixed address, and make only short term use of night shelters, as well as people who stay with family and friends on an informal basis. Residential homeless people refers to persons who stay in residential shelters for the homeless (Van Doorn, 2005; Wolf et al., 2002). The third definition is based on an internally used framework, namely the European Typology of Homelessness and Housing Exclusion (ETHOS), and states that only people who are roofless, houseless (e.g., residential clients of a shelter facility), or living in insecure or inadequate housing are considered "homeless" (Amore, Baker, & Howden-Chapman, 2011; Feantsa, 2005).

In the current thesis the first definition is used, because it is the most comprehensive definition as it includes people who are (still) at risk of becoming homeless. Besides, this definition is also used in the context where the research described in the current thesis was conducted (i.e., SMO Breda). Finally, this definition includes people who live in a residential shelter and people who receive ambulatory care from (social) workers of a shelter facility. The latter are persons who have been at serious risk of losing their dwelling or who were (literal or residential) homeless in the past. Hence, these people can also be considered as *formerly* or even *potentially* homeless people. In the current thesis the following terms are used interchangeably: homeless people, homeless clients, (formerly) homeless people, (formerly) homeless clients, and (potentially and formerly) homeless people. These terms all refer to the first definition: "All people who receive support from an organization providing shelter and ambulatory care".

Description of the Homeless Population
To estimate the size of the homeless population, the definition issue also plays a role (e.g., Demaerschalk et al., 2018), which is particularly visible at the European level. Nationally comparable figures are not available because every country has its own system to report the number of homeless people, so no reliable figures can be found on the total number of homeless people within the European Union. However, it is clear that the number of homeless people in the individual EU Member States has increased enormously in recent years: with the exception of Finland (Feantsa, 2018). In the Netherlands, Statistics Netherlands (CBS) has been monitoring the number of homeless people since 2009. This number only includes registered homeless people who receive benefit under the Work and Social Assistance Act (Wet Werk en Bijstand, WWB), people who have registered their postal address at a low-threshold shelter for homeless people according to the Personal Records Database (Basisregistratie Personen, BRP), and a selection of people who use the National Alcohol and Drug Information System (Landelijk Alcohol en Drugs Informatiesysteem, LADIS) (Statistics

Netherlands, 2019). Statistics Netherlands counted 30,500 people as homeless in 2016 (Statistics Netherlands, 2016; in 2009 17,800), while the Dutch Federation of Shelters (Federatie Opvang) counted 60,120 homelessness clients in the same year (Federatie Opvang, s.d.). The latter uses the broader definition that includes those who receive ambulatory care from a shelter facility (i.e., the first definition). In the region of Breda (the city where the research described in this thesis is conducted), almost 1,500 people were registered as homeless in 2015 (Gemeente Breda, 2015) under the definition applied in the current research. Despite the increase in the number of homeless people in the EU and the Netherlands, the figures in the Breda region have remained quite stable during the last decade (approx. 1,500 on a yearly base).

Statistics Netherlands also examined the composition of the homeless population in the Netherlands in 2016. Most homeless people are male and unmarried, and 18% is divorced. The proportion of young people is high (33% is younger than 30 years). Many homeless people resides in the western parts of the Netherlands (65%), especially in bigger cities. Most of the homeless people has a lower (61%) or intermediate (34%) education level. Hence, the proportion of highly educated people is strongly under-represented among the homeless population. Moreover, the majority of the homeless people receive social benefits (more than 80%), while only 6% of the homeless people were employed in 2016. Furthermore, 29% has limited debts (up to 1,000 euros), 12% has higher debts (between 1,000 and 10,000 euros), and 6% had a debt of 10,000 euros or higher. Additionally, 39% was diagnosed with mental health problems (Coumans, Arts, Reep, & Schmeets, 2018). There are no recent figures on the composition of the homeless population in the region Breda.

SOCIAL PARTICIPATION

Definitions and Relevance of Social Participation

Although social participation is a commonly used term, there are different definitions used in research and practice (Piškur et al., 2014). Several authors report the following definition:

> Participation is the performance of people in actual activities in social life domains through interaction with others in the context in which they live. Four social life domains are included: (1) domestic life; (2) interpersonal life (including formal relationships as well as informal social relationships, family relationships, and intimate relationships); (3) education (informal, vocational training, and higher education) and employment (remunerative and non-remunerative, excluding domestic work); (4) community, civic, and social life, including religion, politics,

recreation, and leisure (hobbies, socializing, sports, arts, and culture). (Dalemans, De Witte, Wade, Van den Heuvel, 2008, p. 1073; Verdonschot, De Witte, Reichrath, Buntinx, & Curfs, 2009, p. 304)

Moreover, Levasseur et al. (2010) provides a slightly simpler definition: "Social participation is a person's involvement in activities providing interactions with others in society or the community" (Levasseur, et al. 2010, p. 2146). Levasseur et al. (2010) extends this definition with a taxonomy of social activities based on levels of the individual's involvement on the one hand, and goals of these activities on the other hand. This taxonomy includes the following six levels: (1) doing an activity in preparation for connecting with other people, (2) being with others, (3) interacting with other without doing a specific activity with them, (4) doing an activity with others, (5) helping others, and (6) contributing to society. All levels include participation, but only levels 3 till 6 include social participation. Additionally, social engagement is only shown in levels 5 and 6 (Levasseur et al., 2010). In the research described in this thesis, the definition of Levasseur et al. (2010) is frequently used, because it distinguishes two main components: (1) involvement in activities, which includes educational, recreational, and labor activities, and (2) social interaction with others, which refers to one's interaction with family members, relatives, friends, neighbours, and other acquaintances (Herzog, Ofstedal, & Wheeler, 2002; Levasseur et al., 2010). Both of these components are important elements of the GTP intervention that is examined in this thesis.

Social participation should not only be considered as an individual's responsibility, but also as a collective responsibility. Therefore, it is interesting to relate social participation to the concept of social quality. The International Association on Social Quality (IASQ) defines social quality as "the extent to which people are able to participate in social relationships under conditions which enhance their well-being, capacity and individual potential" (IASQ, 2018). This definition shows that the individual and its environment are closely related to each other. Hence, well-being of people is influenced by the possibilities to participate in social relationships (Verharen, 2017). Participation in relationships can be promoted on the level of the individual (micro), the level of the community including institutions (meso), and the level of the society and societal structures (macro) (Wolf, 2016). Consequently, to improve the social quality of people, basic conditions must be met. These conditional factors of social quality are: (1) socio-economic security, (2) social cohesion, (3) social inclusion and (4) social empowerment. Socio-economic security focuses on social justice (i.e., equity of people) through human rights legislation to ensure essential condition of existence. Social cohesion addresses solidarity between people through shared values and norms and the process of social recognition. Social inclusion refers to the extent to which people have access to economic, social and

cultural institutions and focuses on social responsiveness. Finally, social empowerment revolves around human dignity as a result of personal (human) capacity and delivers the conditions for social interaction. Social empowerment includes the possibilities for self-determination (IASQ, 2018; Verharen, 2017; Wolf, 2016).

Social participation is a theme that enjoys high priority within the policy of not only the Netherlands, but also the European Union (EU). Hence, the aim of this EU strategy is to contribute to the achievement of smart, sustainable, and inclusive growth (Gros & Roth, 2012), which implies that an inclusive society will enable both economic welfare as well as personal well-being. The Netherlands, as a member of the EU, has a policy in line with the EU. The Dutch government has been transforming the traditional welfare state into a "participation society" (Rijksoverheid, 2013). Under this policy, citizens are encouraged to support each other, while an appeal for government aid is only an option when the person in question has no resources, such as a social network or money, of their own (Van Houten, Tuynman, & Gilsing, 2008).

The intention of the Dutch government to create a participation society was primarily motivated by budget cuts (Putters, 2013; Rijksoverheid, 2013; Verschoor, 2015). When citizens need to use their own resources, the government can limit several expenses. Hence, it is not always deemed necessary to arrange payments for all kinds of benefits. For instance, housekeeping support for an ill person can be provided by family or a neighbor. Aside from economic reasons, ideological arguments are also provided. Citizens need to participate so that the citizens' strength is being exploited and strengthened and social problems are addressed (Oude Vrielink, Van der Kolk, & Klok, 2014). Besides, social participation is also related to an enhancement of well-being of citizens (Eurostat, 2010; Philips, 1967; Wallace & Pichler, 2009) (see section on outcomes of social participation).

Predictors and Outcomes of Social Participation

Social participation of homeless people can be influenced by several factors, such as (1) person-related, (2) care-related, and (3) society- or community-related variables.

Person-related predictors: Two types of person-related variables, which focus on the aforementioned micro-level, can be distinguished. First, demographic variables such as age and education level are determinants of social participation and well-being. Higher education leads to higher levels of participation (La Due Lake & Huckfeldt, 1998; Philips, 1967; Wallace & Pichler, 2009) and age positively correlates with social participation (Eurostat, 2010; Wallace & Pichler, 2009). Second, other person-related predictors include the level of optimism of a person and the extent to which people are able to

master their lives (i.e., self-mastery). Both constructs are positively related to (aspects of) social participation (Applebaum et al., 2013; Bengtsson-Tops, 2004; Schou, Ekeberg, & Ruland, 2005).

Care-related predictors: Care-related variables focus on the meso-level (in this case the relations with institutions). Shelter facilities should facilitate social participation by creating an "enabling niche". This is a safe environment where people can grow, work on self-fulfillment, and are encouraged to connect to other people (Taylor, 1997; Van Regenmortel & Peeters, 2010). An example is offering activities to homeless people with the goal to participate in society again. Several studies have shown that participation in various activities organized by a shelter facility or a health care organization leads to improved social participation and well-being in homeless people (Thomas, Gray, McGinty, & Ebringer, 2011; Kashner et al., 2002; Peden, 1993; Randers et al., 2011; Sherry & O'May, 2013). Additionally, to achieve the best results for homeless people (i.e., social participation and well-being), it is necessary that the client can trust his social worker (positive evaluation of the worker-client relationship), and that expectations regarding possible support are clear (Hser, Evans, Huang, & Anglin, 2004; Lindhiem, Bennett, Trentacosta, & McLear, 2014). Another care-related predictor is duration of support, which is the amount of time during which clients receive support from the shelter facility. Clients with a longer duration of support likely have more complex care demands and are expected to be at a higher risk of institutionalization, which can lead to lower levels of social participation (Rapp & Goscha, 2012).

Society- or community-related predictors: Society- or community-related variables, which especially focus on the macro-level and partly on the meso-level, refer to the influence of actors other than the homeless individual or the shelter facility. This type of predictors is closely related to the aforementioned conditions of social quality. For example, the social network of homeless people and community members play a crucial role in accepting homeless individuals as full citizens, in facilitating them to participate in activities or networks, and to accept them as a part of their own network. Besides, the government needs to establish a structure in which homeless individuals can find their way in the system like every other person. Consequently, homeless people have the right to access to economic, social and cultural institutions. However, the social justice system is often not accessible for homeless people (Amado, Stancliffe, McCarron, & McCallion, 2013; Van der Maesen & Walker, 2005; Wolf, 2016). Although society-related predictors of social participation of homeless people are important, the current thesis focuses on care-related and demographic predictors because it aims to examine social participation from the (formerly) homeless individual's perspective. By gaining deeper insights into care- and person-related predictors of social participation and

their relation to well-being, the current research aims to increase our understanding of the implications for interventions, such as the GTP intervention, for homeless people that can be applied by shelter facilities and other social services. This does not mean that societal aspects are not taken into consideration. For example, we include social support (social network/contacts), but this is examined from the homeless individual's perspective.

Outcomes: Several studies showed a relation between social participation and well-being (including related constructs such as happiness and quality of life[1]). Philips (1967) already found half a century ago that the greater the extent of participation, the greater the degree of happiness. Hence, people who participate have more positive feelings which make them feel more happy (Philips, 1967). More recent studies confirmed the relationship between social participation and well-being. A study conducted by Eurostat, the Statistical Office of the European Union (EU), showed that a higher level of social engagement is related to higher levels of happiness and life satisfaction (Eurostat, 2010). Additionally, another European study showed that participation increases happiness and quality of life at the individual level; and that at the societal level, higher levels of participation correlate with higher levels of subjective well-being. Participation can lead to: (1) Various indirect social rewards, such as access to friends, networks, and jobs; (2) Direct personal rewards, such as personal fulfillment through giving to others (Wallace & Pichler, 2009). Finally, a study conducted among homeless people also showed that social satisfaction (e.g., social life, relationships with friends, family, and partner) is an fundamental component to overall subjective well-being (Biswas-Diener & Diener, 2006).

GROWTH THROUGH PARTICIPATION

Growth Through Participation ("Verder Door Doen" in Dutch) is an innovative intervention for (formerly) homeless people which aims to enhance social participation and well-being. GTP was developed on the basis of eclectic principles and trial and error. Hence, it is partly based on effective principles from the literature regarding strength-based and recovery-oriented approaches (Rapp & Goscha, 2012) and it is partly based on positive experiences from practice (SMO Breda, 2014a). GTP even includes working

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1 Although some scholars distinguish well-being from quality of life to a greater or lesser extent (e.g., Costanza et al., 2006; Sirgy, 2012) and some provide same definitions for both constructs (e.g., Camfield & Skevington, 2008; Diener, 2009), in the current thesis these constructs are used interchangeably unless an explicit distinction is made (e.g., in Chapter 3 well-being is defined as a broader construct than quality of life). When the term well-being is used, it refers to subjective well-being which means it is based on the personal experiences of the homeless person.

Chapter 1

with (specific) strength-based and recovery-oriented approaches and methods. The fundamental principles of strength-based and recovery-oriented approaches are first described, including their relation to social participation, and finally, the GTP intervention is described.

Strength-Based and Recovery-Oriented Approaches

Most shelter facilities (and other social services) work according to strength-based and recovery-oriented approaches and related methods. Rapp and Goscha (2012; first edition 1997), the founders of "The Strengths Model", describe the principles of recovery-oriented support in the context of mental health care, but the principles can be translated to the context of shelter facilities. These authors consider quality of life as the consequences of the niches that a person inhabits. Niches are the "environmental habitats of a person or category or persons" (Taylor, 1997) (e.g., living arrangement, education, recreation, labor). The quality of a person's niches is a function of that person's aspirations, competencies, and confidence, in combination with environmental resources, opportunities, and social relations. In short, individual and environmental factors play a role in enhancing well-being of individuals (micro-, meso-, and macro-level). Related principles include: (1) people's ability to recover, (2) a focus on the individual instead of pathology, (3) the worker-client relationship as essential, (4) interventions offered in the community because the community provides resources, and (5) importantly, the client as the director of his own trajectory (referring to self-mastery). In the Netherlands, several authors developed approaches and methods that share similarities with the strengths model or are based on the model, such as the Individual Rehabilitation Approach (Korevaar & Droës, 2016), the Comprehensive Approach to Rehabilitation methodology (Den Hollander & Wilken, 2013), and Strengths Work (Wolf, 2016). These approaches and methods are frequently used by Dutch shelter facilities.

In all these approaches and methods social participation plays a crucial role. As previously mentioned, niches form a core element of the strengths model, where environmental strengths such as social relations play a crucial role. This is also the reason that the role of community is underlined by Rapp and Goscha (2012). It is important that a person's niches enable the person to enhance their quality of life. Hence, the main objective of social services is finding or creating enabling niches. Examples of created enabling niches include housing programs, supported education, and peer-run services. However, to achieve the best outcomes, a natural enabling niche should be found, which includes regular labor opportunities, recreation opportunities, and family involvement. This means that workers of social services should facilitate social participation of their clients, i.e., they should encourage their clients to be involved in regular activities in society/community, where clients can interact with others in society or community.

This is much broader than interaction with peers or social workers.

Description of GTP

GTP includes working with specific strength-based and recovery-oriented approaches or methods and provides a framework focused on accomplishing the best outcomes for clients. It can be applied as a supplement to recovery- and strength-based working methods. In the framework, organizational-related variables (i.e., variables related to the both the organizational context and behavior of employees) are integrated (SMO Breda, 2014a). The current chapter already emphasized the importance of environmental factors for homeless people, simultaneously, the organizational context is important for interpreting outcomes and behavior of individuals, such as employees and clients (Schalk, 2012). Conclusively, GTP is not just a method for workers who are primarily working with clients, but it is an comprehensive organizational approach to facilitate social participation and well-being of clients.

Stichting Maatschappelijk Opvang Breda e.o. (SMO Breda) developed the GTP intervention in 2014, and implemented it in 2015, aiming to improve the quality and quantity of the support in line with government policy. SMO Breda provides shelter and ambulatory care for approximately 900 homeless people on a yearly basis and is located in Breda, which has about 182,000 inhabitants. SMO Breda has four residential shelters. One of these shelters is for short stays only (6–12 weeks), but the other three shelters allow for a longer stay (from one year up to a life-time), depending on their needs and demands. The facility also offers ambulatory support, where employees mentor clients in their own houses. SMO Breda has approximately 180 employees who were mostly educated in the field of social work. Employees who are working directly with clients are additionally educated in working according to strength-based approaches and in basics of group work. GTP is divided into three layers. A visualization of the main components of GTP is presented in Figure 1.

The first layer (Principles) shows starting points for both clients and employees. This involves creating a social environment with maximum development opportunities, as well as recognizing strengths and talents and the need for autonomy and facilitating an organizational culture where flexibility and creativity are stimulated. The second layer (Approaches and Forms) distinguishes client-oriented working methods and organizational forms and consists of five components. The first component concerns the group approach ("I want to participate"), which consists of various group activities in which clients can participate depending on their preferences, talents, and needs (see Chapter 2). The second component, the individual approach, concerns the individual support of clients by a social worker (case management).

Figure 1. Visualization of key components of Growth Through Participation (Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019)
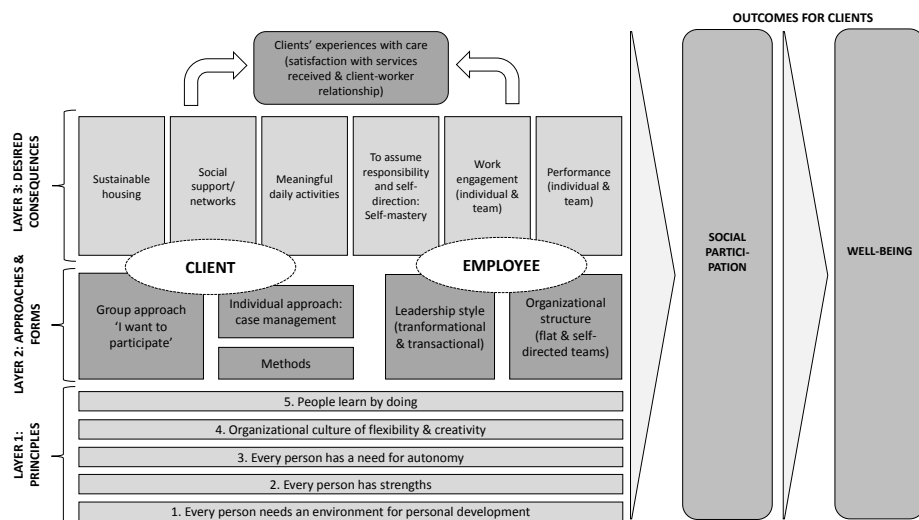
The third component includes methodologies that are in line with the principles of GTP (i.e., strength-based and recovery-oriented approaches) and offer frameworks and guidelines for employees to provide appropriate support for clients. The fourth component, leadership style, consists of a combination of transactional and transformational leadership. The final component concerns a flat organizational structure and working with self-directed teams. Regarding the third layer (Desired Consequences), a distinction is made between desired consequences with respect to clients and employees, although the concept of self-mastery is relevant for both groups. The desired consequences for clients consist of three goals, namely finding and maintaining sustainable housing, building a supportive social network and having a meaningful daily activities. For employees, the desired consequences consist of achieving work results (team performance) and being involved in the work (work engagement). A significant amount of attention is devoted to the client's perception of service provision. The efforts made by both clients and employees should result in a client's positive experience with care. All activities are ultimately focused on the main objectives of the intervention, namely promoting well-being of clients through social participation (SMO Breda, 2014a).

GTP is not yet implemented in other shelter facilities or social services, but some organizations (e.g., several peer support initiatives/groups, mental health care, centers for arts, cooperation for reintegration) share an important part of the intervention: their clients also participate in the "I want to participate" program or they play a role

in facilitating the program. Hence, not only (formerly) homeless clients participate in the educational, recreational and labor activities of "I want to participate", but they also meet and interact with people from outside the shelter facility. This program can be considered as a "created enabling niche", because it aims to create a safe environment in which people can practice their participatory skills. The objective is not to stay in this environment, but to participate in regular activities in the community (SMO Breda, 2014a).

A more detailed description of "I want to participate" is presented in Chapter 2, and more detailed information on GTP is presented in Chapter 5.

AIM AND OUTLINE OF THE PRESENT THESIS

The aim of the current thesis is to evaluate GTP, including the factors that enhance the primary outcomes of GTP (i.e., social participation, self-mastery, quality of life/well-being). This leads to the following research questions:

1. What factors enhance or impede social participation, self-mastery, and quality of life/well-being?
2. How are all these variables related to each other?
3. What are the outcomes of the GTP intervention?
4. How did organization-related variables change during the implementation of GTP?
5. How are these organization-related variables related to each other?

The current research aims to contribute to literature because, in addition to examining the outcomes of GTP, it investigates indicators (i.e., factors) in promoting social participation, self-mastery, and quality of life and shows how these concepts are interrelated. Although these concepts were studied in other target groups, such as the regular population, they were studied to a lesser extent in the homeless population and certainly not as a coherent framework which includes interrelatedness of social participation, self-mastery and well-being (including determinants) among homeless people. Moreover, the current research is based on a broader approach to evidence-based practice (Hermans, 2005). It is not based on testing a single theory, but is based on studying indicators and their relatedness, and these indicators include the role of professionals and the organization. This research approach fits in seamlessly with the GTP intervention, which has been developed mainly on the basis of practical experiences through a bottom-up process.

The current thesis consists of five empirical studies (Chapter 2 to 6) that aim to evaluate GTP as well as the factors that enhance the primary outcomes of GTP. All studies are conducted among clients and workers of SMO Breda. The five empirical chapters are based on empirical papers that have been published or have been prepared for submission. The chapters are arranged in the order of the research questions, which means that they are not presented chronologically. Table 1 presents the titles, goals, methods, and relation to the aforementioned research questions of the five studies presented in this thesis.

Chapter 2 describes exploratory qualitative research in which we investigate clients' experiences with participation in educational, recreational, and labor activities (activities that are part of the "I want to participate" program) in relation to their physical, social, and mental well-being. Additionally, the research also explores clients' experiences with participation in a sports intervention ("Sports Surprise") in relation to two specific aspects of well-being, namely Sense of Coherence (Antonovsky, 1979) and social support (Bates & Toro, 1999). A brief description of both the "I want to participate" program and "Sports Surprise" (an intervention of "I want to participate") is given. We present the results from semi-structured interviews to provide insights into the relationship between participation in activities in the safe environment of the shelter facility and well-being from the clients' perspectives.

Chapter 3 presents the results of a cross-sectional quantitative study in which we test a mediation model where social participation is a mediator between care-related and demographic (i.e., client-related) predictors on the one hand, and well-being on the other hand. We distinguish the following care-related predictors: (1) participation in various group activities in the shelter facility and (2) client's experiences with care, such as their satisfaction with the social worker and the shelter facility, as well as the following demographic predictors: (1) age and (2) education level. In this study well-being is defined as a combination of quality of life, absence of psychological distress, and self-esteem.

Chapter 4 describes a mixed-method study of associations between person-related and care-related variables as predictors of both social participation and quality of life through the mediator of self-mastery. Self-mastery plays a basic role in GTP and strength-based and oriented-approaches, since a higher level of self-mastery is related to higher levels of social participation and quality of life. We distinguish the following person-related predictors: (1) optimism, (2) age, and (3) education level and the following care-related predictors: (1) experiences with care, and (2) duration of support.

Table 1. Brief description of the five studies

Study		Title	Goals	Method	Relation to Research Question
1	CLIENT	How is Participation Related to Well-Being of Homeless People? An Explorative Qualitative Study in a Dutch Homeless Shelter Facility.	1) Exploration of experiences with participation in educational, recreational, and labor activities in relation to physical, social and mental well-being 2) Explorations of experiences with participation in a sports intervention in relation to the sense of coherence and social support.	Qualitative (semi-structured interviews)	1 & 2
2		How to Enhance Social Participation and Well-Being in (Formerly) Homeless Clients: A Structural Equation Modeling Approach	Examination of care-related and demographic predictors of well-being through the mediator of social participation	Quantitative (cross-sectional)	1 & 2
3		The Importance of Self-Mastery in Enhancing Quality of Life and Social Participation of (Formerly) Homeless People: Results of a Mixed-Method Study	Examination of associations between person-related and care-related variables as predictors of both social participation and quality of life through the mediator of self-mastery.	Mixed-method (quantitative: cross-sectional; qualitative: semi-structured interviews	1 & 2
4		Growth Through Participation: A Longitudinal Study of a Participation-Based Intervention for (Formerly) Homeless People	Examination of the outcomes for clients of GTP (i.e., changes in quality of life, social participation, self-esteem, clients' experiences with care, psychologic distress)	Quantitative (longitudinal)	3
5	EMPLOYEE	The Importance of Organizational Embedding for an Innovative Intervention: A Case Study	1) Examination whether organization-related variables changed during implementation of GTP. 2) Examination of the relationship between organization-related variables.	Quantitative (longitudinal & cross-sectional)	4 & 5

Next to quantitative testing of a mediation model of self-mastery, we also examine predictors and outcomes of self-mastery by conducting qualitative research through qualitative semi-structured interviews.

Chapter 5 reveals the outcomes of a longitudinal quantitative study on GTP and comprises three measurement time points. We examine whether (1) quality of life increased during the GTP intervention; (2) social participation (e.g., labor/recreation), self-esteem, clients' experiences with care (i.e., satisfaction with the services received and with the client–worker relationship), and psychological distress improved during GTP, and whether (3) clients exhibiting psychological distress benefit more from GTP than others. Additionally, a comprehensive description of GTP is presented.

Chapter 6 presents the outcomes of a quantitative study on the organization-related variables that play a fundamental role in the GTP intervention. This study consists of two parts. In the first part, which consists of a longitudinal study, we examine whether these organization-related variables changed during the implementation of GTP. In the second part of the study, we examine the relationship between these variables by applying a cross-sectional study design. Therefore, we tested a model in which both individual and team work engagement mediates the relationship between job autonomy, transformational (i.e., charismatic) and transactional leadership style, family and adhocracy culture on the one hand, and team performance on the other hand. In this study, we stress the importance of an organizational embedding of interventions and advocate linking outcomes for clients (i.e., content) to organization-related aspects.

Chapter 7 provides an integration of all previous chapters, discusses the main findings of this thesis, and deliberates on what this research means for practice and policy. Moreover, limitations of the research and recommendations for future research are presented.

Chapter 2

How is Participation Related to Well-Being of
Homeless People? An Explorative Qualitative
Study in a Dutch Homeless Shelter Facility

Chapter 2

ABSTRACT

The majority of homeless people is socially excluded which negatively affects their well-being. Therefore, participation-based programs are needed. The current research is conducted within a Dutch homeless shelter facility that offers educational, recreational, and labor activities to clients in an environment which is designed to feel safe (an enabling niche). The main aim of these activities is to facilitate social participation. We conducted two qualitative studies consisting of 16 semi-structured interviews, to explore clients' experiences with participation in activities in relation to their well-being. The findings showed that clients experienced that participation had led to an improvement of physical, social, and mental well-being. In general, clients reported that due to participation in activities they have strengthened their social support network, improved their (mental and physical) health, self-esteem and personal growth. We concluded that in order to facilitate lasting positive outcomes of participation in practice, it is necessary to focus on group cohesion, and on the social worker's behavior and attitude.

INTRODUCTION

Participation, defined as 'a person's involvement in activities that provides interaction with others in society or the community' (Levasseur, Richard, Gauvin, & Raymond, 2010, p. 2146), is an important element of civil society because it provides people with access to networks, jobs, and other resources. Due to the aspect of social interaction, participation helps people obtain direct personal rewards such as personal fulfilment through giving to others and increased self-esteem (Wallace & Pichler, 2009).

For the large majority of homeless people, participation is not self-evident because they are often socially isolated (Van Straaten et al., 2016). In most cases homeless people have lost or damaged social ties with their families, are unemployed and excluded from the housing market, nor do they participate in recreational activities such as sports, and are excluded from educational activities (Gupta, 1995; Vandermeerschen, Van Regenmortel, & Scheerder, 2016; Wolf, 2016). Moreover, some homeless people have lost the social skills to interact with others or to maintain a job due to various reasons such as substance addiction (Latkin, Mandell, Knowlton, Vlahov, & Hawkins, 2016; Tam, Zlotnick, & Robertson, 2003), aggressive and other violent behaviors (Roy, Crocker, Nicholls, Latimer, & Reyes-Ayllon, 2014) and mental disorders (Fazel, Khosla, Doll, & Geddes, 2008). Therefore, it is extremely difficult for them to start participating in society again.

Several Dutch organizations that provide shelter services and ambulatory care (shelter facilities) focus on training the skills of their homeless clients through promoting participation in safe environments before attempting to participate in society. These safe environments, or so called 'enabling niches', are places where people can grow, work on self-fulfillment, and are being stimulated to connect to other people (Taylor, 1997; Van Regenmortel & Peeters, 2010). For example, the shelter facilities offer activities to homeless people with the goal to participate in society, in turn resulting in an enhancement of well-being. Participation in these safe environments enables homeless people to practice interacting with others (thus improving their social skills), to learn to take responsibility, and to improve their self-esteem.

Although the relationship between participation and well-being in the general population has often been examined (e.g., Eurostat, 2010; Wallace & Pichler, 2009), only a few studies explored this relationship in the homeless population. Some of these studies focused on the requirements and barriers to participate in activities (Bradley, Hersch, Reistetter, & Reed, 2011; Zuvekas & Hill, 2000), but they did not focus on the outcomes of social or occupational participation. Other studies examined the outcomes of specific interventions that are based on group work and strengths in homeless people and

showed positive effects of participation on social skills, self-knowledge, feelings of understanding, and an increase in self-confidence (e.g., Daniels, D'Andrea, Omizo, & Pier, 1999; Cordero Ramos & Muñoz Bellerin, 2017). Furthermore, studies on participation of homeless people in sports activities showed positive effect on aspects of well-being, such as an increase in social support and physical health, reduced substance abuse and symptoms of mental illness and an enhanced personal development (Peachey, Lyras, Borland, & Cohen, 2013; Randers et al., 2011; Sherry & O'May, 2013). However, none of these studies focused specifically on participation in different kinds of activities and its influence on the broad concept of well-being.

Regarding the conceptualization of well-being, research on well-being of homeless people has witnessed a significant paradigm shift in the last decade. Traditionally, research focused especially on objective outcomes in homeless people such as physical and mental health disorders and substance abuse (Fazel et al., 2008; Fischer & Breakey, 1991; Tam, Zlotnick, & Robertson, 2003). Nowadays, research on homelessness is increasingly focusing on subjective outcomes such as (experienced) well-being, quality of life, and meaningfulness (Biswas-Diener & Diener, 2006; Hubley, Rusell, Palepu, & Hwang, 2014).

In line with this paradigm shift we used a comprehensive approach of well-being and therefore we focused on three dimensions of well-being: physical, mental (i.e., psychological), and social well-being. A person can experience a stable sense of well-being only when the physical, mental, and social resources are sufficient to meet a particular physical, mental, and/or social need (Dodge, Daly, Huyton, & Sanders, 2012).

The current research focused on the participation of homeless people (i.e., clients of a shelter facility) in the safe environment of a shelter facility in the Netherlands. Specifically, the clients' experiences with the participation-well-being relationship were explored in two studies, whereby:

- Study 1 explored homeless clients' experiences with participation in educational, recreational, and labor activities in relation to their (reported) well-being and;
- Study 2 focused on the homeless clients' experiences with taking part in a sports intervention and its influence on two aspects of well-being, i.e., the sense of coherence (Antonovsky, 1979) and social support (Bates & Toro, 1999).

Despite the fact that the two studies were independently developed, we combined them in the current paper because both studies explore the relationship between activities and subjective well-being of homeless people. Although the data collection of the

second study (January until April 2016) took place before the data collection of the first study (February until May 2017), the broader study in which we examined the homeless clients' experiences with participation in activities in relation to well-being is presented first, followed by the second study that addresses clients' experiences in relation to participation in a specific activity and how that relates to specific aspects of well-being.

METHOD

In the current research, a qualitative approach was used to explore the relationship between participation in activities and well-being because we aimed to explore the experiences of clients of a Dutch shelter facility on this relationship. Qualitative research is the best method to explore these experiences, because it helps researchers to explore perceptions and feelings of research participants and to gain understanding of the research topic (Sutton & Austin, 2015).

Context of the Two Studies

The Dutch shelter facility (i.e., SMO Breda e.o.), in which both explorative studies were conducted, provides shelter and ambulatory care for approximately 900 homeless people on a yearly base. It is located in a medium-sized city (about 182.000 inhabitants) in The Netherlands (Breda) and it has four residential shelters. One of these shelters is for short-stay only (6 to 12 weeks) while in the other three shelters clients can stay for a longer period of time (from one year up to a life-time), depending on their needs. The facility also offers a form of ambulatory support, where employees are mentoring people in their own houses. The organization has 170 employees, mostly educated in the field of social work. Employees who are working directly with clients are additionally educated in a strength-based approach and in principles of group work.

Study 1

Aim and Research Question

The first study explored the influence of participation of homeless clients on well-being and it aimed to answer the following research question: 'How do homeless clients experience their participation in education, recreational, and labor activities in relation to their physical, mental, and social well-being?'.

Specifically, this study focused on group-based educational, recreational, and labor activities that are organized under the label 'I want to participate' (SMO Breda, 2017). The participation related activities were all supervised by a social worker who is educated and/or experienced in the particular activity (e.g., a supervisor of a woodworking activity is also educated and/or experienced in woodworking). Examples of these activities

are presented in Table 1.

Participants of the 'I want to participate' program can choose from the different type of activities, depending on their own preferences and strengths. However, participants are supposed to formulate a personal goal related to their needs with emphasis on what they want to learn during the activities. The program's main goal is to teach clients how to participate in society and therefore the activities focus on learning from each other (peer support), developing strengths and various (social, practical, or work-related) skills sometimes even with the ability to earn an officially recognized diploma. Once clients obtain these participatory skills within the enabling niche of the facility, they are facilitated to participate in social- and work related activities in society and thus outside of the protective environment.

Table 1. Examples of educational, recreational and labor activities that are organized under the label 'I want to participate'

Education	Recreation	Labor
Computer course	Mosaic work	Gardening
Resistance training	Ceramics (creative)[b]	Ceramic products manufacturing[b]
Bee-keeper course	Woodworking (creative)[b]	Woodwork manufacturing[b]
Group meetings with several recovery-based themes[a]	Sports (e.g., boxing, swimming, and Sports Surprise)	Housekeeping (e.g., cleaning, linen room)
	Karaoke	Professional cooking
	Theatre	Taxi driving

[a] Examples are: how to find a house, how to cope with addiction, how to improve social skills, and how to make a budget.
[b] These activities are separated: for example creative ceramics have a slower pace, another aim and mostly other participants than ceramic products manufacturing. The manufacturing activities prepare participants to work in industry or in a factory.

Additionally we explored whether the client's satisfaction with the activity is playing a role in his experiences with the relationship between participation and well-being. When a homeless person is not satisfied with the activity, the supervisor or the group, the likelihood of discontinuing the activity will be higher and/or the benefits of participation might be lower or absent, or they might even be contra-productive.

Procedures and Participants
The first study was conducted in the period of February until May 2017. Ten clients

(eight males and two females) from two long-stay residential shelters were selected to participate in a semi-structured interview. The interviewer visited the two shelters and asked who wanted to participate voluntary in this research. A purposeful sampling method was used, which is a commonly used technique in qualitative studies for the identification and selection of cases who are able to provide a lot of information (Palinkas et al., 2015). The interviewer selected individuals based on variation in age, duration of support (i.e., residence time), and participation level in the 'I want to participate' program. The average age of participants was 52 years and the mean duration of support from the shelter facility was over 3 years. Five participants participated on a regular base in the 'I want to participate' program (2.5 days or more per week) and the other five participants were less active (less than 2.5 days per week). For those who were not participating in activities anymore (Participants 2, 4, and 10), the questions were related to their experiences with activities they used to participate in. In Table 2 demographic characteristics of participants are presented. All interviews were conducted at the shelter, after participants filled in an informed consent form. The interviews had an average duration of 45 minutes.

Table 2. Demographic characteristics of participants (Study 1)

Participant	Gender	Age (years)	Duration of support (years)	Participation level 'I want to participate' (days per week)
1	Female	63	.5	2.5
2	Male	62	3	0[a]
3	Male	77	3	2.5
4	Male	58	5	0[b]
5	Male	64	4	4.5
6	Male	35	2.5	1.5
7	Male	60	2	2.5
8	Female	34	1	3.5
9	Male	37	1.5	1.5
10	Male	28	.5	0[b]

[a] previously participated 2.5 days per week
[b] previously participated 4 days per week

Interview Description

We used semi-structured interviews which means that before the interviews were conducted, main topics and most of the open-ended questions related to these topics were formulated (McIntosh & Morse, 2015). During the interview, the interviewer asked

additional questions based on the client's answers. We formulated the following topics and interview questions: (1) demographics (age, gender, residence time), (2) level of participation in activities (example question 'How many day/times per week are you joining the activities?'), (3) physical, social, and mental well-being (example question 'What is the influence of your participation in educational activities on your physical functioning?'), and (4) satisfaction with the (a) supervisor of the activities, (b) activity itself, and (c) peer group (example question 'What do you think of the group of partici-pants?'). In Table 3 a description of these topics and questions is provided along with the reason for including these topics and questions.

Analysis
The data analysis procedure consisted of three steps. In the first step the interviews were transcribed using non-verbatim transcription technique. We did not choose to transcribe data word-for-word (i.e., verbatim), but only transcribed the relevant verbal data related to our research topic (Halcomb, Cert, & Davidson, 2006) because for proper data analysis it is not always necessary to transcribe the full text as long as there is a focus on the research topics. In the next step the answers from participants were structured in a meta-matrix (Miles & Huberman, 1994) around the themes and ques-tions from the interview description (see section "Interview description"). We created two types of meta-matrices. In the first matrix we included educational, recreational, and labor activities on the one hand and physical, mental, and social well-being on the other hand (Table 4). We entered the data in this matrix per client. In the second matrix we included the answers of all participants (Table 5). In the third step, color codes were used to distinguish relevant quotes associated with the different themes. By using this method, we were able to explore the answers from each individual participant in detail and we were able to perform systematic comparisons between participants (Miles & Huberman, 1994). This method has recently been successfully applied in studies in social and behavioral sciences (e.g., Nicolaisen, Stilling Blichfeldt, & Sonnenschein, 2012; Trabold, O'Malley, Rizzo, & Russell, 2017). Finally, the main activities of the data analysis of this study were conducted by the second author and re-checked by the first author of this manuscript.

Table 3. Interview description (Study 1)

	Topic	Example questions	Reason(s) for including this topic/these questions
1	Demographics	- What is your age? - Do you consider yourself as male or woman? - How long have you been staying at this shelter facility?	Demographic variables might influence the client's experiences of participation in activities in relation to well-being. E.g., an older client can have physical difficulties whereby he experiences a lower physical well-being independent from his level of participation in activities. Clients who are staying longer at this facility can have other perceptions of participation.
2	Level of participation in activities	- How many days/times per week are you joining the activities? - Which activities are you joining?	The participation level might influences the client's experiences. E.g., clients who participate more in activities have more and probably other experiences than clients who participate less. We examined the type of activities (education, recreation, and labor) in order to ask the proper question at topic 3 (if a client does not participate in recreational questions, we do not need to ask a question about recreational activities).
3	Physical, social, and mental well-being	- What is the influence of your participation in educational/recreational/labor activities on your physical/social/psychological functioning? (nine possible questions: type of activity vs. type of functioning)	This is the main part of the interview (i.e., exploration of research question).
4	Satisfaction with the supervisor, activity itself, and peer group	What do you think of... - the supervisor? - the activities (per type of activity)? - the group of participants? Further exploration (if not mentioned): And how does that influence your participation and/or functioning...?	When a homeless person is not satisfied with the activity, the supervisor or the group, the likelihood of discontinuing the activity will be higher and/or the benefits of participation might be lower or absent or they might even be contra-productive.

Table 4. Meta-matrix per participant (example of Participant 1, 63 year-old-woman) (Study 1)

	Educational activities	Recreational activities	Labor activities
Activities client is joining	Computer course	Creative activities under which mosaic work and ceramics.	Housekeeping
Physical well-being	Typing is becoming faster and faster. My fingers have become more supple	I notice that my arm muscles became stronger, because I move these more.	It's a bit hard to say, but I walk more, so physically it makes you better. I have improved my condition. My arms and legs have become stronger, because I'm using my arm and leg muscles more. I have gained more endurance.
Social well-being	I don't use Facebook and during the computer course I hardly get the chance to chat with other people. You have to be busy with the computer course.	I can talk to people who are also joining creative activities. This became easier. Now I know how I can improve my communication. The other residential clients did not became real friends. I don't think I can interact with people in that way. I prefer supporting people. Hence, I became more helpful. I wouldn't call myself a coach (...) People asked me for help more often (...).	The same applies as with recreation. I have learned to interact with more people. Now I know better how to communicate.
Psychological (mental) well-being	I have learned how to work with a computer.	I'm proud of myself. I can do something. I have accomplished something. I believe that I have become more independent. I also gained more insight into getting a job done.	The same applies as with recreation activities. I gained more insight into getting a job done.

Table 5. Part of meta-matrix with aim to compare answers (Study 1)

Topic	Question	Participant 1	Participant 2	Etc. (participant 3 to 10)
2	How many times a day/per week are you joining the activities?	*5 day times per week, i.e., 2.5 days.*	*Only in the beginning I joined the activities for 5 day times per week. Currently, I am not joining the activities because of my physical condition.*	...
3	What is the influence of your participation in educational activities on your physical well-being	*Typing is becoming faster and faster. My fingers have become more supple*	n.a.[a]	...
Etc. (1 to 4)	...	...	...	...

[a] only participated in recreational and labor activities in the past

Study 2

Aim and Research Question

In the second study, which consisted of six semi-structured interviews, we explored the influence of a sports intervention, 'Sports Surprise', on two aspects of well-being and we aimed to answer the following research question: 'How do homeless clients experience their participation in Sport Surprise in relation to their sense of coherence and social support?'.

Sports Surprise is one specific activity of the aforementioned 'I want to participate' program. Notably, it consists of two phases that need to be accomplished to enable homeless clients to participate in society. In the first phase, clients are stimulated to play various sports in the protective environment of the shelter facility on a weekly base and under supervision of a social worker. Clients are not informed in advance which sport they will play each time (a surprise element). In the second phase, clients participate in sports in the context of a regular sports association outside the shelter facility. During this phase, clients go through three stages: (1) paying a visit to an external sports association and playing sports under supervision of an external sports coach in the presence of a sports coach from the shelter facility, (2) participating in a trial training session of a specific type of sports that clients became enthusiastic about, and (3) becoming a member of a sports association where each client is linked to a 'buddy', a

member of the sports association. The buddy helps the client with the introduction to other members of the sports association. Furthermore, participants can do voluntary work in return for paying the membership fee.

We explored how Sport Surprise influenced the sense of coherence and social support, because the intervention draws attention to these two constructs. The sense of coherence (i.e., one aspect of mental well-being) is defined as

> A global orientation that expresses the extent to which one has a pervasive, enduring, though dynamic, feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected (Antonovsky, 1979; p. 132).

The sense of coherence contains three dimensions: (1) comprehensibility, a belief that things happen in an orderly and predictable fashion, (2) manageability, a belief that one has the skills or ability or resources to take care of things, and (3) meaningfulness, a belief that things in life are interesting and really worthwhile (Antonovsky, 1979).

We used the following categorization of social support (i.e., one aspect of social well-being): (1) tangible support involving material aid, such as shelter, food, clothing and monetary assistance, (2) advice or appraisal support that consists of information and assistance, (3) belonging support that is about a sense of attachment and community, and (4) self-esteem support which is related to positive feelings generated about oneself through the interaction with others (Bates & Toro, 1999).

Procedures and Participants

This study was conducted in the period from January 2016 until April 2016 and consisted of six semi-structured interviews. Because of the amount of participants of Sports Surprise and the willingness and ability to participate in the current study, we used total population sampling: all clients who were joining Sports Surprise in January 2016 (three males and three females) participated in this study on a voluntary basis. Two participants were living in a residential shelter and four were living in their own dwelling with ambulatory care from the shelter facility. Furthermore, their average age was 47 years and the mean duration of support from the shelter facility was almost 5 years. All participants filled in an informed-consent form and during the study they participated with an average of once in every two weeks in Sports Surprise. In Table 6 demographic characteristics of participants are provided.

Table 6. Demographic characteristics of participants (Study 2)

Participant	Gender	Age (years)	Duration of support (years)
11	Female	60	4
12	Female	42	5
13	Male	37	6
14	Male	46	2.5
15	Female	52	6.5
16	Male	45	5.5

Interview Description

In the interviews specific questions were asked about both the sense of coherence and social support. These two constructs were operationalized based on the aspects of comprehensibility, manageability, and meaningfulness (Antonovsky, 1979) and tangible, advice, belonging, and self-esteem support (Bates & Toro, 1999) (see section "Aim and research question"). Example questions were 'has the way you are coping with stories or information changed, since you joined Sports Surprise?' (comprehensibility), 'Did you get help or assistance from co-participants (of Sports Surprise) with buying food or clothes?' (tangible support), and 'Did co-participants advice you regarding to work or health?' (advice support). The semi-structured interviews had an average duration of 45 minutes. In Table 7 a description of these topics and questions is provided along with the reason for including these topics and questions.

Analysis

The data analysis procedure of Study 2 also consisted of three steps. First, we transcribed all interviews using non-verbatim transcription technique. Second, we clustered the interview quotes around topics with the use of computer software KODANI DED Standard (version 1.1.8) (Doorewaard, Kil, & Van de Ven, 2015). This form of data processing was comparable to the method of the meta-matrix (Miles & Huberman, 1994) that was used in the first study. Specifically, we filled in one matrix with all the participants' answers (comparable to Table 5). Finally, we summarized the main aspects of the participants' answers. In this way it was possible to make systematic comparisons between participants. Additionally, the main activities of the data analysis of this study were conducted by the third author and re-checked by the first author of this manuscript.

Table 7. Interview description (Study 2)

	Topic	Example questions	Reason(s) for including this topic/these questions
1	Sports Surprise	- How did you experience Sports Surprise the last 10 weeks? - What did you like/dislike? - Why...?	General evaluation of experiences of Sports Surprise. In order to interpret the answers on the main topics adequately, it is important to know whether clients had positive or negative experiences and feelings and how this is caused.
2	Social support	- Did you get help or assistance from co-participants (of Sports Surprise) with buying food or clothes or other material things? How was this related to participation in Sports Surprise? Why...? - Did anything in your life related to your living situation, daily activities, financial situation, social life change due to participation in Sports Surprise? Why...? - Did co-participants advice you about work or health?' Why...? - Did you get to know more people due to your participation? Why...? What does it mean to you? - Did the way you are in touch with people change due to your participation? Why...? What does it mean to you? - How did/do you interact with co-participants? Did it change? Why...? What does it mean to you?	First main part of the interview: exploration of research question regarding tangible, advice, belonging, and self-esteem support.
3	Sense of coherence	- Did the way you are coping with stories or information changed, since you joined Sports Surprise? Why...? - Did you gain more autonomy the last period? (How) is that related Sports Surprise? How...? - Did you notice changes on the way you make decisions? For example, if someone offers you assistance, do you make a decision faster? (How) is that related to Sports Surprise? - How do you cope with stories/information people tell you? - Do you consider the things you do more interesting and worthwhile? Why? (How) is that related to Sports Surprise?	Second main part of the interview: exploration of research question regarding sense of coherence (i.e., comprehensibility, manageability, and meaningfulness).

RESULTS

Study 1

Participation and Physical Well-Being

Most participants (8 out of 10) experienced positive influences of participation on their physical well-being and the other two participants experienced neither positive nor negative influences. Several times participants mentioned that they experienced benefits in terms of improved physical flexibility. A 77-year-old participant illustrated:

> I notice that my flexibility increases. I use the stairs more often and walk through all these hallways… I can better keep on moving. Walking is getting better because of this. (Participant 3, 77-year-old man)

Furthermore, one participant mentioned that the suppleness of his fingers has increased as a result of a computer course. Benefits for physical well-being were also mentioned related to sports activities. For example, one participant reported that he has remained fit due to the weekly walking activity, and another participant has noticed an improvement of his condition due to a weekly swimming activity. Moreover, labor activities also led to positive physical outcomes, which was illustrated by one participant who told that he had walked a lot during participating in an activity in a ceramics workplace. Other mentioned positive influences of participation on physical well-being were improvement of muscle strength, quality of sleep and energy gain.

Participation and Mental Well-Being

With regards to mental well-being, most participants (8 out of 10) experienced positive influences as a result of participating in activities. Some clients reported positive mood changes, mostly happiness, because they could think of something pleasant instead of thinking about their problems. These positive mood changes also caused increased calmness and patience among some participants.

Other experienced benefits of participation in activities were (1) enhancement of self-esteem and recognition that was caused by the feeling that they can attribute to society, (2) to be more independent, (3) to be proud, (4) to have a familiar feeling, (5) to have more self-reflection, and (6) to have a daily structure. A participant mentioned:

> I improved my self-esteem. I was contributing. This was increasing my self-satisfaction. Thereby I was recognized by other people. (Participant 1, 63-year-old woman)

Chapter 2

Another participant reported:

> I am more motivated to take action, because now I get energized from working and I have got greater peace of mind. I notice I have become more enterprising. When I am done working I am very satisfied. (Participant 7, 60-year-old man)

Although most participants (8 out of 10) experienced a positive influence of participation on their mental well-being, two participants noticed a negative influence and one participant did not experience any benefits regarding to his mental well-being[2]. One client mentioned bad group cohesion because some of the group members were people he knew from his past (during the time he was in prison) and therefore he experienced a flattening of effect. Another participant reported that he had the feeling of being stigmatized during his attempts to participate in activities outside of the shelter because he is a client of the shelter facility:

> People outside the shelter think that everyone who is living here, is a drug or alcohol addict or a child rapist. (Participant 3, 77-year-old man)

Participation and Social Well-Being
Most participants (7 out of 10) experienced positive influences on their social well-being as a result of participating in activities, such as (1) getting to know other people, (2) making friends and getting social support from them, (3) developing stronger communication skills, and (4) becoming more social and helpful. One participant told that he has been doing voluntary work in a nursing home for elderly people, under supervision of a social worker of the shelter facility. Through the process of working with elderly people, his behavior has changed in a positive way that is needed for social interaction. This respondent reported:

> I am able to see the entire world again and now I see it in a different way. I assume things easier from the elderly. They do not make me aggressive. They help me to train my behavior. (Participant 6, 35-year-old man)

Four participants experienced negative influences of participation on their social well-being, such as a bad group cohesion and negative experiences with some of the group members[3]. One participant wanted to get to know new people because the group consisted of people that he knew from his past of which he wanted to disconnect[4].

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2   One participant reported both a positive and a negative influence on mental well-being.
3   One participant reported both a positive and a negative influence on social well-being.
4   The same participant reported this experience regarding to mental well-being.

Satisfaction and its Role in Participation and Well-Being
All participants indicated that their satisfaction with the (1) supervisor, (2) activities and (3) peer group were essential to keep on participating in the activities and to increase their well-being. First, two participants reported that they discontinued participation in activities because of inadequate attitudes and behaviors of their supervisors, and one client indicated that he was participating in a certain activity because of the supervisors. He illustrated this as follows:

> If it wasn't for these two, I wouldn't have done it. The way the supervisors are acting is very important to the activity. (Participant 5, 64-year-old man)

In their answers, participants reported that the supervisor must be (1) knowledgeable, (2) sympathetic and present, (3) give autonomy to participants, (4) show respect, and (5) act on an equal level. Second, only a few participants indicated that satisfaction with the activity itself was also crucial for them to keep participating. They reported that activities must (1) be meaningful and give a sense of fulfilment, (2) fit to personal intelligence level and life phase, and (3) provide a structure.

Finally, on questions regarding satisfaction with the group, a little less than half of the participants (4 out of 10) answered that they would stop participating if they were not satisfied with their peer group. Two of them already had a bad experience with the group that led to discontinuation of their participation in activities. One of these participants reported that the group has made him aggressive and depressed leading to an increased chance of relapse.

Study 2
Sports Surprise and Sense of Coherence
Clients experienced a positive influence on two of three variables of sense of coherence, namely on manageability and to a lesser extent on meaningfulness, but they did not report an influence on comprehensibility. Regarding manageability, most participants (4 out of 6) reported that they had obtained skills to recognize and use resources better than before, due to participating in Sports Surprise. A participant mentioned:

> Now I think better about it and look for a solution. I figure out if I can do something or not. (Participant 11, 60-year-old woman)

Another participant reported:

> If you are in the group, then you must take them into account. That is some-times difficult for me. But it is good to learn those things. It is fun. (Participant 14, 46-year-old man)

While one participant mentioned that he had a stronger belief that things in life are interesting and worthwhile, the remaining participants could not clearly state what the influence was of Sport Surprise on meaningfulness. However, all six participants experienced an increase of their involvement in situations that are important to them and they found it worthwhile to take on challenges. One participant illustrated this by mentioning:

> It is easier to start new things. It is also easier to get over problems. I am just feeling better and my condition is improving. (Participant 16, 45-year-old man)

Sports Surprise and Social Support
We asked participants about their experiences on the influence of participating in Sports Surprise on (1) tangible, (2) advice, (3) belonging, and (4) self-esteem support. First, the influence of Sports Surprise on tangible support was experienced as marginal. Most participants (5 out of 6) reported that they did not get any material aid due to participa-ting in Sports Surprise. However, three of them were telling that they have been giving material aid to others. A participant stated:

> I give a lot of things away. I am also getting things, but these are of different values. (Participant 12, 42-year-old woman)

One participant ended his addiction treatment with the support of the shelter facility, went to live in a residential shelter facility and he also took control over his financial situation. Although it was hard for him to define the exact influence of Sports Surprise on this positive development, he reported that the shelter facility played a role in it.

Second, we found a more defined experienced influence regarding advice support. All six participants reported that they gave information and assistance to other participants and stakeholders of Sports Surprise. Four participants reported that they gained sup-port from participants and stakeholders of Sports Surprise, especially regarding their financial situation.

Third, it seemed that participants also experienced that Sports Surprise had a positive influence on belonging support in terms of enhanced sense of attachment and community. All participants experienced pleasure in connecting to other persons and they even made new friends. Noticeably, they did not only expand their social circle with co-participants of Sports Surprise, but also with contacts outside the shelter facility. A participant reported:

> Then I have to send a message to some persons and they are ready to help me. I have built more than just a social tie with them. (Participant 15, 52-year-old woman)

Finally, most participants (5 out of 6) reported higher levels of self-esteem support. Most of them experienced increased social interaction with several persons, among whom were also other persons than they knew from Sports Surprise.

Sports Surprise in Relation to Other Aspects of Well-Being
Although we did not explicitly ask whether respondents experienced a positive influence on well-being due to their participation in Sports Surprise, all respondents reported benefits on their well-being. They all reported a physical health improvement (i.e., less physical complains) and three participants have noticed positive changes in their mental health (i.e., less negative mood). These positive influences of participation in Sport Surprise on well-being are mainly due to obtaining several skills, such as (1) dealing with anxiety, (2) pushing boundaries, and (3) a better endurance. Accordingly, some of the participants also reported that sports is like a distraction for the mind.

DISCUSSION AND CONCLUSION

In two studies we explored how homeless clients experienced their participation in activities in relation to their well-being within the context of a Dutch shelter facility. We found that clients experienced that participation has led to an improvement of important components of physical, social, and mental well-being. In general, clients reported that due to participation in activities they have improved their social support, have increased their mental and physical health (i.e., mood and physical condition), and have enhanced their self-esteem and personal growth. The current findings are in line with research among the general population: participation in activities results in several (1) indirect social rewards (i.e., access to friends, networks, jobs and resources) and (2) direct personal rewards (i.e., personal fulfilment due to giving to others, fulfilling passions and commitments) leading to an improvement of well-being (Wallace & Pichler, 2009).

However, some clients reported that they have experienced a negative influence of participating in activities on aspects of their social and mental well-being which is related to their experiences with the group cohesion and the supervisor (i.e., social worker). First, the clients who have experienced a bad group cohesion, experienced lower or even negative benefits of participation on their social and mental well-being. This is in line with findings related to group therapy in clinical settings: clients who experience a better group cohesion also have more benefits of this intervention (Budman et al, 1989; Taube-Schiff, Suvak, Antony, Bieling, & McCabe, 2007). Second, clients also have experienced that the supervisor's attitude and behavior plays an important role in the participation and well-being relationship: the supervisor can hinder or facilitate clients' participation in activities. This is not surprising as various previous research shows that clients who have a better connection with their (social) worker have better treatment outcomes (Altena et al., 2017; Chinman, Rosenheck, & Lam, 2000).

We also found that clients experienced that participation expands their social circles leading to an enhancement of advice support. Although clients did not report that participation led to finding a job or obtaining tangible support, we found that the majority of the participants experienced an increase in a variety of resources, such as practical and social skills. Additionally, clients reported that participation has increased their self-esteem, recognition, personal development, and that it had led to a feeling of being meaningful and worthwhile. These reported experiences are also in line with conclusions drawn by Eurostat (2010) regarding social participation and social isolation. Participating in social activities on both personal and community level makes people happy (Eurostat, 2010). In our study happiness was explicitly mentioned in relation to mental well-being.

Methodological Remarks

The current research had several methodological remarks. First, both studies were conducted within the context of one organization and therefore the transferability to other populations cannot be established. However, a qualitative research does not aim to attempt to generalize the findings to a wider population (Sutton & Austin, 2015). Therefore, other designs (i.e., quantitative) and related research questions could be applied.

Second, both studies had a small sample size (respectively 10 and 6 participants). However, Guest, Bunce, and Johnson (2006) indicated that a sample of six interviews can already be an adequate size to find basic elements for meta-themes and that a sample size of 12 would be enough for saturation. This implies that our sample size would be sufficient to draw valid conclusions within the context of the study.

Third, in qualitative research it is always necessary to realize the particular role of the researchers in the interpretation of the collected data, because researchers have their own filter and experiences (Sutton & Austin, 2015). In order to enhance accuracy of data interpretation, most of the data-analyses was re-checked and supervised by a second researcher (i.e., first author of this manuscript).

Finally, we address a content-wise limitation: only participation inside or under supervision of employees of the shelter facility was examined in this study. It is important for homeless people to participate in society in a broader way, and not only in the safe environment of a shelter facility. For example, it is still an open question whether the shelter facility is stimulating homeless people hard enough to participate in society. Therefore, future research should focus on participation in activities in society as a whole and the steps that are necessary to accomplish social participation.

Implications

The findings of this research indicated that, in order to facilitate lasting positive outcomes of participation in practice in homeless clients, it is important to focus on (1) group cohesion and (2) the supervisor's behavior and attitude. We found that when group participants were satisfied with the group and the supervisor, they felt recognized, built confidence, and their motivation to continue the activity increased. Therefore, it is important to encourage homeless clients to not only interact with people from their former network (e.g., with whom they have had negative experiences in the past), but to increase contact with people who they can trust. Of course every participant in the group had his own problems and personal history, but with the right mix of people it is possible to create a positive atmosphere leading into a safe learning environment.

Furthermore, our findings demonstrated that it is crucial that supervisors of a group activity are trained on social and communicating skills. We found that the supervisor fulfils a crucial role, since he can facilitate or hinder client participation in groups. Specifically, it is important that the supervisor is knowledgeable, sympathetic and present, is promoting autonomy of participants, is showing respect, and is able to act on an equal level. A way to accomplish this is to stimulate that social workers should be courageous and feel comfortable to share personal stories with their clients. Through the process of sharing, relationships of equality between clients and workers can be built (Urek, 2017).

Additionally, our research supported the importance of creating a safe environment (i.e., enabling niche), in which participants are given responsibility, are feeling that they are equal to each other (including the supervisor), and are experiencing respect and recognition for what they are doing and who they are. Shelter facilities should imple-

ment the principles of the concept of the enabling niche (Taylor, 1997) into practice.

Finally, on the level of governmental policy it is important that shelter facilities are stimulated to develop group based interventions. Unfortunately, some Dutch institutions that offer services to homeless people have recently been implementing cost cutting measures by ending activity programs for their clients, mainly due to negative incentives from the government and health insurance companies.

Chapter 3

How to Enhance Social Participation and
Well-Being in (Formerly) Homeless Clients:
A Structural Equation Modeling Approach

ABSTRACT

In the present study we examined care-related and demographic predictors of well-being among 225 (formerly) homeless clients of a Dutch organization providing shelter services and ambulatory care (shelter facility). The role of social participation as a mediator was considered. Social participation is important for homeless people, as they are often socially isolated. Moreover, social participation enhances well-being and induces happiness. In this study we used the following care-related predictors: (1) participation in various group activities in the shelter facility, and (2) client's experiences with care, such as their satisfaction with the social worker and the shelter facility. Additionally, age and education level were included as demographic predictors. Results from Structural Equation Modeling show that the client's experiences with care and education level are predictors of well-being with a mediating role for social participation, and that participation in activities at the shelter facility is a direct predictor of well-being. However, age is not significantly related to social participation or well-being. We suggest that interventions for the homeless should be based on a combination of individual and group approaches. Special attention should be given to the client-worker relationship. We also recommend that vulnerable children are provided with solid education, and we call for research into the cost-effectiveness of group-based interventions.

INTRODUCTION

Social participation, defined as 'involvement in activities that provides social interaction with others in society or the community' (Levasseur, Richard, Gauvin, & Raymond, 2010, p. 2146), is a strong predictor of well-being and happiness (Eurostat, 2010; Phillips, 1967; Wallace & Pichler, 2009). Specifically, it provides people with access to others, networks, jobs and other resources; it helps people gain direct personal rewards such as personal fulfilment through giving to others; and it contributes to self-esteem (Wallace & Pichler, 2009). Social participation is important for homeless people because they are often socially isolated (Van Straaten et al., 2016). The obvious reason is that the majority of the homeless population has frequently experienced negative life events, such as a loss of social ties with family and friends, the loss of a job, and their house (e.g., Wolf, 2016), and some of the homeless people have even lost their skills to participate in society due to their low physical and mental health conditions (Gadermann, Hubley, Russell, & Palepu, 2013), substance misuse (Tam, Zlotnic, & Robertson, 2003) and aggressive and other behaviors (Fazel, Khosla, Doll, & Geddes, 2008). Hence, for homeless people it is a particular challenge to participate in society again. This means that homeless people should have opportunities to interact with others so that they can build new relations, for example through participation in activities as a starting point for social participation (Levasseur et al., 2010).

Most previous research on the social participation of homeless people has focused on housing programs. Although some authors have demonstrated that housing enhances the social integration of homeless people (Barendregt et al, 2017; Gulcur, Tsemberis, Stefancic, & Greenwood, 2007), others have concluded that this relationship does not exist (Tsai, Mares, & Rosenheck, 2012). One study even found a negative association between housing programs and social participation (Chang, Helfrich, Coster, & Rogers, 2015). Furthermore, an undesirable side-effect of housing interventions can be loneliness (Busch-Geersema, 2013) as a result of a lack of social participation. Given the inconsistent findings on the influence of housing programs on social participation and the undesirable side-effect of loneliness, it is clear that social participation by homeless people cannot be achieved by providing housing only. Therefore, it is necessary to investigate the role of other predictors of social participation in order to be able to develop rehabilitation and participation-based interventions for homeless people. Housing can be one of the aspects of such an intervention, but in our opinion other factors can also enhance social participation and well-being among homeless people. Consequently, in the current study we explored determinants of well-being among clients of an organization providing shelter services and ambulatory care (i.e., shelter facility), and we included social participation as a relevant factor.

Chapter 3

Predictors of Social Participation and Well-Being

Social participation of homeless people can be influenced by several factors, such as care-related, demographic-related, and society- or community-related variables. The latter refers to the role of others instead of the role of the homeless person himself or the role of the shelter from which he receives support. For example, the social network of homeless people and even the community members play a crucial role in accepting homeless individuals as full citizens, in facilitating them to participate in activities or networks, and to accept them as a part of their own network. Additionally, the government needs to facilitate a structure in which homeless individuals can find their way in the system like every other person. Hence, homeless people have the right to have access to economic, social and cultural institutions. However, the social justice system is often not accessible for homeless people, due to various reasons, for example because of practical issues, such as a lack of a postal address and a lack of financial resources, and issues related to stigmatization of homeless people (Amado, Stancliffe, McCarron, & McCallison, 2013; Van der Maesen & Walker, 2005; Wolf, 2016).

Although it is very interesting to examine society-related predictors of social participation of homeless people, the current study focused only on care-related and demographic predictors, because we aimed to examine social participation from the (formerly) homeless individual's perspective. By gaining deeper insights in care-related and demographic predictors of social participation and its relation to well-being, we aimed to contribute to implications for interventions for homeless people. Consequently, in the current study, we focused especially on two care-related predictors: (1) clients' participation in various group activities organized by the shelter facility as a part of the support delivered to (formerly) homeless clients, and (2) clients' experiences with care. We chose these two predictors because they improve social participation and well-being in homeless people (Kashner et al., 2002; Peden, 1993; Randers et al., 2011; Sherry & O'May, 2013). Additionally, and in line with previous literature, we included age and education level as demographic predictors of social participation and well-being (La Due Lake & Huckfeldt, 1998; Philips, 1967; Wallace & Pichler, 2009).

Care-Related Predictors

Several studies have shown that participation in various activities organized by a shelter facility or a health care organization leads to improved social participation and well-being in homeless people. Peden (1993) has shown that participation in a music program increases interaction with others, decreases loneliness and isolation, and fosters a sense of well-being. One of the advantages is that the use of music provides the care-worker with an opportunity to create a therapeutic relationship with homeless clients (Peden, 1993). Thomas, Gray, McGinty, and Ebringer (2011) have demonstrated that participa-

ting in an art intervention is a good starting point for social participation. Specifically, participation in the program helped homeless people to become actively involved and accepted members of the intervention group. In addition, it reduced addictive behaviors of participants and it resulted in improvements in mental health, as participants could do something else instead of consuming alcohol and drugs while simultaneously reclaiming a positive identity through self-discovery. In this process, participants developed a new and positive self-image that enabled them to establish new roles and relationships (Thomas et al., 2011). Participation in a work therapy program can also lead to a decrease in drug and alcohol related problems, and it can prevent a further loss of physical functioning among homeless people (Kashner et al., 2002). However, Kasher et al. (2002) did not find any effects on psychiatric outcomes. Sports interventions for homeless people and comparable target groups (e.g., people in poverty) have also been reported to achieve positive outcomes such as increased social support, reduced substance abuse and symptoms of mental illness (Sherry & O'May, 2013), and improved physical health (Randers et al., 2011). Accordingly, for shelter facilities to facilitate social participation and well-being in homeless people, it is important that they offer their clients various activities related to education, recreation, and labor.

Since social participation is currently a high-priority issue for most European governments (Gros & Roth, 2012), the main goal for social workers in shelter facilities is to enhance social participation among their homeless clients. This leads to the question whether satisfaction with the social worker and with the services received is associated with higher levels of social participation. To our knowledge there are no studies on the relationship between experience with care (such as satisfaction about the facility and the social worker) and social participation, or on the relationship between experiences with care and well-being among homeless people. McCabe, Macnee, & Anderson (2001) conducted a study on satisfaction with care among homeless patients, and one of their findings was that well-being played a role in the evaluation of the satisfaction with health care. However, these authors did not consider well-being as an outcome of satisfaction with care. In their view, care workers should take well-being into account in the treatment to increase satisfaction (McCabe et al., 2001). Regarding the relationship between client satisfaction and outcomes in more clinical settings, it has been found that shared decision-making and having a choice in the treatment are predictors of better clinical outcomes (Lindhiem, Bennett, Trentacosta, & McLear, 2014). This is also consistent with research conducted among addicted patients in community-based drug treatment programs, which demonstrated that a greater satisfaction was positively related to desired treatment outcomes. In this study satisfaction has been operationalized as satisfaction with the services, the counsellor, and the program (Hser, Evans, Huang, & Anglin, 2004). This means that experiences with the social worker and the shelter

facility should be considered when studying predictors of desired outcomes, such as social participation and well-being.

Demographic Predictors

Demographic variables, such as age and education level, are also determinants of social participation and well-being. For example, La Due Lake and Huckfeldt (1998) found that the level of education is positively related to one particular form of social participation, namely political participation. Phillips (1967) reported a very strong positive relationship between education level and social participation; more than half of the study subjects with college training scored significantly higher on social participation compared to those who had lower education (high school or less). More recent research also shows a positive relationship between education level and participation, especially regarding voluntary work (Wallace & Pichler, 2009). The relationship between education level and social participation is probably associated with the following issues. First, the higher level of skills of educated people facilitates social participation (La Due Lake & Huckfeldt, 1998; Philips, 1967). Second, higher educated people are more interesting for others because of the prestige that is related to higher education (Phillips, 1967). Finally, higher educated people have more opportunities to participate for instance in voluntary work (which in turn increases their social participation) because they have a higher level of socio-economic security (Wallace & Pichler, 2009). Education also predicts well-being. For example, Philips (1967) found that highly educated people report more positive feelings and happiness. Additionally, Wallace and Pichler (2009) have reported a positive correlation between education level and life satisfaction.

Social isolation seems to increase with age. Eurostat (2010) has reported that older people have fewer friends, because friendships break up or friends die, while it is difficult to replace these social contacts. Further, Wallace and Pichler (2009) have shown that older people participate less in certain types of activities such as sport clubs, peace and educational associations, but that they participate more in voluntary associations. However, it remains unclear whether their participation in voluntary associations compensates for the lack of participation in other types of activities. Also, there is no consensus in the literature whether age is correlated with well-being (Diener, 2009a). In summary, both age and education level seem to be related to social participation, and education level is also related to well-being. Since all the above-mentioned studies on the relationship between demographics and social participation were conducted among the general population, it remains unclear whether the same mechanisms are valid for (formerly) homeless people.

The Mediating Role of Social Participation

In the current study we consider social participation as a mediator between care-related and demographic predictors and well-being. However, there are to our knowledge no empirical studies that address the question whether social participation can be viewed as mediating the relationship between care-related and demographic variables (such as experiences with care, participation in activities in the shelter facility, education level and age) and well-being as an outcome. Although we did find evidence for a relationship between these specific predictors and social participation (La Due Lake & Huckfeldt, 1998; Kashner et al., 2002; Peden, 1993; Philips, 1967; Sherry & O'May, 2013; Thomes et al., 2011) and between social participation and well-being (Biswas-Diener & Diener, 2006; Eurostat, 2010; Wallace & Pichler, 2009), these authors do not suggest a specific line of causation between the constructs in a model with social participation as a mediator. Therefore, we derived our reasoning from other studies focused on ageing and on sports participation, without focusing on the homeless population (Hirve et al., 2013; Marlier et al., 2015). The study on ageing showed that social networking (an aspect of social participation) mediates the relation between socio-economic status (including education level) and quality of life (Hirve et al., 2013). Regarding the study on sports participation, a model was tested in which social capital (including social ties) mediates sports participation (a specific form of participation in activities) and mental health (one of the aspects of well-being), whereby education also was considered as a predictor of mental health through social capital (Marlier et al., 2015). Specifically, Marlier et al. (2015) and Hirve et al. (2013) tested their proposed models using Structural Equation Modeling (SEM) with similar concepts as social participation as mediator.

The Present Study

The aim of the present study is to examine care-related and demographic predictors of well-being among clients of a shelter facility in the Netherlands. We tested a mediation model (Figure 1) in which social participation mediates the relationship between predictors related (1) to care (experiences with care and participation in activities in the shelter facility) and (2) to client demographics (age and education level) on the one hand, and well-being on the other. We expected all relationships between the variables to be positive, except for the age-social participation association (an older age is related to less social participation).

Figure 1. Hypothesized model in the present study

Our study contributes to the literature by emphasizing the mediating role of social participation in the relationship between care-related and demographics predictors on the one hand, and well-being on the other. It is important for shelter facilities to acquire more knowledge and understanding of all these factors, including their interrelatedness. With this knowledge they can develop a rehabilitation program that promotes social participation with the main goal of enhancing sustainable well-being among homeless people. Moreover, to our knowledge we are the first to include care-related predictors in this model.

METHOD

Design and Participants

In the Netherlands, it is common practice to define 'all people who receive support from the shelter facility' as 'homeless' or 'houseless' persons even if they are living in their own dwelling and can be categorised as 'formerly homeless people' (e.g., Kruize & Bieleman, 2014; Planije, Tuynman, & Hulsbosch, 2014). The reason for this is that people who have their own dwelling are still at risk of homelessness mostly due to their financial situation and/or their (mental) health condition. For example, research showed that a substantial group, of at least 17 to 25 percent of people relapse in homelessness after they obtained housing (Kostiainen, 2015; Mayock, O'Sullivan, & Corr, 2011; Mc-Quistion, Gorroochurn, Hsu, & Caton, 2013; Tuynman & Planije, 2012). To deal with this risk, people who have their own dwelling but are still in risk of relapsing in homelessness, can receive support from a shelter facility. In international context, only people who are rooflessness, houselessness (e.g., residential clients of a shelter facility), living in insecure housing or in inadequate housing are considered as 'homeless' (Feantsa, 2005; Springer, 2000). Hence, this definition might include a smaller group as homeless. Therefore, in the current study we used the term '(formerly) homeless clients' which includes residential and ambulatory clients of the shelter facility. Residential clients are persons who live in one of the shelters, and ambulatory clients are persons who live in their own dwelling but have been at serious risk of losing their dwelling or who were homeless in the past.

For our study we used the baseline data (the data that were first available for analyses) from a larger longitudinal study on the effectiveness of a participation-based intervention for homeless people, called 'Growth Through Participation' that was conducted among a Dutch shelter facility which provides residential and ambulatory care to homeless adults. The aim of the larger study was to examine whether 'Growth Through Participation' is effective at both the client level (e.g., effects in terms of well-being) and the organizational level (e.g., effects on team performance and its predictors).

The data from the baseline measurement used in the present cross-sectional study were collected in the period of March to May 2015 among residential and ambulatory clients. In total 47% (*N* = 225) of all clients participated in the current study, of which 57% (*n* = 100) were residential clients and 44% (*n* = 125) ambulatory clients. The following inclusion criteria were used for the eligible participants: (1) at least 18 years old, (2) understanding Dutch, (3) able to give informed consent; with an additional criterion for residential clients: (4) able to participate in an interview, as residential clients were asked to be interviewed at the location of the shelter facility. Ambulatory clients received a printed version of the questionnaire. The two interviewers, experienced in interviewing clients of health care organizations, were trained in interviewing (formerly) homeless clients and the use and meaning of the questionnaire before the data collection started. Information from both the interviews and the questionnaires was only accessible to the researchers involved in the study. We obtained written informed consent from all participants included in the study and participation was voluntary.

Measures

Demographic Characteristics

Demographic characteristics including gender, age, education level, duration of support by the shelter facility and residential situation were assessed. Duration of support was measured by asking the question: 'For how long have you been receiving support from this organization?' and was categorized as 'less than one year' to 'five years or more'. Education level varied from 'no education/primary education' to 'higher education'. Residential situation was divided into three categories: (1) 'a residential shelter (short-term stay)', (2) 'a residential shelter (long-term stay)', and (3) 'living in own dwelling'. A short-term shelter facility is one that provides urgent support to people immediately after they have become homeless with a maximum stay of up to three months. A long-term shelter facility offers a more permanent form of accommodation; depending on the needs of the resident, the duration of the stay can last a lifetime.

Care-Related Predictors

Care-related predictors consist of clients' (1) experiences with care and (2) participation in activities offered by the shelter facility. Experiences with care were assessed using subscales of the Consumer Quality Index for Shelter and Community Care Services (CQI-SCCS) (Beijersbergen & Wolf, 2010). Experiences with the services were assessed using nine items of the subscale 'Services Received'. Satisfaction with the social worker was assessed by means of the four-item subscale 'Client-Worker Relationship', and two items concerning 'General rating' were used to obtain a general impression of the client satisfaction. Examples of items included 'Are you getting as much support as you need?' (Services Received) and 'Is the social worker (who is supporting you) treating you with

respect?' (Client-Worker Relationship). The items were scored on a four-point Likert scale rating from 1 (never) to 4 (always), with the exception of the items concerning 'General rating' which were rated on a scale from 0 to 10. The CQI-SCCS has been used in studies among the homeless before (Asmoredjo, Beijersbergen, & Wolf, 2016; Lako et al., 2013). Participation in activities offered by the shelter facility was measured by gathering information from the registration system about the number of half-day sessions that participants participated in activities (education, recreation, and labor) on a weekly basis. We computed the mean participation rate for a period of four weeks from 2 to 29 March 2015.

Social Participation

As afore mentioned social participation includes two constructs (Levasseur et al., 2010): (1) involvement in activities, and (2) social interactions with others. The first construct was measured using the 'Participation Ladder' (Van Gent, Van Horssen, Mallee, & Slotboom, 2008). This instrument consists of six phases: (1) isolated, (2) social contacts outside of one's house, (3) participation in organized activities, (4) unpaid work, (5) paid work with additional support, and (6) paid work (Van Gent et al., 2008). We assessed which of the six phases applied for a participant by asking what situation was applicable in his case, for example 'I have paid work' or 'I do not have any social contacts'. Consequently, scoring high on the Participation Ladder means that one is more involved in activities that typically provide social interaction with others in community and society, while scoring low refers to one's lower level of participation and thus to more isolation. However, a possible comment on this instrument is that work is valued more than participation in organized activities. Therefore, in additional analysis we used a 3 point scale in which several types of work (phase 4, 5, and 6) were scored at the same level as participation in organized activities (phase 3). To our knowledge there is no other study in which the Participation Ladder is used among homeless people. Nevertheless, we used this instrument, because it has been frequently used within the context the shelter facility during the period of the data collection for the current study and it has been recognised by several financers of shelter facilities (Terpstra, 2011).

The second construct of social participation, namely social interaction with others refers to one's interaction with family members, relatives, friends, neighbors, and other acquaintances (Herzog, Ofstedal, & Wheeler, 2002; Levasseur et al., 2010). In order to capture the construct of interactions with others more explicitly, when compared to the Participation Ladder where interaction is rather implicit, we included assessment of social support in the current study. The concept of social support is relevant as it captures not only one's social interaction with others (Barrera & Ainlay, 1983) (e.g., we explicitly asked whether respondents interact with family, friends, and acquain-

tances), but it assesses also the nature of these interactions. Specifically, it measures to what extent respondents receive for instance emotional and material support from others which is a very relevant when explaining well-being among homeless people (Sherbourne & Stewart, 1991). To measure social support, we used five items derived from scales developed for the 'Medical Outcome Study (MOS) Social Support Survey' (Sherbourne & Stewart, 1991), which has been commonly used in studies among the homeless (Lako et al., 2013; Van Straaten et al., 2016). Participants were asked to specify how often different kinds of support were available to them through (1) family and (2) friends or other acquaintances. Answers could be given on a five-point Likert scale ranging from 1 (none of the time) to 5 (all of the time). One example of an item is: 'How often is your family available to listen to you when you are talking about yourself or your problems?' (Sherbourne and Stewart 1991). In the current study we calculated the average scores on both subscales separately (family and friends/acquaintances) and transformed scores to a 0-100 scale.

Well-Being

When we use the term 'well-being' in the current study, we refer to subjective well-being, as we measure it based on self-reported evaluations. Well-being comprises cognitive and affective aspects (Biswas-Diener & Diener, 2006). More specifically, it concerns whether a person feels and thinks his/her life is desirable, pleasant and good (Diener, 2009b). A synonymous term would be 'quality of life' (Diener, 2009b). Mental health and self-esteem are closely related to well-being (Diener & Seligman, 2009; Dogan, Totan, & Sapmaz, 2013) and thus can be seen as underlying constructs of well-being. Moreover, self-esteem is a good indicator for the affective state of a person (Brown & Marshall, 2001). We therefore understand well-being as a combination of quality of life, absence of psychological distress, and self-esteem. Because we could not find any well-being questionnaire that includes these three constructs, we applied three separate instruments to measure each of the constructs.

Quality of life was assessed by the 26-item 'World Health Organization Quality of Life Brief version' (WHOQOL-BREF) (Skevington, Lotfy, & O'Connell, 2004; WHO, 1998), consisting of five subscales: 'Physical Health', 'Psychological Health', 'Social Relationships', 'Environment' and 'Overall Quality of Life and General Health'. Example items include: 'How would you rate your quality of life?', 'How much do you enjoy life?', and 'How satisfied are you with your personal relationships?'. A five-point Likert scale was used ranging from 1 (very poor or very dissatisfied) to 5 (very good or very satisfied). In the current study we used the total score of the WHOQOL-BREF and transformed this score to a 0-100 scale. The WHOQOL-BREF has been used widely in research among different target groups including homeless people (Ford, Cramb, & Farah, 2014; Garcia-Rea

& LePage, 2008). In order to find out whether there is an overlap between the 'Social Relationships' items (subscale of WHOQOL-BREF) and the items of the MOS Social Support Survey (part of Social Participation, see section "Interview description"), we explicitly compared these two types of items with each other. Hence, while the items of the WHOQOL-BREF assess satisfaction with the personal relationships (including satisfaction with the received support), the items of the MOS Social Support Survey measure the extent to which people feel supported. Hence, these two types of items do not overlap, because they measure different constructs. Additionally, one item of the WHOQOL-BREF measures the extent to which people have the opportunity for leisure activities. This item may overlap the third phase, namely participation in organized activities, of the Participation Ladder (other aspect of Social Participation). However, the Participation Ladder in general can be considered as a predictor of the opportunity to participate in leisure activities as higher scores on the Participation Ladder (i.e., having a job) expands people's opportunity to participate in leisure activities, because a job gives people (financial) resources to participate in non-work-related activities (Paul & Batinic, 2010; Underlid, 1996). Nevertheless, due to possible redundancy between these two items (even if one may argue whether this is the case considering that item of the Participation Ladder is much broader than the item of the WHOQOL-BREF), we conducted an additional analysis where we removed the leisure-activity-item from the WHOQOL-BREF.

Absence of psychological distress was measured using the 'Brief Symptom Inventory' (BSI-53) (De Beurs & Zitman, 2005; Derogatis, 1975). The BSI consists of 53 items and assesses nine patterns of clinically relevant psychological symptoms (dimensions): somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. Every item starts with the question 'During the last week, how much did you experience…' and examples of items include 'thoughts of suicide', 'feeling lonely', and 'having difficulties with making decisions'. A five-point Likert scale was used ranging from 0 (not at all) to 4 (extremely). We reversed the scores so that they measured the absence instead of the presence of psychological distress, and we used the total score of the BSI-53. The BSI has been used widely, also among homeless people (Lako et al., 2013; Velasquez, Crouch, Von Sternberg, & Grosdanis, 2000).

Self-esteem was assessed using the ten-item 'Rosenberg Self-Esteem Scale' (RSES) (Rosenberg, 1965; Van der Linden, Dijkman, & Roeders, 1983). Examples of items include 'On the whole, I am satisfied with myself', and 'I certainly feel useless at times'. A four-point Likert scale was used ranging from 1 (strongly agree) to 4 (strongly disagree). In the current study we transformed scores to a 0-100 scale. The RSES has also been

used in several studies among homeless people (Lako et al., 2013; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000).

Statistical Analysis

Descriptive statistics and scale reliabilities were analysed using SPSS (version 24), and we used AMOS (version 22) (Arbuckle, 2013) for SEM to test the mediation model (Figure 1). This method enabled us to test the hypothesized model statistically through a simultaneous analysis of all variables and relationships with the aim of determining to what extent the model is consistent with the data (Byrne, 2016). It is possible to include both latent and observed variables in the model. Latent variables are variables that are not observed directly, but are operationalized by a combination of observed variables (Byrne, 2016). In the current study we distinguished the following latent variables: experiences with care, social participation, and well-being. We conducted Confirmatory Factor Analysis (CFA) for experiences with care and social participation in order to confirm the expected three-factor structure. Unfortunately, we could not perform CFA for well-being because this latent variable is represented by 89 items (WHOQOL-BREF consists of 26 items, BSI of 53 items, and RSES of 10 items) and CFA should be performed for at least 10 respondents per item, which meant that we would need at least 890 participants in our study instead of the current 225 (Blunch, 2013; Schreiber, Nora, Stage, Barlow, & King, 2006). AMOS has been used in several studies in social sciences and other disciplines including studies on well-being and related aspects (Lin & Yeh, 2013; Hirve et al., 2013; Zhang et al., 2013).

Data were screened for missing data before conducting the analyses. Missing value analysis showed that 3% of the data of all variables used in the mediation model were missing. We handled missing data in two steps. First, regarding the WHOQOL and BSI we used the instructions on missing data from the user manuals (Derogatis, 1975; WHO, 1998). The BSI manual indicates that the total BSI score can be calculated if 12 or fewer items are missing (Derogatis, 1975). The WHOQOL manual states that 20% of the items are allowed to be missing for calculation of the total score, which means that five items can have missing scores for each respondent (WHO, 1998). We calculated the total scores for both scales, total BSI and total QoL, if at least 41 items (BSI) and 21 items (QOL) were filled in. We could not find such instructions in the manuals of the other questionnaires that we used. Therefore, we only computed mean scores if all items of the (sub)scale were filled in. Second, we used the Full Information Maximum Likelihood (FIML) method to obtain estimates of the parameters, which is considered to be one of the best methods to handle missing data as it yields less biased results than the commonly used methods of list-wise or pair-wise deletion (Arbuckle, 2013; Byrne, 2016; Enders & Bandalos, 2001).

The fit of the measurement model was evaluated using a combination of fitness indexes. In the current study we used the Comparative Fit Index (CFI) as a measure for incremental fit, the Root Mean Square of Error of Approximation (RMSEA) as a measure for absolute fit, and the Chi Square/Degrees of Freedom (χ^2/df) as a measure for parsimonious fit. A model is considered to have a good fit if CFI >0.90, RMSEA<0.08, and χ^2/df <3.0 (Arbuckle, 2013; Awang, 2012).

Finally, we computed the significance of the indirect effects of every (significant) predictor on well-being to determine whether partial or full mediation occurs. The direct effects are the effects that go directly from every predictor to well-being. The indirect effects are the effects that go indirectly from every predictor through the mediator (social participation) to well-being. Mediation occurs when the indirect effects are greater than the direct effects. Partial mediation occurs when the direct effect is still significant after the mediator is included in the model and full mediation occurs when the direct effect is not significant (Awang, 2012).

RESULTS

Descriptive Statistics
The demographic characteristics of all participants in the current study are presented in Table 1. Seventy-two percent of the 225 participants is female, the mean age of the participants was 49.3 years, and 56% percent lived in their own house with ambulatory support. The duration of the support by the shelter facility varied: the largest group of participants (36%) received support from the shelter facility for a period of 2 to 5 years. The education level also varied, but most participants had intermediate education (36%).

The means of the other variables are presented in Table 2, namely services received (3.15), client-worker relationship (3.47), general rating (7.28), participation in activities in the shelter facility (1.70), participation ladder (3.40), social support (202), quality of life (60.42), self-esteem (29.49), and absence of psychological distress (3.29). Cronbach's alfas were also calculated and they were all satisfactory, ranging from .81 to .97.

Table 1. Demographic variables (*N* = 225)

Demographics	N (%)
Gender	
Male	163 (72%)
Female	62 (28%)
Age	Mean 49.3 SD 12.57 (range 19-87)
Education level	
No education or primary education	45 (20%)
Lower education	57 (25%)
Intermediate education	81 (36%)
Higher education	33 (15%)
Missing	9 (4%)
Residential situation	
In own house with ambulatory care	125 (56%)
Residential shelter (long-term stay)	81 (36%)
Shelter facility (short-term stay)	19 (8%)
Duration of the support	
< 1 year	52 (23%)
1 to 2 years	44 (20%)
2 to 5 years	80 (36%)
≥ 5 years	49 (22%)

Table 2. Means, standard deviations (in parentheses), and internal consistency coefficient (Cronbach's alfa)

Scale	N	Mean (SD)	α
Services Received	210	3.15 (.63)	.89
Client-Worker Relationship	220	3.47 (.61)	.83
General rating	221	7.28 (1.93)	.81
Participation in activities in the shelter facility	221	1.70 (2.68)[a]	n.a.[b]
Participation Ladder	219	3.40 (1.39)	n.a.[b]
Social Support Family	213	49.60 (35.26)	.95
Social Support Friends and Acquaintances	208	45.91 (33.32)	.95
Total Quality of Life	222	60.42 (16.32)	.92
Self-esteem	211	29.49 (1.94)	.85
Absence of psychological distress	216	3.29 (.64)	.97

[a] 112 participants did not participate in group activities.

[b] Not applicable because scale consists of 1 item.

The Structural Equation Model

The results from the Confirmative Factor Analyses (CFA's) confirmed the three-factor structure for both experience with care and social participation variables. The CFA model for experiences with care had a reasonable fit: χ^2/df was 2.535, CFI was .933, and RMSEA was .083. The CFA model for social participation had a good fit: χ^2/df was 2.369, CFI was .973, and RMSEA was .078. All the factor loadings were significant (p<.001) in both models. We could not perform CFA for well-being because this latent variable was represented by 89 items and our sample size was not large enough to conduct this analysis (Blunch, 2013; Schreiber et al., 2006). However, in the current path models (Figure 2 and Figure 3) the indicators of well-being (quality of life, absence of psychological distress, and self-esteem) were all significantly related to the latent variable of well-being, which implies that the latent variable was represented by these three indicators.

First, we tested the hypothesized model without social participation as mediator, which had a good fit: χ^2/df was 1.018, CFI was .999, and RMSEA was .009. In this model, experiences with care, participation in activities in the shelter facility and education level were significantly related to well-being while a non-significant relationship was found between age and well-being. Only 15% of the variance of well-being was explained by its predictors.

Second, we tested the hypothesized mediation model with social participation as a mediator (Figure 2), which also had a good fit: χ^2/df was 1.858; CFI was .942, and RMSEA was .062. We found support for a model in which social participation mediates the relationship between experiences with care and education level, and with well-being. However, participation in activities in the shelter facility and age were not significantly related to well-being through social participation. The proportion variance explained for well-being was 38% and for social participation 27% in this model.

Third, we tested whether social participation is a partial or full mediator. The indirect effect of experiences with care on well-being was .254, and the direct effect was .013. Since the indirect effect was greater than the direct effect, while the direct effect is not significant when the mediator is included in the model, full mediation occured. Regarding education level, the indirect effect (.113) was greater than the direct effect (.070) and the direct effect was not significant after the mediator enters the model, hence social participation could also be considered a full mediator here.

Finally, we tested a model in which participation in activities in the shelter facility is directly related to well-being and in which age is excluded (Figure 3). We linked participation in activities in the shelter facility directly with well-being, because the first

model (without mediator) showed that participation in activities in the shelter facility was directly and significantly correlated with well-being, whereas the second model (Figure 2) showed that it was not significantly correlated with social participation. Further, we excluded age because it was not significantly related to social participation or to well-being in the first and second model.

Figure 2. Structural Equation Model for well-being, social participation, and predictors (*N* = 225)
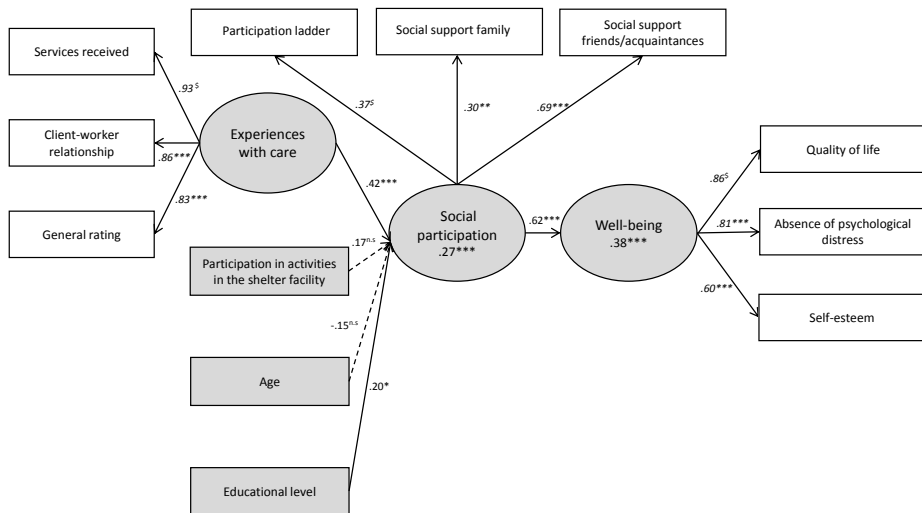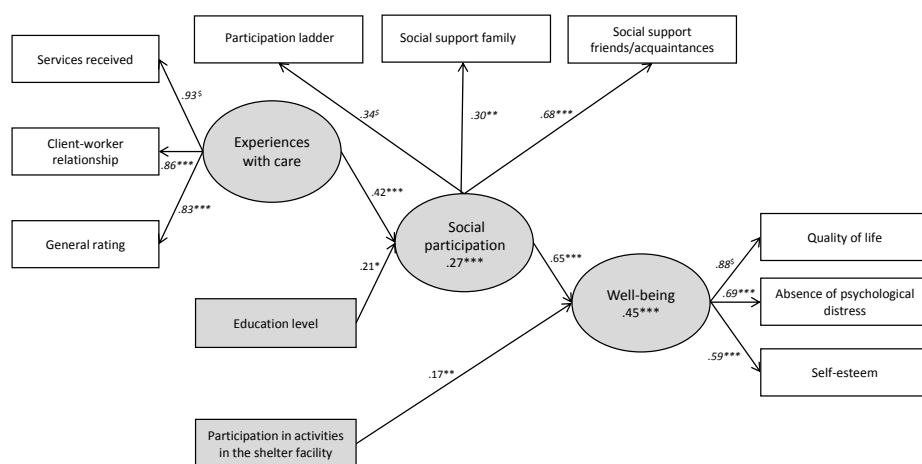

Note. Standardized regression coefficients are shown next to the arrows, and factor loadings are printed in italics. Proportions of variance explained are reported below construct names. Ovals represent latent variables and rectangles represent observed variables. *p<.05. **p<.01. ***p<.001. n.s. p=non-significant. $Loading fixed at the value of 1 in the non-standardized solution.

Consequently, we considered social participation as a full mediator between only two predictors, namely experiences with care and education level, and well-being. The model (Figure 3) had a good fit; χ^2/df was 1.668, CFI was .961, and RMSEA was .055. Participation in activities in the shelter facility was significantly related to well-being in this model. All relations were significant. The proportion variance explained for well-being was 45% and for social participation 27% in this final model.

As stated in section "Study 1" we conducted two additional analyses. In the first analysis we used a 3 point scale regarding the Participation Ladder. By using this adapted scale we valued work on the same level as organized activities. We tested whether the relationships in the SEM model (Figure 3) changed. All relationships remained significant

and the model still had a good fit (χ^2/df was 1.766, CFI was .955, and RMSEA was .058). In the second analysis, we excluded the item regarding the extent to which people have the opportunity for leisure activities from the total quality of life score. Hence, the mean score of WHOQOL BREF changed slightly from 60.42 (*SD* = 16.32) to 61.38 (*SD* = 16.32). All relationships remained significant and the model fit remained exactly the same as the SEM model presented in Figure 3 (χ2/df was 1.668, CFI was .961, and RMSEA was .055). Conclusively, deleting the leisure-item from the total Quality of life scale would not make a significant difference.

Figure 3. Final Structural Equation Model for well-being and predictors (*N* = 225)

Note. Standardized regression coefficients are shown next to the arrows, and factor loadings are printed in italics. Proportions of variance explained are reported below construct names. Ovals represent latent variables and rectangles represent observed variables. **p*<.05. ***p*<.01. ****p*<.001. $^{\text{\$}}$Loading fixed at the value of 1 in the non-standardized solution.

DISCUSSION

The present study examined predictors of well-being through social participation in (formerly) homeless clients of a Dutch shelter facility. We found that the clients' experiences with care and education level are predictors of well-being through social participation and that participation in activities in the safe environment of the shelter facility is a direct predictor of well-being. Age was not significantly related to social participation or well-being. These findings are partially in line with our hypothesized model.

First, as expected, we confirmed that social participation is a mediator between experiences with care and well-being. Social participation is one of the primary goals pursued by shelter facilities, as it provides various benefits. Our research indicates that a higher satisfaction about (1) the services received, (2) client-worker relationship, and (3) the general satisfaction with the support can lead to a higher level of social participation by clients of the shelter facility. Second, and in line with our expectations, education level was found to be related to well-being through the mediator of social participation. Higher educated clients receive more social support from family, friends and other acquaintances and score higher on the Participation Ladder, which implies that they are less socially isolated. Also, they more often have a job than lower educated clients. Additionally, our data confirmed earlier research (Biswas-Diener & Diener, 2006; Eurostat, 2010; Van Straaten et al., 2016; Wallace & Pichler, 2009) that higher levels of social participation lead to an enhancement of well-being, which we operationalized as a better quality of life, less psychological distress and improved self-esteem. Third, and not in line with our hypothesized model, participation in activities at the shelter facility has a direct influence on well-being, rather than an indirect influence. In the introduction we noted that participation in group activities has several benefits, both for well-being and for social relationships (which is one dimension of social participation) (Kashner et al., 2002; Peden, 1993; Randers et al., 2011; Sherry & O'May, 2013; Thomas et al., 2011). A possible explanation for not finding a relationship between participation in group activities and social participation may be the low levels of participation in the shelter facility: about half of the participants in the current sample did not participate in activities, and therefore the average participation rate was low (only 1.7 half-day sessions per week). If the participation level could be increased, it is highly probable that this would have a stronger impact on social participation and even on well-being. Another possible explanation might be that the activities are not focusing enough on social participation, including building relationships with friends and family. In the current study we did not evaluate the quality and the content of the activities, which means that we cannot draw a conclusion on this. However, in another qualitative study that was conducted in the same shelter facility we found that participation in activities in the shelter improved social support, clients made new friends, developed stronger communication skills, and became more social and helpful (Rutenfrans-Stupar, Van der Plas, Den Haan, Van Regenmortel, & Schalk, 2019). Finally, we could not confirm the relationship between age and social participation (i.e., we expected that the older the clients are, the lower their social participation rate would be). It might be that at a higher age, homeless individuals are more involved in social participation programs provided by shelter facilities as they are the most vulnerable group (compared to the younger homeless). Through participation in these programs, they may experience higher levels of social support.

Our findings suggest that shelter facilities can influence social participation and well-being by working on several factors. The finding that clients' experiences with care are related to social participation and well-being, leads to the advice that it is important to enhance client satisfaction, under which the clients' experiences with the client-worker relationship.. This can be fostered by building a client-worker relationship in which the homeless client is treated with respect and his/her autonomy is enlarged. Clients should be provided with valid information at the right moment, and the support should be given in time. Clients should also be stimulated to take decisions on their own. This is in line with previous findings by Lindhiem, Bennett, Trentacosta, & McLear (2014), who already emphasized the importance of the decision-making process in health care. Hence, social workers should build a therapeutic alliance that can be described as 'the collaborative and affective bond between therapist and patient' (Martin, Garske, & Davis, 2000, p. 438) or, in our case, 'the collaborative and affective bond between social worker and homeless client'. A therapeutic alliance can help clients cope with different situations and to regulate their emotions; it ensures that clients are involved in the decision-making process (Lindhiem et al., 2014); and it is related to positive outcomes (Martin et al., 2000). A therapeutic alliance is especially important for homeless people, as they often have lost trust in others and have lost social contacts. Therefore, homeless people need to connect to an 'anchor', which can initially be found in an intensive therapeutic relationship with the social worker (Van Regenmortel, Demeyer, Vandenbempt, & Van Damme, 2006). Accordingly, our recommendation is to train social workers on the principles of therapeutic alliance which can be promoted by applying one of the contemporary strength- and rehabilitation based-approaches that are already used widely by social workers at shelter facilities in the Netherlands (e.g., Den Hollander & Wilken 2013; Wolf, 2016).

The finding that participation in activities in the shelter facility enhances well-being, leads to the advice that shelter facilities should offer clients an activity program that consists of educational, recreational and work activities in a safe environment where they are not stigmatized and are stimulated to work on self-development and to connect to other people. Such an environment is also called an 'enabling niche' in the literature, because it enables clients to learn how to interact with others, to improve their self-esteem, and to take responsibility (Driessens & Van Regenmortel, 2006; Taylor, 1997). Other research supports our findings that in addition to individual mentoring, group interventions can promote beneficial outcomes. For example, other researchers found that a group intensive peer support intervention is an effective substitute for individual case management. Homeless clients experienced positive outcomes, especially in regard to self-reported social integration (Tsai & Rosenheck, 2012). However, a negative side effect of offering activities in a safe environment can be that it raises the threshold to

participating in society; this is the well-known effect of institutionalization (Goffman, 1961), in other words the 'enabling niche' can become an 'entrapping niche'. We assume that there is a very thin dividing line between an enabling niche and an entrapping niche, but with the right precautions institutionalization can be prevented. Therefore, social workers should take care to create an environment (i.e., an 'enabling niche') in which clients have access to others, can reach a better position, in which they are stimulated and enabled to move on to other niches, and in which they interact with other people than only homeless people. They should also be incentivised to set realistic long-term goals (Driessens & Van Regenmortel, 2006; Taylor, 1997). The Participation Ladder used in this study (or a comparable instrument) can give (formerly) homeless clients more insight into their own situation and can help them set, pursue and reach personal goals. However, in the current study we did not examine the extent to which institutionalization took place: future research is needed to examine whether the activities the shelter facility offered during the current study meets the criteria of the 'enabling niche'.

Finally, our research underlines the need for education among (formerly) homeless people. As obtaining higher education qualifications at an older age is not always possible, we call for the solid education of children of homeless people and other vulnerable children. These children are at risk of not receiving proper education, which can cause poverty in the long term as well as various other problems (Zima, Bussing, Forness, & Benjamin, 1997). This can put them at risk of becoming homeless at an older age. Research shows that access to school is not a problem for homeless children, but their school achievements are lower compared to children of non-homeless parents (Masten et al., 1997). Per year in the Netherlands, there are approximately 7000 children of parents who live in a shelter facility (Van Rijn, 2017). The parents mostly receive psychological help for their problems, but the children do not always receive the attention they need (VanMontfoort, 2017). Therefore, special attention should be given to vulnerable children, certainly with respect to their future perspectives, which clearly includes education.

The current study has some limitations. First, it was conducted in the context of a Dutch shelter facility, which might limit its external validity. Second, Structural Equation Modeling tests whether relations exist, but it cannot test the causality between variables. Third, our data relies on self-reports by clients of the shelter facility. Fourth, one of the instruments we used, namely the Participation Ladder, has not yet been scientifically validated. Fifth, other variables such as material deprivation, the presence of debts and (lack of) access to social rights could also be predictors of social participation (Van Straaten et al., 2016). Finally, institutions and civil society also play a fundamental role in realizing social participation for homeless people, because social participation is a

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task for society as a whole. Hence, the model we tested is a simplification of reality and does not take all predictors and perspectives on social participation into account. Accordingly, future research would benefit from a longitudinal or experimental approach in which causality is examined from a different and perhaps more objective point of view, including the opinion of the social workers, government workers, citizens, and, if present, the client's own social network, and whereby societal and political aspects are also included.

In conclusion, interventions for homeless people should be based on a combination of individual and group approaches. Unfortunately, some Dutch (mental) health care institutions have been implementing cost-cutting measures recently, and have stopped offering activity programs to clients. However, we believe that group-based interventions can actually help to save costs, especially when parts of the individual programs are substituted by group work. Health care organizations should look for possibilities to finance group interventions and financers of health care organizations should take a positive approach to these evidence-based methods, given their beneficial outcomes. Clearly, more research regarding the cost-effectiveness of activity-based programs would be helpful.

Chapter 4

The Importance of Self-Mastery in Enhancing Quality of Life and Social Participation of (Formerly) Homeless People: Results of a Mixed-Method Study

ABSTRACT

Self-mastery plays a basic role in strength-based and recovery-oriented approaches applied by (mental) health-care institutions and social services. However, no research has been conducted on a comprehensive model that could provide insight into enhancing self-mastery and outcomes, such as social participation and quality of life, for (formerly) homeless people. The current mixed-method study investigated associations between person-related variables (optimism, age, education level) and care-related variables (experiences with care, duration of support) as predictors of both social participation and quality of life through the mediator of self-mastery among clients of a Dutch shelter facility. Quantitative analysis (Structural Equation Modeling; $n = 97$) showed that: (1) Self-mastery is related to social participation and quality of life; (2) Optimism predicts social participation and quality of life through self-mastery; (3) Age squared predicts social participation through self-mastery, but is not related to quality of life; (4) The variable, clients' experiences with care, is not related to self-mastery, but directly to social participation and quality of life; (5) Education level and duration of support do not predict self-mastery, social participation and quality of life. Qualitative analysis (semi-structured interviews; $n = 36$) revealed: (1) Contrary to the results of the quantitative study qualitative data indicated that there is a positive association between experiences with care and self-mastery. (2) Social participation and health are associated with self-mastery; (3) The absence of external locus of control should also be included as an aspect of self-mastery; (4) Additional promoting and impeding factors for self-mastery (e.g., a daily structure, privacy, house rules). Based on these results we formulated guidelines for social and mental health-care workers to enhance their clients' self-mastery.

INTRODUCTION

Self-mastery is a high priority issue in the Netherlands. The Dutch government aims to promote self-mastery among citizens, which implies that they should take responsibility for their own life. This is related to the concept of the "participation society" in which citizens are encouraged to take care of themselves and each other, so that applying for state support is seen as a last resort (Rijksoverheid, 2013: Van Houten, Tuynman, & Gilsing, 2008). Hence, the role of government is changing: People are given more responsibility and are enabled to take more initiatives themselves, rather than relying on the presence of a large government that regulates numerous matters and is constantly involved in all aspects of daily life. This implies that people need to be capable of mastering their life. For homeless people this is not obvious, as they are often caught up in negative life events and social exclusion leading to a dysfunction of their self-regulation skills (Wolf, 2016), which makes it difficult for this group to master their lives.

For (mental) health-care institutions and social services, including organizations providing shelter and ambulatory care for homeless people (i.e., shelter facilities), the transformation into a participation society has significant consequences. Workers of these organizations cannot support their clients in the way they used to do. They need to shift their focus more toward helping clients accomplish social participation and self-mastery instead of focusing on problems and facilitating clients to live in residential shelters. This means that clients should not be institutionalized for extended periods of time and that they are encouraged to build social contacts and to participate in all kinds of activities. In other words; they should live life like most people do.

In this perspective, empowerment plays a central role. Empowerment can be defined as "a process by which people, organizations, and communities gain mastery over issues of concern to them" (Rappaport, 1987, p. 122). At an individual level this construct is defined as "psychological empowerment", which combines "perceptions of personal control, a proactive approach to life, and a critical understanding of the sociopolitical environment" (Zimmerman, 1995, p. 581). The latter refers to understanding how systems function within a context and being able to behave in such a way that one can influence that context, which is closely related to social participation. The construct of empowerment includes a personality component in which "internal locus of control" plays a role, a cognitive component that includes "self-efficacy", and a motivational component that includes "the desire for control" (Van Regenmortel, 2002; Zimmerman, 1995).

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The founders of the concept of self-mastery, Pearlin and Schooler (1978, p. 5), defined self-mastery as "the extent to which one regards one's life-chances as being under one's own control in contrast to being fatalistically ruled". We broadened this definition to a more modern construct consistent with government policy and with the operationalization of empowerment; namely as the desire to determine one's own life including the beliefs that one is able to do this and also feels responsible for it. Hence, self-mastery is a combination of intrinsic motivation (the desire to act in a certain way because it is interesting and satisfying in itself; Deci & Ryan, 1985), self-efficacy (the belief in one's ability to achieve goals including the belief in one's ability to cope with various stressful or challenging demands; Bandura, 1977; Luszcynska, Scholz, & Schwarzer, 2010), and internal locus of control (the belief in one's ability to control the outcomes of life events; Rotter, 1966).

Predictors of Self-Mastery, Social Participation, and Quality of Life

Self-mastery, social participation, and quality of life can be influenced by person-related predictors (e.g., personality, age and education level) and care-related predictors (e.g., experiences with care and duration of support). Results of a previous study show that social participation and well-being are positively influenced by clients' experiences with care (i.e., satisfaction with the services received and satisfaction with the client-worker relationship) and education level (Rutenfrans-Stupar, Van Regenmortel, & Schalk, 2019). Education level is also positively related to self-mastery (Dalgard, Mykletun, Rognerud, Johansen, & Zahl, 2007; Forbes, 2001). Strength-based and recovery-oriented approaches (e.g., Den Hollander & Wilken, 2013; Korevaar & Dröes, 2016; Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019; Wolf 2016) assume that the social worker plays a key role in enhancing clients' self-mastery, which implies that the clients' satisfaction with the client-worker relationship can also be viewed as a predictor of self-mastery. Furthermore, these approaches also assume that the worker must be clear about what clients can expect from the shelter facility (e.g., Den Hollander & Wilken, 2013; Korevaar & Dröes, 2016; Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019; Wolf 2016), which is a relevant aspect of clients' experiences with care.

Another care-related predictor is the duration of support, which is the amount of time that clients are supported by the shelter facility. Clients with a longer duration of support probably have more complex care demands and are expected to be at a higher risk of institutionalization, which in turn leads to lower levels of self-mastery, social participation, and quality of life (Rapp & Goscha, 2012).

We previously mentioned education level as a person-related predictor that can influence self-mastery, social participation and quality of life, but there are other person-

related predictors as well. For example, research shows that a person's level of optimism is positively correlated with two components of self-mastery, namely self-efficacy (Posadzki, Stockl, Musonda, & Touroufli, 2010) and internal locus of control (Gruber-Baldini, Ye, Anderson, & Schulman, 2009). Moreover, optimism is positively related to quality of life (Applebaum et al., 2013; Gruber-Baldini et al., 2009; Schou, Ekeberg, & Ruland, 2005) and to social support or social functioning (Applebaum et al., 2013; Schou et al., 2005).

Further, age is positively related to two aspects of self-mastery, namely to internal locus of control (Chubb, Fertman, & Ross, 1997; Knoop, 1981) and partly to self-efficacy (Woordward & Wallston, 1987). It seems that self-efficacy increases with age, but at a certain (older) age it starts to diminish again. This is also consistent with research on the relationship between social participation and age: At a certain age people will participate less in activities and have fewer friends, because friendships end or friends pass away (Eurostat, 2010; Wallace & Pichler, 2009). The relationship between age and quality of life is unclear, but it is possible that age correlates with quality of life until a certain age (Diener, 2009). Therefore, if age is associated with self-mastery, social participation, and quality of life, we expect this relationship to be quadratic.

Lastly, we treated self-mastery as a mediator between client-related and care-related predictors on the one hand and social participation and quality of life on the other. This is in line with previous research in which self-mastery also mediated the relationship between some of the variables we included in our study (e.g., Dalgard et al., 2007; Kan et al., 2012). However, to our knowledge there are no previous studies that examined the role of self-mastery in the relationship between both person- and care-related predictors and the two outcome variables (i.e., social participation and quality of life.)

The Current Study
The current study aims to: (1) test a structural equation model exploring associations between person-related and care-related variables as predictors of social participation and quality of life through the mediator of self-mastery (Figure 1); (2) explain and interpret the model by using qualitative study findings from interviews with (formerly) homeless people. With the knowledge on (predictors of) self-mastery in relation social participation and quality of life, organizations (such as shelter facilities) are enabled to develop a recovery-oriented program that promotes sustainable social participation and quality of life among (formerly) homeless people.

Figure 1. Hypothesized model of self-mastery
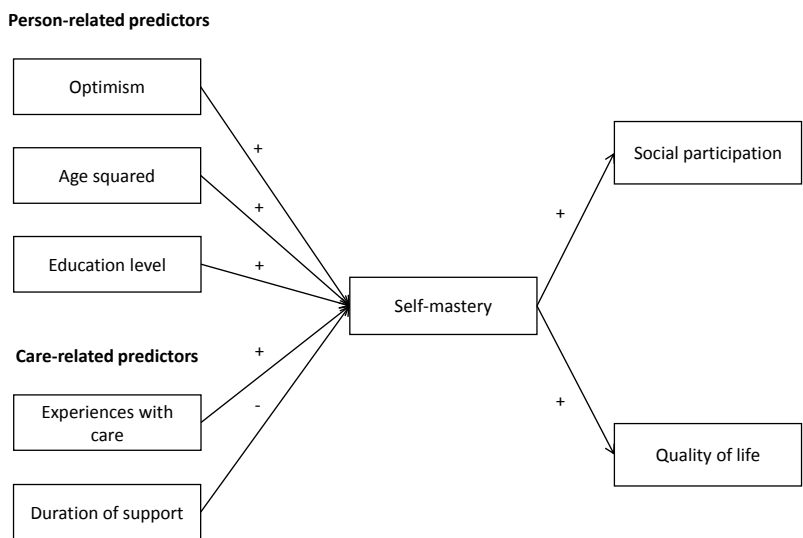
METHODS

Design and Participants

In general, in the Dutch context "all people who receive support from the shelter facility" are defined as homeless or houseless persons (e.g., Kruize & Bieleman, 2014; Planije, Tuynman, & Hulsbosch, 2014). This definition also applies to people who do have their own dwelling, but are still at risk of homelessness mostly due to debts or their (mental) health condition (McQuistion et al., 2013, Tuynman & Planije, 2012). This differs from the European definition of homelessness, which applies only to people who are roofless, houseless (for example residential clients of a shelter facility), or living in insecure or in inadequate housing (Feantsa, 2005). In the current study we use the term "(formerly) homeless people", which includes residential and ambulatory clients of the shelter facility. Residential clients are persons who live in one of the shelters, and ambulatory clients are persons who have their own dwelling but were homeless in the past or are at serious risk of losing their dwelling.

We used a mixed-method design, namely a "convergent parallel design" (Creswell & Plano Clark, 2011), consisting of quantitative and qualitative research among clients of a Dutch shelter facility. Both studies were conducted among all four shelters of this facility and included clients receiving ambulatory care. The quantitative and qualitative study took place simultaneously and we merged the results for comparison after both

data collections. Consequently, both studies were prioritized equally, data were kept independent during the data collection, and results were finally synthesized during the overall interpretation of the data. For both studies we used the following inclusion criteria for the eligible participants: (1) at least 18 years old; (2) understanding Dutch language; (3) able to give informed consent; (4) able to fill out a questionnaire or to be interviewed. Of the total population (measured on 1 April 2018) of 391 clients, 67 clients seemed not eligible, because they either did not meet the selection criteria or were temporarily absent (e.g., were staying in hospital or detention), resulting in 324 eligible clients. Clients were allowed to participate in both studies (21 clients participated in both studies). All clients who participated in the current study gave written informed consent. Clients received a compensation of €2,50 when they participated in an interview or filled out a questionnaire. This amount of money is similar to the regular compensation they receive for voluntary work (i.e., labor-related activities) for one day part. The research protocol was approved by the Ethics Review Board of Tilburg University (EC-2018.12) before the study started. The data were collected between 16 April and 12 June 2018.

The quantitative study had a cross-sectional study design. We used a convenience sampling technique (Etikan, Musa, & Alkassim, 2016), where all eligible clients from the shelter facility were invited to participate in the quantitative study. Ambulatory clients received a written questionnaire which they could fill out independently, but assistance was provided if requested (two clients were assisted during an interview; 42 filled out the questionnaire). Residential clients were preferably interviewed ($n = 47$), but could fill out a questionnaire if they preferred ($n = 6$). Ninety-seven clients participated (30% of eligible participants) of which 53 residential clients and 44 ambulatory clients (respectively 36% of eligible residential clients and 25% of eligible ambulatory clients). Most participating clients were male (72%), were aged in the category 50 to 70 years (53%), had lower (35%) or intermediate education (38%), and their duration of support was 1 to 5 years (44%) (see Table 1).

The qualitative study consisted of 36 semi-structured interviews. We used a purposive sampling technique (Etikan, Musa, & Alkasim, 2016) by applying the following procedure. First, to obtain a representative sample the interviewers determined the number of clients that needed to be interviewed per demographic category, namely gender, age, duration of support, and residential situation. Second, the interviewers went to the different shelter residences to ask who would be willing to participate in an interview, and to check whether the willing clients met the selection criteria and the criteria regarding representativeness. In case more people of one representative group wanted to participate, the person who first registered was selected. Finally, to complete our

representative sample we also asked the social/community workers if they knew people who met the criteria. The workers had no additional role in the interviews. The average duration of the interviews with clients was 40 minutes. Most of the participating clients were male (83%), were aged 50 to 70 years (47%), had lower (25%) or intermediate education (25%), were living in their own dwelling (53%), and their duration of support was five years or more (44%) (see Table 1). The quantitative and qualitative sample formed an accurate representation of the population of clients of the shelter facility (all χ^2 values were non-significant).

Table 1. Demographic variables of clients

Demographics	Quantitative study (*n* = 97)	Qualitative study (*n* = 36)	Population of the shelter facility (*N* = 391)[1]	Chi square
Gender				
Male	72 (74%)	30 (83%)	300 (77%)	1.22[n.s.]
Female	25 (26%)	6 (17%)	91 (23%)	
Age[2]				
18 to 30 years	7 (7%)	2 (6%)	42 (11%)	5.22[n.s.]
30 to 50 years	33 (34%)	14 (39%)	160 (41%)	
50 to 70 years	51 (53%)	17 (47%)	161 (41%)	
≥ 70 years	6 (6%)	3 (8%)	27 (7%)	
Education level				
No education or primary education	16 (17%)	1 (3%)	n.a.[3]	6.54[n.s.]
Lower education	34 (35%)	9 (25%)	n.a.[3]	
Intermediate education	37 (38%)	9 (25%)	n.a.[3]	
Higher education	10 (10%)	7 (19%)	n.a.[3]	
Missing	-	10 (28%)	n.a.[3]	
Residential situation				
In own dwelling with ambulatory care	44 (45%)	19 (53%)	213 (54%)	3.22[n.s.]
Residential shelter (long-term stay)	45 (46%)	14 (39%)	143 (37%)	
Shelter facility (short-term stay)	8 (8%)	3 (8%)	35 (9%)	
Duration of support				
< 1 year	22 (23%)	8 (22%)	100 (26%)	2.53[n.s.]
1 to 5 years	43 (44%)	12 (33%)	147 (38%)	
≥ 5 years	32 (33%)	16 (44%)	146 (37%)	

[1] On 1 April 2018

[2] $M_{\text{quantitative study}}$ = 51.89 (*SD* = 13.05); $M_{\text{qualitative study}}$ = 51.33 (*SD* = 13.84)

[3] The management information system of the shelter facility did not include education level for the total population of the shelter facility.

[n.s.] Non-significant: p>.05

The interviewers of both the quantitative and qualitative research had an education background in social work or health care, and were trained in interviewing (formerly) homeless people before the data collection started. The interviewers were independent, i.e., they did not have a role in the support of clients of the shelter facility where the research was conducted and were not an employee of the shelter facility.

Measures

Quantitative Study

Demographic characteristics were assessed as shown in Table 1. Self-mastery was operationalized as a combination of self-efficacy, intrinsic motivation, and internal locus of control. To this end we used three instruments: (1) the General Self-Efficacy Scale (GSE) (Swarzer & Jerusalem, 1995), (2) the Situational Motivation Scale (SIMS) (Guay, Vallerand, & Blanchard, 2000), and (3) Locus of Control (LOC) scale (Rotter, 1966). The GSE had a Dutch version (Teeuw, Schwarzer, & Jerusalem, 1997), but there were no Dutch versions of the SIMS and LOC scale available. Therefore, we used the back-translation method.

The GSE consists of 10 items that are scored on a 4-point Likert scale, ranging from 1 (*not at all true*) to 4 (*exactly true*). In the current study we used the total score. Additionally, we used an adapted version of the SIMS to measure motivation. The original scale aims to measure motivation to participate in activities. We generalized the original 16 items to measure motivation to master one's life. Answers could be scored on a 7-point Likert scale ranging from 1 (*corresponds not all*) to 7 (*corresponds exactly*), and for our analysis we used the means scores. For the data analysis of the current study we used the subscale "Intrinsic motivation". The last scale used to measure self-mastery, the LOC scale, consists of 29 items of which six are filler items. It is a forced-choice scale: For each item respondents have to choose between two statements. Higher scores represent a higher external locus of control (Rotter 1966). We reversed the total scores resulting in that higher scores represent a higher internal locus of control.

Optimism was assessed using the Dutch version of the Life Orientation Test-Revised (LOT-R) (Scheier, Carver, & Bridges, 1994; Ten Klooster et al., 2010), which is an instrument for assessing people's generalized sense of optimism. It consists of 10 items that can be scored on a 5-point Likert scale ranging from 0 (*strongly disagree*) to 4 (*strongly agree*). The three items that are negatively formulated form the subscale pessimism, the three items that are positively formulated form the subscale optimism, and the other four items are filler items (Scheier et al., 1994; Ten Klooster et al., 2010). We used the total score of the subscale optimism for our analysis.

Chapter 4

Experiences with care were assessed using subscales of the Consumer Quality Index for Shelter and Community Care Services (CQI-SCCS) (Beijersbergen, Christians, Asmoredjo, & Wolf, 2010). We used the subscale "Services Received" consisting of eight items, the subscale "Client-Worker Relationship" consisting of four items, and the two items concerning "General Rating". The latter could be scored on a scale from 0 to 10; the items of the other two subscales were rated on a four-point Likert scale rating from 1 (*never*) to 4 (*always*). We calculated the mean scores for our analysis.

Social participation was assessed using the Community Integration Measure (CIM) (McColl, Davies, Carlson, Johnston, & Minnes, 2001). We used the Dutch translation provided by Van Luijtelaar and Wolf (2012). The CIM consists of 10 items that can be scored on a five-point Likert scale ranging from 1 (*always disagree*) to 5 (*always agree*). We calculated the total score for our analysis. We adapted the items slightly by using the term "society" instead of "community", because we sought to measure social participation in a broader context, while "community" can also be restricted to the location where people are living.

Quality of life was assessed using the Dutch version of the World Health Organization Quality of Life Brief version (WHOQOL-BREF) (De Vries & Van Heck, 1996; WHO, 1998), consisting of 26 items and four subscales: Physical Health, Psychological Health, Social Relationships, and Environment. Answers could be given on a five-point Likert scale ranging from 1 (*very poor or very dissatisfied*) to 5 (*very good or very satisfied*). In the current study we used the total score of all subscales and transformed these scores to a 0-100 scale.

Qualitative Study
Before conducting the semi-structured interviews, the main topics and most of the open-ended questions associated with these topics were formulated. Accordingly, we made an interview description (see Table 2) that included: (1) self-mastery related to the client's living situation, which included the subtopics of feeling at home, household chores, house rules (residential clients), contact with neighbors (ambulatory clients), and paying the rent and other bills (ambulatory clients); (2) self-mastery related to the client's personal trajectory, which included short- and long-term goals related to the living and social situation, and daily activities. We chose to specify self-mastery in terms of these two topics, because it is closely related to the personal situation of the clients. The following question is asked about every topic: "What influence do you have on this?" (which is probed further in relation to motivation, self-efficacy, locus of control). Additionally, the interviewers asked about promoting and impeding factors for every topic and how this relates to social participation and quality of life.

Table 2. Interview description

	Topic	Subtopic	Basic questions	Promoting and impeding factors (i.e., predictors)	Relation to social participation and quality of life (i.e., outcomes)
1	Self-mastery related to the living situation	Feeling at home	- To what extent do you feel at home? - What influence do you have on this feeling? (ask about motivation, self-efficacy, LOC)	Ask further questions, e.g., - What do you need to accomplish this? Why? - What is working and what is not working? Why? - Can you give an example? - To what extent do you feel supported or impeded by the social/community workers of the shelter facility? Why?	- What did you learn or what did you get out of this? - Can you transfer your experiences to other areas of your life? (such as: physical and psychologic health, social relationships, environment, participation in society)
		Household chores	- To what extent do you manage to carry out household chores? - What influence do you have on household chores?	Ibid	Ibid
		House rules[a]	- How are the house rules determined at the location where you are living? - What influence do you have on the house rules?	Ibid	Ibid
		Contact with neighbors[b]	- To what extent do you manage to be a "good neighbor" for the people living next to you? - What influence do you have on being a good neighbor?	Ibid	Ibid

Table 2. (continued)

Topic	Subtopic	Basic questions	Promoting and impeding factors (i.e., predictors)	Relation to social participation and quality of life (i.e., outcomes)
	Paying rent and other bills[b]	- To what extent do you manage to pay your bills related to your living situation? - What influence do you have on paying the bills?	Ibid	Ibid
2 Self-mastery related to the personal trajectory	Goals related to the living situation (short-term and long-term)	- What do you want to achieve with regard to your living situation… in a year…and in the longer term? - What influence do you have on achieving this/these goal(s)? (ask about motivation, self-efficacy, LOC)	Ibid	Ibid
	Goals related to the social situation (short-term and long-term)	Same for social situation	Ibid	Ibid
	Goals related to daily activities (short-term and long-term)	Same for daily activities	Ibid	Ibid

[a] Only applicable to residential clients
[b] Only applicable to ambulatory clients

Analyses

Quantitative Study

We used SPSS (version 23) for descriptive statistics and scale reliabilities, and AMOS (version 22) (Arbuckle, 2013) for Structural Equation Modeling to test the hypothesized mediation model (Figure 1). We included latent and observed variables in our model. A latent variable is not observed directly, but represented by a combination of observed variables (Byrne, 2016). In the current study we distinguished the following latent variables: Experiences with care, self-mastery, and quality of life. Additionally, optimism, age squared and social participation were treated as observed variables.

We could not perform Confirmatory Factor Analysis (CFA), since CFA should be performed for at least 10 respondents per item (Blunch, 2013; Schreiber, Nora, Stage, Barlow, & King, 2006). All scales used in the current study consisted of 10 or more items and only 97 participants were involved in the quantitative study.

Before conducting the analyses, we screened our data set for missing variables. Missing value analysis showed that less than 1% of the data of all variables used were missing. We investigated whether this had biased the data using Little's Missing Completely At Random (MCAR) test ($\chi^2 = 1642.130$, $df = 3922$, $p > .05$), which showed that the missing data were completely at random. Hence, we concluded that the incomplete data sample is still representative of the hypothetically complete data (Little 1988). To obtain estimates of the parameters, we used the Full Information Maximum Likelihood (FIML) method, which is one of the best approaches to handle missing data (Arbuckle, 2013; Byrne, 2016; Enders & Bandalos, 2001).

Qualitative Study

The interviews were recorded by using a voice-recorder, with permission of the participants, and then the interviews are transcribed verbatim (i.e., word-for-word). We used NVivo (QSR NVivo version 12) to store, organize and analyze qualitative data. The qualitative study contains both elements of deductive and inductive arguments (Hayes, 2000; Teddlie & Tashakorri, 2009). The deductive approach is reflected in that, as already described in Paragraph Qualitative Study in the Chapter Measures, the interview questions were formulated around themes in the hypothesized model (Hayes, 2000; Teddlie & Tashakorri, 2009). The actual analysis of qualitative data followed the inductive approach as described by Hayes (2000) where two researchers (1) identified meaningful units of text, (2) grouped and named units of text that were associated with each other into meaningful categories (nodes), and (3) clustered the categories into emerging themes. Note that two-third of the interviews were coded by two researchers while the rest was coded by one of them. Approximately 80% of the coding

corresponded between the two coders. The second author of this paper did the second coding process and discussed significant differences between the two coding processes including categories and themes with the first author. We could not include whether age squared, education level, and duration of support enhance the levels of self-mastery, social participation, and quality of life, because for this type of analysis a quantitative approach is needed.

RESULTS

Quantitative Study

The means and Cronbach's alphas (which were all satisfactory) of the variables concerning clients' experiences with care ($M_{\text{services received}}$ = 3.14, Cronbach's α = .91; $M_{\text{client-worker relationship}}$ = 3.46, Cronbach's α = .86; and $M_{\text{general rating}}$ = 7.71, Cronbach's α = .88), optimism (M = 8.05, Cronbach's α = .71) self-mastery ($M_{\text{intrinsic motivation}}$ = 5.32, Cronbach's α = .83; $M_{\text{self-efficacy}}$ = 30.47, Cronbach's α = .87; and $M_{\text{internal locus of control}}$ = 11.19, Cronbach's α = .62), social participation (M = 36.66, Cronbach's α = .84), and quality of life ($M_{\text{physical health}}$ = 24.09, Cronbach's α = .82; $M_{\text{psychological health}}$ = 21.13, Cronbach's α = .81; $M_{\text{social relationships}}$ = 10.17, Cronbach's α = .67; and $M_{\text{environment}}$ = 28.00, Cronbach's α = .78) are presented in Table 3.

Table 3. Means, standard deviations (in parentheses), and internal consistency coefficients (Cronbach's alphas)

Scale	*n*	Mean (SD)	α
Services Received	86	3.14 (.70)	.91
Client-Worker Relationship	96	3.46 (.59)	.86
General Rating	95	7.71 (1.58)	.88
Optimism	95	8.05 (2.45)	.71
Intrinsic motivation	97	5.32 (1.25)	.83
Self-efficacy	95	30.47 (5.80)	.87
Internal Locus of Control	84	11.19 (3.46)	.62
Social Participation	95	36.66 (6.16)	.84
Physical health (QoL)	94	24.09 (5.43)	.82
Psychological health (QoL)	91	21.13 (4.25)	.81
Social relationships (QoL)	93	10.17 (2.63)	.67
Environment (QoL)	86	28.00 (5.21)	.78

To test the model, we first tested the hypothesized model without the mediator (self-mastery). This model had a fair fit (χ^2/df = 1.704, CFI = .914, RMSEA = .086) (criteria for 'good' model fit are: χ^2/df <3.0, CFI >0.90, and RMSEA<0.08; Arbuckle, 2013; Awang, 2012). However, in this model duration of support and education level were not significantly related to either quality of life or social participation, and age squared was only related to quality of life. The proportion variance explained for social participation was 32% and for quality of life 38%.

Second, we tested the hypothesized model with the mediator, but without the non-significant predictors (duration of support and education level). This model had a good fit (χ^2/df = 1.518, CFI = .923, RMSEA = .073). All relations between the variables were significant (p<.05). The proportion variance explained for self-mastery was 44%, for social participation 50%, and for quality of life 85%.

Third, we tested a model with the mediator which included, besides the indirect paths, also the direct paths from the predictors to the outcome variables. Both optimism (β = .55; p < .001) and age squared (β = .30; p < .05) predicted self-mastery significantly; and self-mastery significantly predicted social participation (β = .68; p < .001) and quality of life (β = .96 ; p < .001). However, the variable, experiences with care, was not significantly related to self-mastery (β = -.02; p > .05). The direct effects of experiences with care on social participation (β = .36; p < .001) and quality of life (β = .29; p < .05) were significant, which leads to the finding that experiences with care is a direct predictor of social participation and quality of life. The direct effects of optimism on social participation (β = -.04; p > .05) and on quality of life (β = -.15; p > .05) were significant and smaller than the direct effects when the mediator (self-mastery) was not included in the model (these values were for social participation β = .33; p < .001, and for quality of life β = .35; p < .001). Additionally, the direct effect of age squared on quality of life (β = -.05; p > .05) was significant and smaller than the direct effects when the mediator (self-mastery) was not included in the model (β = .26; p < .05). However, the direct effect of age squared on social participation in the model with the mediator (β = -.13; p > .05) was stronger compared to the model without the mediator (β = .06; p > .05).

In conclusion, the variable "Experiences with care" is directly related to social participation and quality of life. On the one hand, self-mastery is a full mediator of the relationship between optimism and both outcome variables (social participation and quality of life). On the other hand, it is a full mediator of the relationship between age squared and quality of life. However, self-mastery is not a mediator of the relationship between age squared and social participation. This final model is presented in Figure 2 and had a good fit (χ^2/df = 1.332, CFI = .950, RMSEA = .059) (Figure 2). The propor-

Chapter 4

tion variance explained for self-mastery was 39%, for social participation 50%, and for quality of life 81%.

Figure 2. Final model of self-mastery
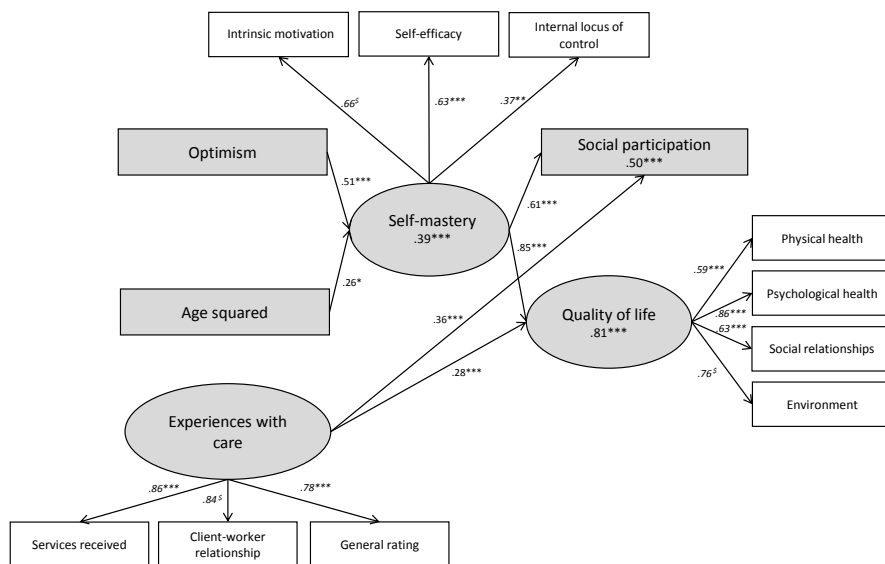
Note. Self-mastery does not mediate the age squared - social participation relationship.
Standardized regression coefficients are shown next to the arrows, and factor loadings are printed in italics. Proportions of variance explained are reported below construct names. Ovals represent latent variables and rectangles represent observed variables. *p*<.05. **p*<.01. ***p*<.001. ⁵Loading fixed at the value of 1 in the non-standardized solution.

Qualitative Study

The focus of the qualitative study was to gain deeper knowledge of self-mastery and its importance in enhancing social participation and quality of life. We also explored promoting and impeding factors for self-mastery.

Nodes and Themes

We derived the following nodes from the qualitative data (Table 4): (1) Living conditions: factors that are associated with the residential situation; (2) Goals: long- and short-term goals related to the personal trajectory; (3) Daily structure: including daily activities and the meaningfulness of these; (4) Experiences with care: including expectations about the support of the shelter facility and the importance of the client-worker relationship; (5) Impeding factors: general factors that hinder self-mastery; (6) Internal locus of control:

the belief in one's ability to cope with stressful or challenging demands (Rotter, 1996); (7) Health: physical and psychological health, including coping with addiction; (8) Household chores: activities related to the regular work of a household; (9) External locus of control: a negative belief in one's ability to cope with stressful or challenging demands (Rotter, 1996); (10) Promoting factors: general factors that enhance self-mastery; (11) Self-efficacy: the belief in one's ability to achieve goals including the belief in one's ability to cope with various stressful or challenging demands (Bandura, 1977); (12) House rules: rules or agreements related to a residential setting; (13) Social contacts: topics related to social relationships and social support; (14) Financial resources: topics related to the financial situation of clients, including the lack of financial resources and debts; (15) Social participation: participation in society or community, including labor-participation; (16) Intrinsic motivation: the desire to act in a certain way because it is interesting and satisfying in itself (Deci & Ryan, 1985); and (17) autonomy: (the ability of) making own decisions.

Table 4. Nodes identified, the frequency of references and relation to the hypothesized model

Nodes	Reported by number of respondents	References (the number of text passages encoded at this node)	Relation to the hypothesized model (Figure 1)
Living conditions	36	321	Additional predictor (specific)[1]
Goals	36	304	No direct relation to the model[2]
Daily structure	36	288	Additional predictor (specific)[1]
Experiences with care	36	247	Predictor in model
Impeding factors	32	242	Additional predictors (general)[3]
Internal locus of control	33	170	Aspect of self-mastery (mediator in model)
Health (physical and psychological)	33	167	Main aspects of quality of life (outcome in model)
Household chores	32	162	No direct relation to the model[4].
External locus of control	33	159	Opposite of internal locus of control (internal LOC is aspect of the mediator self-mastery)
Promoting factors	31	159	Additional predictors (general)[3]
Self-efficacy	33	136	Aspect of self-mastery (mediator in model)
House rules	22	131	Additional predictor (specific)[1]

Table 4. (continued)

Nodes	Reported by number of respondents	References (the number of text passages encoded at this node)	Relation to the hypothesized model (Figure 1)
Social contacts	32	124	Social participation and quality of life (i.e., social relationships) (both are outcomes in model)
Financial resources	28	96	Additional predictor (general)
Social participation	30	84	Social participation (outcome in model)
Intrinsic motivation	28	73	Aspect of self-mastery (mediator in model)
Autonomy	21	38	Additional predictor (specific)[1]

[1] Predictors that are not yet included in the model, but are reported as an influencing factor of self-mastery in the qualitative study. It includes a specific topic which means that it is a clearly identified/defined topic.
[2] Related to the specification of self-mastery (i.e., personal trajectory; topic in interview description)
[3] Predictors that are not yet included in the model, but are reported as an influencing factor of self-mastery in the qualitative study. It includes a general category in which specific predictors are also included.
[4] Related to the specification of self-mastery (i.e., living situation; topic in interview description)

We clustered these nodes into themes (Table 5) that were formulated based on the structure of the hypothesized model: (1) Self-mastery: A combination of internal locus of control, the absence of external locus of control, self-efficacy, and intrinsic motivation; (2) Outcomes of self-mastery: Health (physical and psychological) and social participation.; and (3) Promoting and impeding factors for self-mastery: Living conditions, daily structure, experiences with care, health, house rules, financial resources, social participation, and autonomy. The nodes *goals* and *household chores* were not included in one of the themes, because they were not directly related to the model, but to the specification of self-mastery in the interviews (i.e., personal trajectory and living situation).

Theme 1: Self-Mastery
Our results showed that locus of control, self-efficacy, and intrinsic motivation were all found to be important aspects of self-mastery among most of the respondents (Bandura, 1977; Deci & Ryan, 1985; Rotter, 1966). Specifically, the employment of internal locus of control in self-mastery was indicted by 33 respondents (170 references). For example, a participant reported:

Table 5. Themes derived from nodes

Themes	Nodes
Self-mastery	Internal locus of control External locus of control (negative association with self-mastery) Self-efficacy Intrinsic motivation
Promoting and impeding factors for self-mastery	Living conditions Daily structure Experiences with care Health House rules Financial resources Social participation Autonomy
Outcomes of self-mastery	Health (physical and psychological) Social participation

Yes, it is actually chanting, singing according to a Buddhist/Japanese way, that is actually very beautiful. You can learn from every mistake you make. You can make a new decision every time. You can choose any moment to look ahead instead of backwards. Yes, I have benefited a lot from it, despite my addiction (Respondent 12, 45-year-old male).

And another participant reported:

With regard to the budget course, I joined that course [budget course] because you must also be able to handle your financial situation. So that's why I took the course. So, in the future if I have to be independent regarding my finances, then I am willing to do that, I have no problems with that (Respondent 6, 60-year-old male).

External locus of control also seemed to play an important role as a negative aspect of self-mastery as reported by 33 respondents (159 references). An illustration:

I should work. But I also look at my age and that is going to be a tricky one, especially now that I haven't worked for more than 5 years. Go and tell a boss how it is possible that you have not worked for so many years. I also visited the UWV [Employee Insurance Agency]. They said: Yes, but ma'am, you can learn that again. I said: look at my age. UWV: yes, there is nothing wrong with it, there is enough work. I said: no, it must be work that suits me. Because when I go to

work, I don't get a regular job (Respondent 13, 44-year-old female).

And another respondent illustrated external locus of control as follows:

It does not make sense, I have worked in geriatrics for about 20 years. You can make as many plans as you want to and look ahead as much as you want, but your body determines your health. You can stay on your path to accomplish your goals but you will be frustrated by circumstances that are beyond your control (Respondent 5, 63-year-old male).

Thirty three respondents (136 references) indicated the relevance of self-efficacy in self-mastery. Some illustrations:

Maybe later when they say well you go your own way well and we trust you, and then you have to pay that bill yourself, yes then I am able to do that. Yes, I have no problems with that (Respondent 6, 60-year-old male).

Despite the alcohol addiction, you keep bearing that name "alcoholic". But I did go to the institute for addiction for guidance. And I completely got rid of it and now and then I sometimes drink a beer, but I'm in control. I don't have to worry about having a hangover in the morning (Respondent 31, 48-year-old male).

Intrinsic motivation was found to be important aspect of self-mastery in 28 respondents (73 references). For example, a respondent reported:

But again I just don't want to worry about that. Then I'd rather grab a bucket of soapy water and go and clean the toilets, and yes, that certainly gives me a good feeling and it's clean and tidy again. And those who don't want to do it, that's not my problem, I am living here (Respondent 3, 55-year-old male).

Theme 2: Outcomes of Self-Mastery
A majority of the respondents reported that self-mastery is important for the improvement of their social participation; in 30 interviews the topic of social contacts was mentioned in relation to self-mastery (84 references). A respondent illustrated this as follows:

Yes, I am thinking about these things. I am already quite old and to find work is very difficult now for me, so that's why I do activities, to participate in society again and to get to know people" (Respondent 6, 60-year-old male).

We also found that self-mastery is important in enhancing physical and psychological health (including coping with addiction) in our respondents (33 respondents mentioned health in relation to self-mastery; 167 references). In the hypothesized model quality of life was included as an outcome, but in the interviews this was not specifically reported, but the afore mentioned concepts of physical and psychological health are two basic aspects of quality of life (WHO, 1998). An example:

> I think it is related to my past, because when I visited a mental health care institution, it turned out that I had PTSD and a slight form of borderline, and something else. So, I was dealing with serious aggression problems then. But I have all that under control. So I'm happy about that (Respondent 7, 57-year-old male).

Social contacts were also associated with self-mastery which is a third aspect of quality of life and this concept is also related to social participation (WHO, 1998). Specifically, 32 respondents mentioned the topic of social contacts (124 references). Two examples related to the meaning of social contacts:

> Both of them [children] are from a different mother. I had no contact at all with my daughter. After 24 years we spoke each other again and I told my story and the first thing she said "you did well". Well, at that moment she called me daddy for the first time (Respondent 21, 58-year-old male).

> Yes, they do support me, so that's why I think it's important if you can be with other people, you know? That's always good, because when you're alone, you can't talk to yourself, you know? So that's why I think it's important to have social contacts (Respondent 6, 60-year-old male).

Theme 3: Promoting and Impeding Factors
We found that living conditions (mentioned in all 36 interviews; 321 references), daily structure (36 interviews; 304 references), experiences with care (36 interviews; 247 references), health (33 interviews, 167 references), house rules (22 interviews; 131 references), financial resources (28 interviews; 96 references), social participation (30 interviews; 84 references), and autonomy (21 interviews; 38 references) were all associated with self-mastery. Specifically, most respondents reported factors that are mostly considered as circumstances that they do not have control over, such as non-supportive house rules, a lack of financial resources, and not feeling at home in a residential shelter, as impeding factors for self-mastery. For example, a respondent reported:

> It depends on the diversity of people who live here, the lack of privacy, the need
> to heed the rules, not being free to choose what you want to do or don't want
> to do. So, we are too close together to make you feel comfortable, I do not feel
> at home (Respondent 5, 63-year-old male).

However, the reported promoting factors can be seen as circumstances that clients feel
they have (some) control over. Hence, a majority of the respondents considered their
daily structure, the autonomy to decide how to spend their day, and their privacy as
promoting factors. A respondent reported:

> In comparison with the short-stay shelter, here you have a private room that
> you can go to. If you close the door . . . they leave you alone (Respondent 1,
> 42-year-old male).

Regarding experiences with care clients reported that the social/community worker
who supported the client can be considered as either a promoting or impeding factor
for self-mastery. Especially the delivery of fast and tailored care is considered positively.
A respondent reported:

> I even got a new mentor. I had insisted on this, and yes, she [the former mentor]
> actually impeded me in my recovery or in my opportunities to grow, and thus in
> the process of taking control of my life . . . I was allowed to choose who would
> be my mentor. It is very interesting that not everyone is allowed to do so. I had
> been around for so long that I had 6 different mentors. Well, I was tired of these
> changes (Respondent 30, 27-year-old female).

Considering the association between self-mastery and social participation, several re-
spondents also reported that they experienced that work-related participation impedes
self-mastery. Specifically, being unable to work (e.g., due to health problems) or being
unable to find a job is considered to be problematic but also as something the clients
feel is beyond their control. A respondent illustrated this as follows:

> Since the last 2 months I do not work anymore. Two to three months ago I had
> a job and I worked for different companies, but now I am very ill due to COPD.
> I also had pneumonia. I cannot do anything anymore and had to give up my job
> (Respondent 34, 60-year-old male).

We also found that health can also be considered a impeding factor for self-mastery.
Respondents reported that due to health problems they were unable to master their

lives. A respondent reported:

> Yes, sometimes I have no peace of mind, I am anxious and I cannot do my things [household chores], cook, sweep, that will not work if I am so restless. Then it is as if the demons are talking to me and then I cannot do things like that (Respondent 3, 55-year-old male).

And another respondent said:

> When things are going well, you want to take responsibility regarding your financial situation and you manage to do so, but that is not the case when you have a relapse [alcohol-addiction] (Respondent 12, 45-year-old male).

This implicates that social participation and health can also be considered as influencing factors of self-mastery (next to outcomes of self-mastery).

New Insights
The qualitative results yielded new insights regarding the theoretical framework, presented in the hypothesized model (Figure 1). Additional findings related to our hypothesized model are (1) the absence of external locus of control should also be included as an aspect of self-mastery (external locus of control was mentioned in 33 interviews; 157 references); (2) several promoting and impeding factors should be included into the model, namely living conditions, daily structure, health, house rules, financial resources, social participation, and autonomy. The qualitative data did not directly indicate that optimism plays a role in enhancing self-mastery (optimism was not derived as a node from the qualitative data). We can speculate that is it hard to examine optimism in relation to self-mastery by conducting an interview. Finally, physical and psychological health seemed to be more important than the whole concept of quality of life.

CONCLUSION AND DISCUSSION

Conclusion
The current research investigated associations between person-related (i.e., optimism, age, education level) and care-related (i.e., experiences with care, duration of support) variables as predictors of social participation and quality of life through the mediator of self-mastery among clients of a Dutch homeless shelter facility. Quantitative analysis showed that self-mastery is correlated with social participation and quality of life. Optimism predicts social participation and quality of life through self-mastery. Additionally, age squared predicts quality of life through self-mastery, but is not related

to social participation. However, our hypothesized model is only partially confirmed in the quantitative study, because (1) clients' experiences with care is not related to self-mastery, but directly to social participation and quality of life; (2) education level does not predict social participation and quality of life directly, nor through the mediator of self-mastery; (3) nor did duration of support. The qualitative results yielded new and additional insights: (1) Contrary to the results of the quantitative study qualitative data indicated that there is a positive association between experiences with care and self-mastery; (2) Both social participation and (aspects of) quality of life (i.e., physical and psychological health) are associated with self-mastery. These relationships seem to be circular. For example, losing a job for health reasons (i.e., one aspect of quality of life) gives people the feeling of having less control over their life which in turn affects their quality of life; (3) The absence of external locus of control should also be included as an aspect of self-mastery; (4) Clients reported additional promoting factors for self-mastery, such as daily structure, the autonomy to decide how to spend their day, and privacy; and they reported several impeding factors, such as non-supportive house rules, a lack of financial resources, and a sense of not feeling at home.

Discussion

We first discuss the results of the confirmed relations we found in the current study and then we discuss the findings on the non-confirmed relations. Finally, we discuss the additional (innovative) findings of the qualitative study.

Confirmed Relations

First, the in our research confirmed correlations between (1) self-mastery and social participation and (2) self-mastery and quality of life is in line with previous studies. The founders of "The Strengths Model" (Rapp & Goscha, 2012; first edition of their work is from 1997) already emphasized the importance of self-mastery, for example the principle that the client is the director of his own trajectory and the importance of aspirations including beliefs and having confidence that they can be achieved in a positive manner (which is closely related to concepts such as intrinsic motivation, self-efficacy, and internal locus of control). In their "Theory of Strengths" self-mastery is related to an enhanced quality of life which also includes major aspects of social participation and social functioning, such as, being surrounded and supported by friends and companions. This means that our findings are emphasizing the importance of the knowledge on self-mastery that is included in strength-based and recovery-oriented approaches, because self-mastery also enhances quality of life and social participation among (formerly) homeless people.

Second, our quantitative study confirmed the relation between optimism and quality of life through the mediator of self-mastery. Previous studies already showed that optimism is positively correlated with (components of) self-mastery (Gruber-Baldini et al., 2009; Marshall & Lang, 1990; Posadzki et al., 2010). However, these studies were conducted among other target groups and to our knowledge our research is the first one that examines this relationship among (formerly) homeless people.

Third, our quantitative analysis showed that age squared predicts quality of life through the mediator self-mastery. This means that a positive relation between age and quality of life through self-mastery exits until a certain age. Older people may not have the desire or ability to master their life leading to a lower quality of life (Eurostat, 2010; Wallace & Pichler, 2009;). There is also a lack of literature on this specific mediation-relationship. We already stated that age (squared) is related with several aspects of self-mastery (Chubb et al., 1997; Woordward & Wallston, 1987) and with quality of life (Diener, 2009). Hence, our study contributes to the understanding of the relationship between age, self-mastery, and quality of life.

Finally, qualitative analysis showed that experiences with care are associated with self-mastery. Clients described how a good bond with the social worker can enhance their levels of self-mastery, especially in combination with fast and tailored care. This indicates that client values (e.g., autonomy, fairness, and comprehensiveness) need to be recognized, as these values play a central role in tailored care (Schoot, Proot, Ter Meulen, & Witte 2005).

Non-Confirmed Relations
Regarding the non-confirmed relations, we have three discussion points. First, self-mastery did not mediate the relationship between age squared and social participation. Although age squared was positively related with self-mastery, it was not indirectly related to social participation. This is surprising, especially since we found that quality of life was related to age squared through self-mastery. As already stated the relationship between age squared on the one hand and quality of life and social participation on the other hand in relation to self-mastery should be further explored in future research.

Second, we also did not find a relationship between education level and self-mastery, nor between education level and social participation, and not between education level and quality of life in contrast to previous research (Dalgard et al., 2007; Forbes, 2001; Rutenfrans-Stupar, Van Regenmortel, & Schalk, 2019). However, in previous research self-mastery, social participation, and quality of life were measured using different measures or constructs. Hence, future research is needed to confirm or reject the

hypothesis whether education level is a determinant of self-mastery, social participation, and quality of life.

Third, duration of support also was not associated with self-mastery, social participation or quality of life. We expected that clients with longer duration of support would have lower levels of self-mastery, social participation, and quality of life, because of complex care demands and a higher risk of hospitalization. Clients with longer duration of support might have more complex problems compared to those with a shorter duration of support, but the latter group mostly deals with more urgent problems (e.g., dealing with becoming homeless and adapting to the new situation). Additionally, we can speculate that clients with longer duration of support did not feel institutionalized and were not in a phase of becoming lethargic with regard to their personal recovery. The shelter facility where the current research was conducted had adopted strength-based and recovery-oriented approaches (Den Hollander & Wilken, 2013; Rapp & Goscha, 2012; Wolf, 2016), which may have led to reducing the risks of institutionalization for clients. However, to examine this further research is required.

Additional Findings
Finally, some remarks related to an extension of our model, we found that clients reported several promoting and impeding factors. In summary, qualitative findings added the following client-related predictors to our model: Physical and psychological health, social participation, financial resources, a sense of feeling at home, and privacy (the last two aspects can also be viewed as care-related predictors). They also added the following care-related variables: daily structure, the autonomy to decide how to spend the day, and house rules. In our view these factors contribute to the presented model, because they are related to clients' daily activities and both clients and social workers can have an influence on these factors. Strength-based and recovery-oriented approaches pay explicit attention to these factors (Den Hollander & Wilken, 2013; Rapp & Goscha, 2012; Wolf, 2016). For example, physical and psychological functioning, social participation, financial situation, living conditions, and daily activities, are included as major topics in formats for recovery plans and strengths assessments that are frequently used by organizations that use these approaches.] (Den Hollander & Wilken, 2013; Rapp & Goscha, 2012; Wolf, 2016).

Besides, we found that a lower or the absence of external locus of control also should be included in the concept of self-mastery. In the quantitative part of our study we used the LOC scale (Rotter, 1966) in which internal locus of control is the opposite of external locus of control. Hence, these two constructs are not divided into separate subscales which means that we included this concept in our analysis. However, when

using other scales or questionnaires attention must be paid on the operationalization of locus of control in relation to self-mastery.

Limitations of our Study

Our study has some limitations. First, we used a cross-sectional study design. To test causal relationships between variables it is recommended to use longitudinal data. Second, we conducted the current research within the context of one shelter facility. To increase the transferability of the results, a multi-site research is needed. Third, although the participants formed an accurate representation (in terms of demographic variables) of the population of clients of the shelter facility, the currently used sample techniques have some limitations. Convenience sampling, used in the quantitative study, is vulnerable to hidden biases and we do not know whether the sample is representative in terms of scores on the questionnaires used in the current research (related to self-mastery and its outcomes and content-wise predictors). Purposive sampling, used in the qualitative study, is also vulnerable to selection bias, because the interviewers had influence on the choice of participants (Etikan et al., 2016). Fourth, despite we assessed whether the current samples (of the quantitative and qualitative study) were representative compared to the population of clients of the shelter facility researched in the current study in terms of demographic variables, we did not compare the current samples to the whole homeless population in the Netherlands or broader. In the Netherlands and in other European countries comparable figures are not available because every country has its own system to report the number of homeless people (e.g., in some figures residential clients are not included) (e.g., Demaerschalk et al., 2018), and therefore we could not make a reliable comparison to assess the representativeness of our samples. Fifth, other factors might influence social participation and quality of life, such as ethnicity (Michalos & Zumbo, 2001; Vaughan, Kashner, Stock, & Richard, 1985) and employment status (Vaughan et al., 1985). We did not include these variables in our research, but it is recommended to include these kind of variables in future research. Finally, we used general questionnaires to measure self-mastery in the quantitative study, but in the qualitative study, we specified the concept of self-mastery to self-mastery in the living situation and the personal trajectory. Therefore, one has to be cautious about drawing conclusions on self-mastery related to other life areas. All in all, for future research we recommend conducting a multi-site longitudinal study in which a distinction is made between specified self-mastery (such the living situation and personal trajectory) and general self-mastery.

Implications for Practice

The current study yielded insights regarding predictors and outcomes of self-mastery. Self-mastery is a basic aspect of strength-based and recovery-oriented approaches (e.g.,

Den Hollander &Wilken, 2013; Korevaar & Dröes, 2016; Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019; Wolf 2016). Our study highlights the importance of enhancing self-mastery among clients, because it seems to enhance social participation and quality of life. Therefore, it is important that social workers make use of the knowledge on self-mastery that these approaches provide. This is especially relevant, seeing how our research indicates that social workers play an important role in enhancing clients' social participation and quality of life, and probably also in enhancing their self-mastery by building a good client-worker relationship, being clear about the expectations regarding the care provided (also about the duration of activities related to the care), and by truly focusing on the needs and values of clients (tailored care).

Based on the insights produced by the current research, we have formulated practical recommendations for social and mental health-care workers to help enhance self-mastery among their clients. These recommendations include (1) working on a positive attitude among clients, which can be facilitated by enhancing strengths and talents; (2) creating an environment that makes the clients feel home, where privacy is taken into account and house rules are formulated together with clients; (3) providing for a daily structure in which clients are enabled to make their own choices and to work on their physical and psychological health and to acquire financial resources. The latter can be facilitated by stimulating clients to participate in educational, recreational, and work activities that focus on their health (e.g., sports activities will enhance physical and psychological health; Randers et al., 2011; Sherry & O'May, 2013) and on their financial situation (e.g., a course to deal with debts or finding a job) (Rutenfrans-Stupar, Van der Plas, Den Haan, Van Regenmortel, & Schalk, 2019).

Chapter 5

Growth Through Participation: A Longitudinal Study of a Participation-Based Intervention for (Formerly) Homeless People

ABSTRACT

The current longitudinal study examined a participation-based intervention for homeless and formerly homeless clients, Growth Through Participation (GTP), developed by a Dutch organization providing shelter services and ambulatory care. GTP is based on a combination of group and individual approaches, whereby clients are enabled to learn to identify their strengths and talents, to develop social skills through interaction with each other, and to learn to once more lead a structured life. The study was conducted among 172 (formerly) homeless clients and comprised three measurement time points. It examined whether (1) quality of life increased during the GTP intervention; (2) social participation (e.g., labor/recreation), self-esteem, clients' experiences with care (i.e., satisfaction with the services received and with the client–worker relationship), and psychological distress improved during GTP; (3) clients exhibiting psychological distress benefit more from GTP than others. Results from latent growth modeling showed that quality of life and the amount of time clients spent on labor activities increased significantly, but the amount of time clients spent on recreational activities decreased over time. Clients with psychological distress experienced increased quality of life and self-esteem, and reduced psychological distress. Other variables did not significantly change during GTP. Although not all hypotheses were (fully) confirmed, it can be concluded that GTP seems to be a potentially promising intervention. It is recommendable to conduct a multi-site RCT to determine the efficacy of GTP.

INTRODUCTION

In the Netherlands, the number of homeless people has almost doubled from 17,800 in 2009 to 30,500 in 2016 (Statistics Netherlands, 2016). Homelessness is a serious problem, because it is often associated with multiple issues, such as substance addiction (Dietz, 2010), mental disorders (Belcher, 1991; Creech et al., 2015; Fazel, Khosla, Doll, & Geddes, 2008), physical health problems (Creech et al., 2015), unemployment (Burke, Johnson, Bourgault, Borgia, & O'Toole, 2013), and social isolation (Van Straaten et al., 2018). Moreover, homeless people occasionally cause public nuisances in cities and neighborhoods in the form of criminal activity and violent behavior, such as aggression (Coston & Friday, 2016; Roy, Crocker, Nicholls, Latimer, & Ayllon, 2014). Consequently, it is important both for homeless people themselves and for their surroundings that they receive proper care and support.

Organizations providing shelter services and ambulatory care (i.e., shelter facilities) aim to deliver optimum homeless support services while observing the requirements of the government. The Dutch government has been transforming the traditional welfare state into a "participation society" (Rijksoverheid, 2013). Under this policy, citizens are expected to support each other, and appealing for aid from the government is only an option when the person in question has no resources, such as a social network or money, of their own (Van Houten, Tuynman, & Gilsing, 2008). Since most of homeless people do not have such resources, they need to seek support from organizations such as shelter facilities, which in turn attempt to adjust their policies and methods in order to facilitate social participation by the homeless. Consequently, shelter facilities have been developing various participation-based programs (Davelaar & Hermens, 2014).

An example of a participation-based intervention developed for residential and ambulatory clients of a shelter facility in the Netherlands is Growth Through Participation (GTP). This program is based on a combination of group and individual approaches. In the group approach (consisting of educational, recreational, and labor activities), clients are enabled to learn to identify their strengths and talents, to develop social skills through interaction with each other, and to learn to once more lead a structured life. As such, they practice skills needed for social participation, first in the safe environment of the shelter facility, and subsequently in society. In addition to the group approach, clients are supported on an individual basis by a case manager with the aim to facilitate social participation through goal setting, monitoring, and evaluation (SMO Breda, 2014a).

An innovative aspect of GTP is the minimization of individual contacts in favor of group activities. For example, most clients need to work on their social skills, to cope with

their addiction, or to handle their financial situation, and clients can therefore work on these goals together in groups. Next to these educative group meetings, learning, and developing skills can also be facilitated in recreation group activities. For instance, when clients practice sports together, they also develop social skills, discover their talents, and experience how it feels to participate in activities of daily living. One of the advantages of learning in groups is that it enables clients to learn from each other (i.e., peer support) and they get to know new people. Additionally, by participating in labor activities clients are stimulated to develop their labor skills and may even have the opportunity to earn an officially recognized diploma, which improves their chances on the labor market (SMO Breda, 2014a). GTP is in line with Dutch government policy, as the majority of the support provided to (formerly) homeless clients under this method is offered in group form, allowing for cost reductions. However, the most important goal is the enhancement of social participation, because this improves clients' physical, social and mental well-being (Rutenfrans-Stupar, Van der Plas, Den Haan, Van Regenmortel, & Schalk, 2019).

The shelter facility that developed GTP (i.e., SMO Breda e.o.) is aiming to create an "enabling niche" (i.e., an environment in which personal growth is stimulated) by offering a safe environment in which homeless people are enabled to learn and to develop their strengths and skills (Driessens & Van Regenmortel, 2006; Taylor, 1997). However, previous research involving this shelter facility revealed a risk that the environment could become too safe and too comfortable, because of which clients may restrict their participation to the shelter facility, instead of proceeding to participate in society (Rutenfrans-Stupar et al., 2019). In other words, the enabling niche may become an entrapping niche, an environment in which people's self-development is restricted (Taylor, 1997). To ensure the creation an enabling niche instead of an entrapping niche, the shelter facility applies the following principles: (1) most activities are organized outside the residence in which the client lives, (2) a variety of people (i.e., not only homeless) participate in the offered activities, (3) the main objective is the development of skills through the improvement of strengths with the aim of social participation, and (4) people are treated with respect and viewed as persons who have talents, strengths, and capabilities for self-mastery (SMO Breda, 2014a).

GTP is intended to result, first, in an enhanced quality of life, which is defined as "individuals' perceptions of their position in life in the context of the culture and value system in which they live in relation to their goals, expectations, standards, and concerns" (WHO, 1998, p. 11). Quality of life can be divided into physical and psychological health, social relationships, and salient features of the environment (WHO, 1998). Second, GTP aims to increase social participation and self-esteem, improve clients'

experiences with care, and reduce psychological distress.

It was expected that (formerly) homeless clients with above-average psychological distress to benefit more from GTP than others, as GTP more accurately addresses the needs of this target group. In general, homeless mentally ill people often have negative experiences with moving from one entrapping niche to another, because they are often hospitalized for longer periods, which may result in institutionalization (Rapp & Goscha, 2012). GTP represents a very different working method than the usual care this target group receives, because the traditional method used to focus on clients' problems instead of talents, strengths, and self-development (SMO Breda, 2014b). To the extent that activity-based programs existed, these were mostly organized within residences, with participants consisting only of clients from the relevant residence. However, (formerly) homeless clients without or with less psychological distress are generally not particularly socially excluded, as compared with mentally ill homeless people, which implies that for these people the point at which the safe environment of the shelter facility becomes too safe and too comfortable occurs earlier. Commonly, these people still have more "natural" resources for participation than (formerly) homeless clients with severe psychological distress. Although the homeless with below-average psychological distress also benefit from practicing their skills in a safe environment, it is possible that for them the enabling niche will more rapidly turn into an entrapping niche.

The Current Study
The current study is the first to examine the quantitative outcomes of GTP. GTP has only been evaluated through internal evaluations by the management of the shelter facility; some aspects have been evaluated by a consultancy agency, primarily with regard to process measures (Dimensus, 2017); and one part of GTP (participation in activities) has been evaluated in depth through qualitative research (Rutenfrans-Stupar et al., 2019). Additionally, a crosssectional study about predictors of well-being among (formerly) homeless clients was conducted by using the baseline data of the current study (Rutenfrans-Stupar, Van Regenmortel, & Schalk, 2018). However, no quantitative studies have been conducted in which the outcomes of GTP were examined. Demonstrating these outcomes of the GTP would not be only of importance for the current shelter facility but can also provide information that may be useful for other organizations that would like to implement GTP. Additionally, the current study contributes to the literature on the effectiveness of interventions. Only a small number of longitudinal studies have been conducted that help to create an evidence base in Europe for effective interventions (De Vet et al., 2017; Rensen, Van Arum, & Engbersen, 2008).

The hypotheses of the current study are:

1. Quality of life among (formerly) homeless clients will increase during the GTP intervention (primary outcome);
2. GTP enhances social participation, self-esteem, clients' experiences with care, and reduces psychological distress (secondary outcomes); and
3. Clients with above-average psychological distress will benefit more from GTP than clients with below-average psychological distress.

METHOD

Design and Participants

In the current study the term "(formerly) homeless clients" was used, because it includes both residential and ambulatory clients of the shelter facility. In the Netherlands, commonly "all people who receive support from the shelter facility" are defined as "homeless" or "houseless" persons (e.g., Kruize & Bieleman, 2014). This includes people who have their own dwelling, because these people are still at risk of becoming homeless mostly due to their financial situation or their (mental) health status. Internationally a smaller definition of homelessness is mostly used: Only people who are roofless, houseless (e.g., residential clients of a shelter facility), or living in insecure or inadequate housing are defined as "homeless" (Springer, 2000). Hence, the term "(formerly) homeless clients" that was used in the current study includes residential and ambulatory client of the shelter facility.

The GTP intervention was evaluated by a longitudinal single group study. It was not possible to use a control group, because the organization implemented the intervention for all clients at the same moment (April to May 2015), which was necessary because the intervention was also subject to organizational changes (e.g., positions of management and other employees) and potential cost-saving procedures. Moreover, it was not advisable to use clients of another shelter facility as a control group, because those organizations are currently also improving their working methods by implementing similar interventions.

The study initially consisted of four measurement time points. However, the first measurement point (i.e., pretest) was excluded because this was the only measurement point for which the original scales of all of the questionnaires used were not applied and using that measurement point would create a very high level of participant dropout, namely 73%. Consequently, three time points were distinguished: T1, T2, and T3. T1 was conducted in the period of March to May 2015, T2 in the period of October to

December 2015, and T3 in the period of May to the start of August 2016. Clients were eligible if they: (1) were at least 18 years old, (2) understood Dutch, (3) were able to give informed consent, and (4) were able to participate in an interview. This last criterion was only applicable for residential clients. In total, 479 clients were assessed for eligibility, because this was the total number of clients receiving support at the first measurement time point. Forty-five clients did not meet the inclusion criteria (Figure 1), 179 clients refused to participate in the current study, and 6 participated but refused to fill in the informed consent form; these clients were therefore excluded. Furthermore, 6 other clients were excluded because they did not fully complete the questionnaire (i.e., less than 75% of the questionnaire completed). In total, 225 clients participated at the first measurement time point, of which 53 no longer received services from the shelter facility after six months. These clients were excluded because they were barely exposed to the intervention.
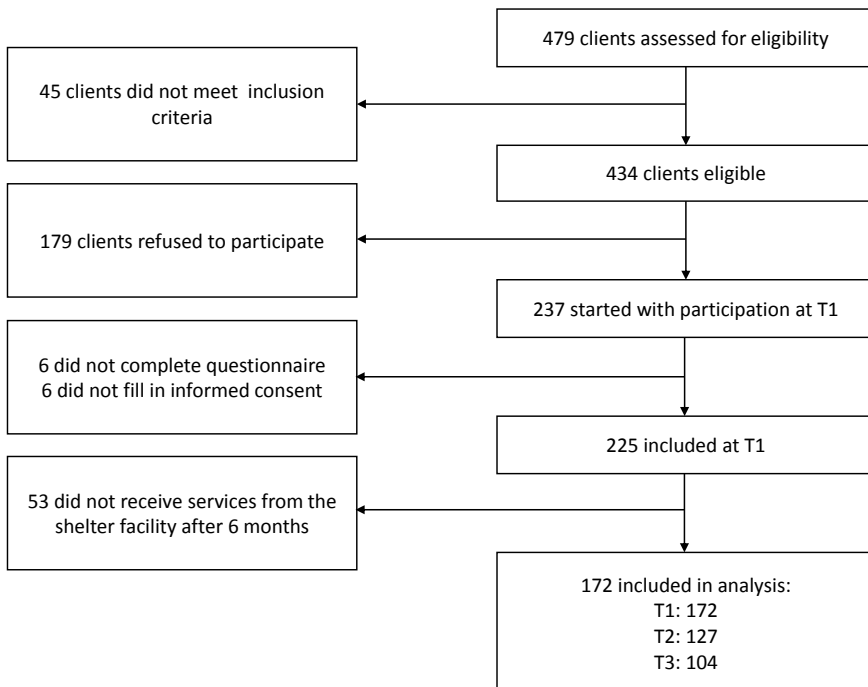
Figure 1. Participant flowchart

Table 1 provides the descriptive statistics (Demographic variables) of the participants that were included in the analysis (n ¼ 172): 75% was male, the average age was 49 years, 35% had an intermediate education level, 48% had lower education or less, slightly more than half of the participants (53%) resided in their own homes, and 58% had been supported by the shelter facility for 1–5 years.

Table 1. Demographic variables of participants at the baseline measure (*n* = 172)

| Demographics	n (%)
Gender	
Male	129 (75%)
Female	43 (25%)
Age	Mean 49.04 SD 12.48 (range 21-87)
Education level	
No education or primary education	37 (22%)
Lower education	45 (26%)
Intermediate education	60 (35%)
Higher education	25 (15%)
Missing	5 (3%)
Residential situation	
Own dwelling with ambulatory care	92 (53%)
Residential shelter (long-term stay)	70 (41%)
Shelter facility (short-term stay)	10 (6%)
Duration of support	
< 1 year	31 (18%)
1 to 2 years	34 (20%)
2 to 5 years	66 (38%)
≥ 5 years	41 (24%)

Procedures

Separate data collection procedures were used for residential clients (i.e., clients living in a residential shelter facility) and ambulatory clients (i.e., clients living in their own home with support from social workers from the shelter facility). Residential clients were interviewed by an interviewer at the facility where they lived. The interviewers were trained in conducting interviews and in interviewing (formerly) homeless clients. They had a university degree, were specially hired as research assistants, and were not involved in activities related to the primary process of the shelter facility. All interviews for the three measurement time points that were used in the current study were conducted by the same two interviewers. The average duration of the interviews was 45 minutes. Ambulatory clients received a written questionnaire, sent to their home address, to complete. Written informed consent was obtained from all residential and ambulatory clients who were included in the analysisof the data of the current research.

Before the start of the data collection, the research was approved by the management board of SMO Breda, in which decision the official client board was involved. Human participants (i.e., clients of the shelter facility) were protected in accordance with Dutch law, and all customary requirements of due care in scientific research were observed.

Description of the GTP Intervention

Figure 2 provides a visualization of the main components of the intervention. GTP is divided into three layers: (1) principles, (2) approaches and forms, and (3) desired consequences. In addition to these layers, the behavior of clients and employees (including managers) plays a central role in the intervention. The efforts of clients and employees are intended to result in positive experiences with care, such as satisfaction with the services received and with the client-worker relationship. All these components (three layers and clients' experiences with care) should contribute positively to quality of life, social participation, self-esteem, and psychological functioning.

Figure 2. Visualization of key components of GTP
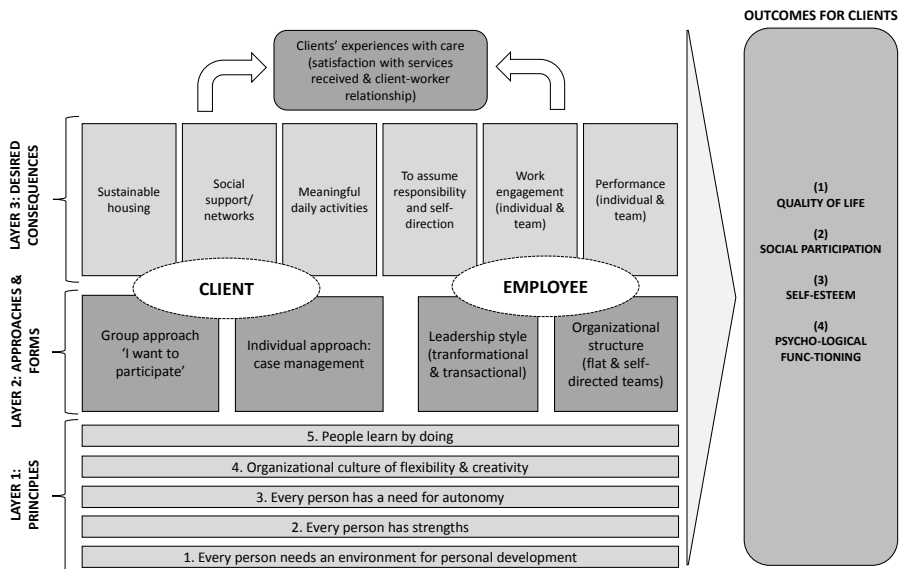
Layer 1: Principles

The first principle, "Every person needs an environment for personal development", is related to the concept of the enabling niche (Taylor, 1997). As previously mentioned (see Introduction Section), the shelter facility aims to provide a safe environment, also called an enabling niche, for clients (Driessens & Van Regenmortel, 2006; Taylor, 1997). Nota-

bly, learning and the development of skills are not only important goals for clients, but also for employees, as they too must to some extent work on personal development.

The second principle, "Every person has strengths", concerns the assumption that every person (i.e., clients and employees) has several strengths, talents, skills, but that these may be hidden due to the central position occupied by problems and negative life experiences (Wolf, 2016). Hence, in such cases, strengths can be rediscovered by reflection on life, for example by performing an assessment of strengths (Rapp & Goscha, 2012; Wolf, 2016), and by creating new, positive experiences. In GTP, the strengths of employees are as important as those of the clients, because talent management improves organizational client-related outcomes (Michaels, Handfield-Jones, & Axelrod, 2001). An example within GTP is that employees with a specific hobby are encouraged to investigate whether they can practice their hobby as a means of supporting clients in groups.

The third principle, "Every person has a need for autonomy", refers to a basic need that relates to self-determination, that is, that people have a choice. In organizations, relationships might be based on power, such as worker-client or manager-subordinate, in which autonomy is not encouraged, which creates a potential risk that the client or subordinate is being controlled (Deci & Ryan, 1987). A principle of GTP is that autonomy must always be respected and that relationships are based on equality.

The fourth principle is that the members of the organization should have the intention to facilitate or create an organizational culture of flexibility and creativity in which people can be autonomous and allowed to make mistakes if they learn from them. This type of culture is consistent with the structural dimension of "flexibility and discretion" of the "Competing Values Framework" described by Cameron and Quinn (1999).

The final principle, "people learn by doing", means that people "learn from experiences resulting directly from one's own actions, as contrasted with learning from watching others perform, reading others' instructions or descriptions, or listening to others' instructions or lectures" (Reese, 2011, p. 1). The essence of GTP is that clients discover talents, develop strengths, and practice skills, all by doing, for example through participation in group activities. It is not the care worker who gives clients instructions about what they must do, but the clients themselves learn through a process of trial and error. Employees also learn by doing. Social workers seek to adopt an accommodating learning style as described by Kolb (2015; Wolf, 2016).

Layer 2: Approaches and Forms
Layer 2 forms the core of GTP and includes working methods to support clients and

organizational forms and aspects. The first component of this layer, the group approach (which is called "I want to participate"), consists of participation in educational, recreational, and labor activities. Clients can choose several activities based on their preferences, talents, and needs. They formulate a goal regarding what they want to learn through their participation in the chosen activities. The main objectives of "I want to participate" are to develop strengths and obtain skills that are useful for social participation. Most activities are supervised by a social or community worker (with an intermediate education level or Bachelor degree) with experience in the relevant activity (e.g., a sports activity is supervised by a social worker who is familiar with the principles and possibilities of sports). The average number of clients in a group per social worker is six. Some activities are organized by (former) clients and based on principles of peer support. Clients are expected to participate in the "I want to participate" program for 8–20 hours per week, depending on their needs, housing situation, and the hours they already devote to social participation. Efforts are aimed at the best achievable result: If someone can participate in society, that type of participation takes priority and will be encouraged. If necessary, the social worker can contact external organizations to facilitate social participation. Clients are expected to participate in group meetings on a weekly basis. These meetings are organized around several themes but can also consist of relaxing activities (SMO Breda, 2014a).

The second component is the individual approach, which among others entails the individual support of clients by a case manager (i.e., a social worker with a Bachelor degree) for approximately 1 hour per week, depending on the clients' needs. Clients in crisis situations receive more hours of support; clients who reside in their own homes and who are stable require less support. These ambulatory clients are expected to participate in group meetings, where they can also meet with their case manager. Key components of case management are the building of a client–worker relationship which is based on respect and trust, but also allows for confrontation. The case manager is responsible for the creation of a personal recovery plan together with the client; if possible, a strengths assessment and ecogram (in which social relations are explored) are also made. Where applicable, the recovery plan describes at least three goals: (1) to find sustainable housing, (2) to build social contacts, either through reestablishment of contacts from the past or the creation of new ones, and (3) to find a meaningful activity program (in or outside the shelter facility; efforts are aimed at the best achievable result). Ideally, the same case manager follows the client throughout the care trajectory (SMO Breda, 2014a). However, within the shelter facility in which the current study was conducted, this was not always possible for organizational reasons.

The third component, leadership style, consists of a combination of transactional and transformational leadership. Research shows that a transactional and especially a transformational leadership style can enhance team performance and organizational outcomes (Cummings et al., 2010). Transformational leadership is a person-focused style in which the leader provides (1) inspirational motivation by having a vision, (2) individualized attention by building relationships, (3) intellectual stimulation by encouraging followers to learn, and (4) idealized influence by being a role model (Bass, 1985). Transactional leadership is a task-focused leadership style centered around the exchange process between leaders and followers (e.g., the leader gets things done by rewarding employees; Bass, 1985). Within GTP, these two leadership styles are considered complementary. Managers are coached and supported by team coaches. Special attention is given to leadership style, but team coaches also provide advice and support on a various range of topics, such as team building, team performance, and working methods (SMO Breda, 2014a).

The fourth component, organizational structure, is characterized by a flat organizational structure and a working method involving autonomous teams following the principles of self-directed work teams such as self-management, the assignment of jobs to team members by team members, planning and scheduling of work, making servicerelated decisions, and taking action to solve problems (Wellins et al., 1990). Self-directed teams have a collective responsibility, are encouraged to achieve autonomy (i.e., self-determination), and receive feedback on their team performance (Wall, Kemp, Jackson, & Clegg, 1986). In GTP, teams are supervised by a manager who is not part of the team. Managers have a span of control of approximately 70–80 employees in the primary process, who are divided into about 7–8 teams. There are no coordinators or team leaders, but support is provided by the team coaches. Every team coach supports approximately 80–90 employees (SMO Breda, 2014a).

Layer 3: Desired Consequences
The third layer is divided into desired consequences for clients and desired consequences for employees; these two meet in the middle at the concept of "taking responsibility and direction." For both clients and workers, it is necessary to assume responsibility and self-direction to achieve goals. Among clients, this concept is practiced at two levels. First, at the personal level, every client has a personal recovery plan with goals that are based on the client's strengths and talents. In this context, it is important for the client to be the director of his own trajectory (Rapp & Goscha, 2012; Wolf, 2016). Second, at the level of the living situation, clients reside in an intramural setting are encouraged to seize as much autonomy as possible in their living situation, and clients who live in their own homes are encouraged to take control of their living situation

with the goal to remain housed. Employees are also expected to take responsibility and apply direction in their work because this can result in positive organizational outcomes (e.g., Hackman & Oldham, 1980).

For clients, the desired consequences are the three goals: Sustainable housing, building social contacts, and a meaningful daily activity program. For employees, the desired outcomes are to perform well and to be engaged in their work, meaning that they have "a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption" (Schaufeli, Salanova, Gonz_alez-Rom_a, & Bakker, 2002, p. 74). Work engagement can appear at both individual and team levels (Tims, Bakker, Derks, & Van Rhenen, 2013) and can be encouraged through a transformational leadership style (Tims, Bakker, & Xanthopoulou, 2011), which is part of the second layer of GTP. Team members themselves also play an important role in the level of individual work engagement, as the team members are responsible for performance interviews with each other, team meetings, the recruitment and the filling of positions in the team and the training of their own skills. Work engagement leads to improved team performance (Christian, Garza, & Slaughter, 2011). As mentioned above, self-directed teams require feedback on their work (Wall et al., 1986). Results are therefore measured via a digital dashboard accessible by employees and managers, which provides information about results at individual and team levels.

Outcomes for Clients
The layers and components of GTP are intended to result in positive experiences with care on the part of clients, which includes satisfaction with the services received and a positive working relationship between employee and client. Previous research showed that there exists a positive relationship between experiences with care and outcomes for (formerly) homeless clients. Specifically, experiences with care are a predictor of social participation and well-being, defined as the combination of quality of life, self-esteem, and the absence of psychological distress (Rutenfrans-Stupar et al., 2018). Additionally, the other components of GTP are also intended to result in these outcomes for clients.

Measures
Demographic variables were assessed as shown in Table 1. The primary outcome, quality of life, was assessed by the World Health Organization Quality of Life Brief version (WHOQOL-BREF) (Skevington, Lotfy, & O'Connell, 2004; WHO, 1998). This questionnaire consists of 26 items, divided into four subscales: Physical health, psychological health, social relationships, and environment. Each item was rated on a 5-point Likert scale, ranging from 1 (very poor or very dissatisfied) to 5 (very good or very satisfied). Because

quality of life is the primary outcome, the total score and the scores on all subscales were used. The scores were transformed to a 100 point scale in conformance with the instructions of the SHOQOL-BREF manual (WHO, 1998).

Secondary outcomes included social participation, self-esteem, clients' experiences with care, and reduction of psychological distress. Social participation was assessed using various instruments. First, the Participation Ladder was used (Van Gent, Van Horssen, Mallee, & Slotboom, 2008), which consists of six phases, namely (1) isolated, (2) social contacts outside of the home, (3) participation in organized activities, (4) unpaid work, (5) paid work with additional support, and (6) paid work (Van Gent et al., 2008). Participants were asked which of these phases applied to them. Second, five items derived from scales used in the Medical Outcome Study MOS) Social Support Survey (Sherbourne & Stewart, 1991) were used, which consisted of five items respectively for family for friends or other acquaintances. Each item was rated on a five-point Likert scale, ranging from 1 (none of the time) to 5 (all of the time). In the current study, calculations were based on the total score based on all 10 items. Third, participants were asked how many hours they participated in activities, in which they had contact with other people, in the last week. The questionnaire explicitly stated that this question concerned activities outside the shelter facility. The answers (number of hours) were divided into labor, recreational, and educational activities. Because clients barely participated in educational activities outside the shelter facility (M(T1) = .50 hours a week, SD = 2.48), this item was eliminated from the analysis.

Self-esteem was assessed using the Rosenberg Self-Esteem Scale (RSES), which consists of 10 items (this instrument has no subscales). These items were scored on a four-point Likert scale ranging from 1 (*strongly agree*) to 4 (*strongly disagree*) (Rosenberg, 1965; Van der Linden, Dijkman, & Roeders, 1983). Clients' experiences with care were assessed using two subscales from the Consumer Quality Index for Shelter and Community Care Services (CQI-SCCS) (Asmoredjo, Beijersbergen, & Wolf, 2017; Beijersbergen, Christians, Asmoredjo, & Wolf, 2010), namely services received and client-worker relationship. Response categories ranged from 1 (*never*) to 4 (*always*). In the current study, the total score based on 13 items (nine items from the subscale Services Received and four items from the subscale Client-Worker Relationship) was calculated. Psychological distress was measured using the Brief Symptom Inventory (BSI-53) (De Beurs & Zitman, 2005; Derogatis, 1975). The 53 items of this scale assess nine patterns of psychological symptoms: Somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. Items were scored on a five-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*) (De Beurs & Zitman, 2005; Derogatis, 1975). In the current study, the total sore of the

BSI-53 was used.

All scales used in the current study had moderate to high internal consistencies across measurement points (range at T1 = .67-.95, T2 = .70-.97, T3 = .73-.96). Additionally, all instruments, except the Participation Ladder and the questions about the hours spent on activities outside the shelter facility, have been used in studies among homeless people before (e.g., De Vet et al, 2017; Lako et al., 2013; LePage & Garcia-Rea, 2008; Van Straaten et al., 2016).

Statistical Analyses

Descriptive statistics were analyzed using SPSS (version 24). To test whether the primary and secondary outcomes increased across time, Latent Growth Modeling (LGM) was used with the support of AMOS (version 22) (Arbuckle, 2013). LGM is a flexible analytic technique for modeling change over time, which takes variability in rate of change at the individual level into account and focuses on correlations over time, changes in variances and in mean values (Hess, 2000). A major advantage is that LGM can handle missing data, as it uses data from all participants, not only from those who have completed the questionnaire, and as such provides less biased information on treatment effects (Choi, Golder, Gillmore, & Morrison, 2005; Feingold, 2009). LGM is an especially suitable technique for social and behavioral intervention studies (Curran & Muthén, 1999; Feingold, 2009; Preacher, Wichman, MacCallum, & Briggs, 2008). Figure 3 shows the path diagram that was used to test growth in every primary and secondary outcome variable (Hypotheses 1 and 2). In order to test the third hypothesis, it was needed to conduct a multi-group analysis (i.e., clients defined by the baseline characteristic, the level of psychological distress). Therefore, the grouping variable (psychological distress) was specified as a predictor of both intercepts and slopes and tested whether every primary and secondary outcome variable changed across time using a conditional growth curve (Preacher et al., 2008) (Figure 4).

Additionally, to test the third hypothesis, a dummy variable of psychological distress was created. Therefore, the cut-off point for BSI was calculated using the Jacobson and Truax method of calculating clinical significance (Jacobson & Truax, 1991) with the following formula: Cut-off = $((SD_{patient} * M_{nonpatient}) + (SD_{nonpatient} * M_{patient}))/(SD_{patient} + SD_{nonpatient})$. According to De Beurs and Zitman (2005), the mean (and standard deviation) of the BSI total score for the Dutch patient population is 1.23 (.72) and for the Dutch nonpatient population is .42 (.40), which lead to a cut-off score of .71. The BSI total scores of the first measurement point were used: Participants with BSI >.71 had 'above-average' psychological distress.

Figure 3. Latent growth model used to explore rate of change in primary and secondary outcome variables
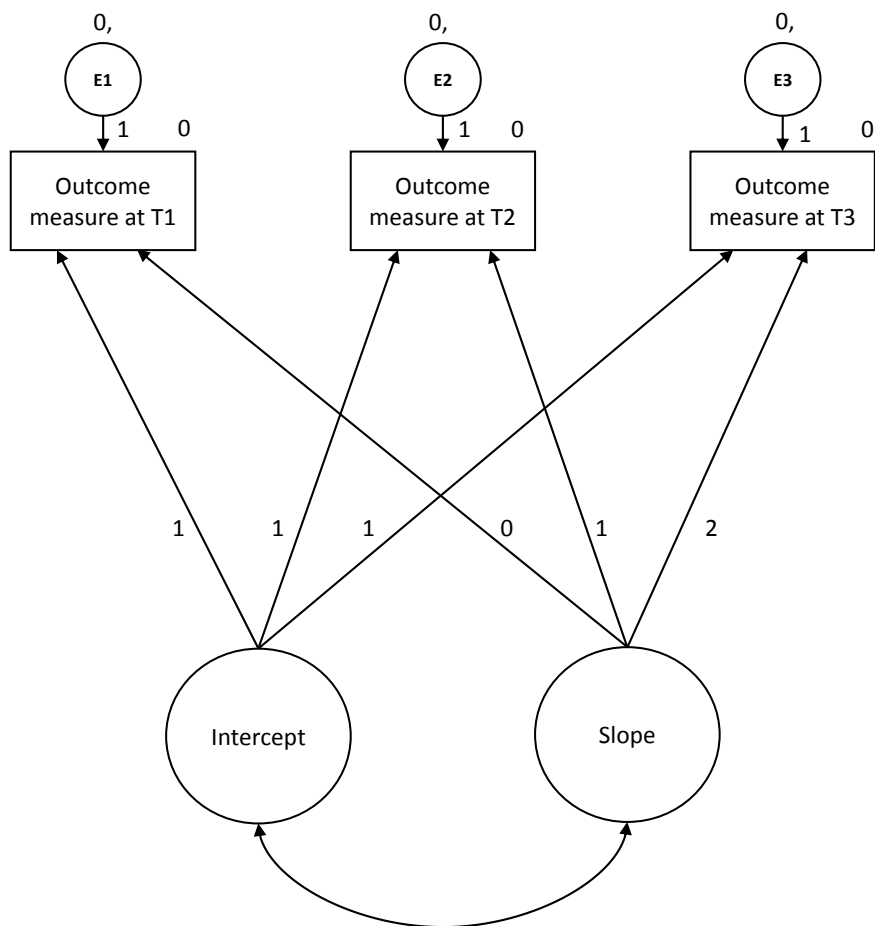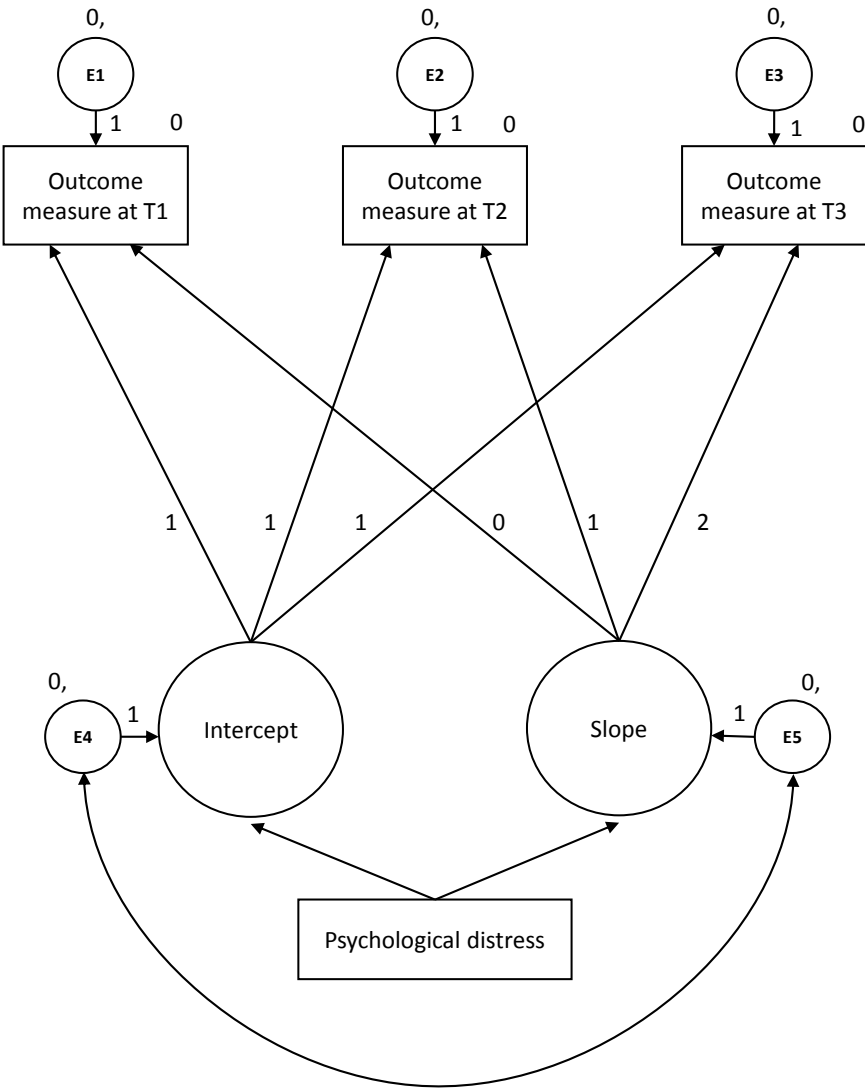
Figure 4. Conditional latent growth model with psychological distress as an exogenous predictor

In the current study missing data had to be handled, as 24% of the data were missing, including missing time points (as shown in Figure 1) and unanswered questions. To investigate whether the missingness had biased the data, Little's Missing Completely At Random (MCAR) test (χ^2 = 12,408, df = 24,727, p = 1.00) was used, which showed that data were missing completely at random and therefore it can be concluded that the incomplete data sample is still representative of the hypothetically complete data (Little, 1988). Missing data was handled in two steps. First, with regard to BSI and WHOQOL, the mean scores were calculated according to the instructions for missing data (Derogatis, 1975; Skevington et al., 2004). According to the BSI manual, it is permissible to calculate the total BSI score if twelve or fewer items are missing (Derogatis, 1975). Skevington et al. (2004) indicated that the total score of WHOQOL may be calculated when 20% or less is missing, and mean scores of subscales may be calculated when two items are missing, except where it concerns the Social Relationships subscale, where only one item may be missing (WHO, 1998). Second, the Full Information Maximum Likelihood method was used, because this is considered one of the most preferred methods to handle missing data (Arbuckle, 2013; Byrne, 2016; Enders & Bandalos, 2001), especially when data are MCAR (Preacher et al., 2008).

To evaluate the model fit of every tested latent growth model, a combination of fitness indexes was used, namely the Comparative Fit Index (CFI) (Hu & Bentler, 1995), the Normed Fit Index (NFI) (Bentler & Bonett, 1980), and the Incremental Fit Index (IFI) (Bollen, 1989). All these fitness indexes should be close to one with a minimum of .90 (e.g., Arbuckle, 2013).

RESULTS

To test whether primary and secondary outcomes changed across time, LGM was used (n = 172). As shown in Table 2, the total quality of life increased significantly (M(T1) = 59.70, m = .92, p = .04), including the subscales social relationships (M(T1) = 58.32; m = 1.94; p = .02) and environment (M(T1) = 59.50, m = 1.72, p < .001). As such, the first hypothesis was confirmed. Regarding the secondary outcomes, the number of hours a week clients spent on labor activities increased significantly (M(T1) = 5.83, m = .72, p = .02). However, the number of hours a week clients spent on recreational activities decreased significantly (M(T1) = 16.60, m = -2.53, p = .03). Other variables did not increase or decrease significantly. This means that the second hypothesis was mainly rejected. All fit indexes were acceptable (> .90): CFI varied from .916 to 1.000, NFI varied from .903 to 1.000, and IFI varied from .918 to 1.108.

Table 2. Results from latent growth modeling (n = 172)[a]

Outcome measures	T1 mean (SE)[b]	Slope (SE)	P-value slope	χ^2	CFI	NFI	IFI
Primary outcomes							
Quality of life	59.70 (1.23)	.92 (.44)	.04[*]	16.161	.949	.939	.950
Physical health	60.93 (1.54)	-.15 (.70)	.84	8.205	.970	.954	.970
Psychological health	60.16 (1.44)	.77 (.61)	.21	4.747	.992	.980	.993
Social relationships	58.32 (1.65)	1.94 (.85)	.02[*]	.067	1.000	1.000	1.021
Environment	59.50 (1.32)	1.72 (.58)	.00[**]	18.143	.916	.903	.918
Secondary outcomes							
Psychological distress (BSI)	.73 (.05)	-.01 (.02)	.47	1.089	1.000	.995	1.009
Self-esteem (RSES)	29.60 (.37)	.26 (.18)	.16	4.353	.987	.961	.988
Social support	46.87 (2.04)	-.04 (1.28)	.98	6.750	.959	.931	.961
Participation ladder	3.50 (.10)	.03 (.05)	.51	6.104	.979	.960	.979
Labor[c]	5.83 (.86)	.72 (.32)	.02[*]	1.655	1.000	.994	1.005
Recreation[c]	16.60 (2.08)	-2.53 (1.18)	.03[*]	.737	1.000	.969	1.108
Experiences with care (CQi)	3.26 (.04)	.03 (.03)	.25	3.239	.997	.960	.997

[a] df = 3 for all tested latent growth models.
[b] Intercept.
[c] Outside the shelter facility (hours per week).
[*] p < .05.
[**] p < .01.

To test whether GTP had a larger influence on (formerly) homeless clients with above-average level of psychological distress than on those with lower levels of psychological distress, conditional growth modeling (Preacher et al., 2008) was used. Table 3 shows that psychological distress was a predictor of the initial status of quality of life and all its subscales (all p values <.001), self-esteem (p < .001), and social support (p = .01), and that psychological distress was a predictor of the rate of change (i.e., slope). Concerning rate of change, the total quality of life (m = 2.56, p < .001), including the subscales physical health (m = 3.00, p = .04) and environment (m = 3.99, p < .001), increased significantly over time. As such, the third hypothesis was partially confirmed. All fit indexes were acceptable (> .90): CFI varied from .933 to 1.000, NFI varied from .919 to .995, and IFI varied from .935 to 1.109.

Chapter 5

Table 3. Results from conditional growth modeling with psychological distress as a exogenous predictor (*n* = 172)[a]

Outcome measures	BSI=>Intercept[b] (SE)	P-value (BSI-Icept)	BSI=>Slope[c] (SE)	P-value (BSI-slope)	χ^2	CFI	NFI	IFI
Primary outcomes								
Quality of life	-20.82 (2.01)	.00***	2.56 (.90)	.00**	18.198	.958	.948	.959
Physical health	-22.55 (2.72)	.00***	3.00 (1.45)	.04*	9.111	.977	.961	.978
Psychological health	-24.41 (2.33)	.00***	1.13 (1.27)	.37	12.257	.974	.963	.974
Social relationships	-16.49 (3.23)	.00***	1.07 (1.77)	.55	.866	1.000	.995	1.019
Environment	-17.58 (2.39)	.00***	3.99 (1.15)	.00***	19.237	.933	.919	.935
Secondary outcomes								
Psychological distress (BSI)	.93 (.07)	.00***	-.15 (.04)	.00***	8.147	.988	.977	.988
Self-esteem (RSES)	-4.71 (.68)	.00***	1.09 (.36)	.00**	8.779	.968	.946	.970
Social support	-11.39 (4.18)	.01**	3.91 (2.66)	.14	8.574	.953	.920	.956
Participation ladder	-.23 (.21)	.28	-.11 (.10)	.30	6.392	.984	.959	.984
Labor[d]	1.31 (1.80)	.47	.33 (.67)	.62	3.170	1.000	.988	1.003
Recreation[d]	3.00 (4.39)	.49	.76 (2.47)	.76	1.487	1.000	.945	1.109
Experiences with care (CQi)	-.06 (.09)	.48	.09 (.05)	.07	3.699	1.000	.956	1.004

[a] *df* = 4 for all tested latent growth models.
[b] Group effect on intercept.
[c] Group effect on slope.
[d] Outside the shelter facility (hours per week).
*p < .05. **p < .01. ***p < .001.

DISCUSSION

The current study evaluated whether (formerly) homeless clients from a shelter facility in the Netherlands experienced changes over time in several outcomes after implementation of the GTP intervention. As expected, the total score of quality of life (including the subscales social relationships and environment) increased over time (Hypothesis 1 was confirmed). Additionally, the amount of time clients spent on labor activities outside the shelter facility also increased over time. However, the amount of time clients spent on recreational activities outside the shelter facility decreased over time, and no

changes were found in the scores of the subscales physical and psychological health, nor in the scales psychological distress, self-esteem, social support, participation ladder, and experiences with care (Hypothesis 2 was mainly rejected). (Formerly) homeless clients with above-average psychological distress experienced more improvements over time in quality of life (subscales physical health and environment), self-esteem and psychological distress (i.e., psychological distress decreased) compared to those with lower levels of psychological distress. However, the amount of time these clients spent on labor and recreational activities outside the shelter facility neither increased nor decreased and the scores on other variables also did not change over time (Hypothesis 3 was partially confirmed). Most of these findings were in line with the results of the qualitative study that was conducted to evaluate one of the aspects of GTP, namely the influence of participation in activities on well-being. That study also showed that participants experienced increased physical, social, and mental well-being because of their participation in educational, recreational, and labor activities (Rutenfrans-Stupar, Van der Plas, Den Haan, Van Regenmortel, & Schalk, 2019).

Regarding the second hypothesis, an unexpected outcome was found, namely a decrease in the number of hours spent on recreational activities outside the shelter facility. It is possible that clients have been spending more time on recreational activities inside the shelter facility. This finding would be contradictory to the aim of GTP (i.e., participation in society). However, if the quality of the recreational activities inside the shelter facility is higher than the quality of the recreational activities outside the shelter facility in which clients were participating, this finding can be considered as a neutral or positive outcome. Nonetheless, the number of hours spent on recreational activities inside the shelter facility was not included as a variable in the current study, nor the quality of the activities, which means that a valid conclusion on this matter cannot be drawn.

With regard to the third hypothesis, among clients with above-average psychological distress, the highest change over time after implementation of GTP occurred in the scores on person-centered variables (increased psychological health and self-esteem and decreased psychological distress). This implies that persons with above average psychological distress first work on their personal recovery process in terms of improvement of their own psychological health. This is congruent with the first stages of recovery as described by Powel (2009), in which people are initially overwhelmed by the disabling power of their mental illness and are preoccupied with the illness, which implies that persons first must cope with their psychological distress and functioning. In the next phase, people are enabled to pay attention to their environment, e.g., social functioning, as they begin to challenge the disabling power of the mental illness and

reassume social roles (Powell, 2009; Rapp & Goscha, 2012). It can be speculated that if the duration of the current study had been longer, positive outcomes for the other variables would have been found.

Limitations and Suggestions for Future Research

There are several limitations of the current study. First, a control group was not used, which makes it impossible to compare GTP to care as usual. Therefore, it cannot be concluded whether the significant changes that were found are related to GTP or to other factors. Second, the fidelity of GTP was not measured, because no process measures were included in the current study. However, evaluation from practice showed that important aspects of GTP were implemented (Dimensus, 2017). Nevertheless, future research should include process measures to examine whether the intervention is fully implemented. Third, the intervention was implemented in the period April and May 2015, and the first measurement point was conducted from March to May 2015, which means that there was a partly overlapping period. This implies that there is not a fully adequate baseline measurement (i.e., clients' scores before implementation of GTP), but this does not have a large impact on the results, considering that this type of intervention needs more time to cause a change in clients' scores (Bybee, Mowbray, & Cohen, 1994). Finally, the current study was conducted within one shelter facility in the Netherlands, because GTP is currently only implemented in this organization. The external validity of the present study would benefit if other shelter facilities implement GTP, accompanied with broader research into the efficacy of this intervention. In that case, it is recommended to conduct a Randomized Controlled Trial to examine the effects of GTP in which the fidelity is also assessed.

Implications

Although more research is required to examine the efficacy of GTP, we conclude that GTP seems to be a potentially promising intervention for shelter facilities. First, this participation-based intervention is in line with government policy in the Netherlands and various other Western countries. The current research showed that after implementation of GTP, significant change occurred in an important aspect of social participation, namely the number of hours clients spent on labor activities. Labor is one of the high-priority issues of the Dutch government, even for people with a disability (Rijksoverheid, 2018). Furthermore, this study showed that the scores on the primary outcome measure, quality of life, changed over time, which is also relevant for the government, as one of the government's objectives is to take care of the well-being of their citizens. Second, implementing GTP allows for cost reduction. For example, offering group-based activities is cheaper than individual support, and working with self-directed teams and fewer managers can also reduce costs. The current shelter facility calculated that a

cost reduction of more than 10% could be achieved through implementation of GTP, but has chosen to invest the saved money in the intensity of care (SMO Breda, 2014a). It would be therefore recommendable to perform a cost-benefit analysis to determine whether GTP does in fact facilitate cost reduction compared to alternative approaches.

Chapter 6

The Importance of Organizational Embedding for an Innovative Intervention: A Case Study

ABSTRACT

The current paper uses a practical example to describe how organizational embedding can be an integral part of an intervention. Growth Through Participation (GTP) is an innovative method for the support of homeless people, in which organizational aspects such as job autonomy, leadership style, organizational culture, and team performance are inextricably linked to the principles and working methods related to clients. This method aims to achieve the best results, which include the promotion of social participation and the well-being of clients. By means of research, it was assessed whether the organizational aspects during the implementation of GTP changed and how they are related. This research indicated that the organizational culture did change, but that the variables did not show the coherence they were assumed to have based on the literature. It can be concluded that practice seems to be more complex than theory, however, change processes take time. In the context of follow-up research, we would advise to look for the connection between client-oriented and organizational outcomes.

INTRODUCTION

Healthcare and welfare organizations develop interventions with a view to offering their clients good care. Such interventions usually consist of approaching the client in a different manner. The organizational side of the intervention often receives merely summary attention or none at all, however. This is odd, since the embedding of the intervention within the organization often determines whether the implementation of the intervention is adequate or not, and a better implementation generally means better results for the client (Durlak & DuPre, 2008).

Stichting Maatschappelijke Opvang Breda e.o. (SMO Breda) is an organization providing shelter and ambulatory care to homeless people in and around the city of Breda, the Netherlands, and it has developed an innovative approach to the counseling of clients named Growth Through Participation (in Dutch Verder Door Doen). A fundamental principle of this approach is that the organizational embedding forms an integral part of the intervention, and this pertains to factors such as job autonomy, leadership style, organizational culture, work engagement, and team performance. The intervention itself assumes a capacity for self-management on the part of both the client and the care worker. It requires that everyone within the organization who is involved in or with the intervention to fulfill a different role: aspects such as discretion, targeted action, applying strengths and learning by doing are guiding principles for both clients and care workers. The goal of the intervention is to promote the societal participation and well-being of clients (SMO Breda, 2014).

To research the effectiveness of this intervention, SMO Breda has arranged a PhD study on this matter in collaboration with Tilburg University's Scientific center for care and wellbeing, Tranzo. Tranzo offers an infrastructure to enable the performance of practice-oriented research. Tranzo has set up 'Academic Collaborative Centers' where science practitioners, who generally work in care practice, can pursue (PhD) research under supervision of one or more professors. Sociaal Werk ('Social Work') is one of these collaborative centers, whose goal is to better underpin social work from both the theoretical and practical side, in order to improve the efficiency and effectiveness of social work.

All authors of this paper are affiliated with the Sociaal Werk collaborative center. The first author is a science practitioner and PhD candidate and is supervised by two promoters, who are the second and third authors and professors at the Sociaal Werk collaborative center. The first author was also involved in the introduction of the GTP approach, as a change manager (until early 2017).

This paper describes the results of empirical research conducted within SMO Breda with regard to organizational culture, leadership style, work engagement and team performance, in relation to the organizational change and associated intervention. This means that we studied to what extent these variables changed during the implementation of GTP, and how these variables relate to one another. We will successively discuss: the design of the intervention, the implementation and evaluation of the intervention, the current research questions and the results. Finally, we present a discussion and a conclusion and also address the implications for the practical field, and offer recommendations for future research.

DESIGN OF THE INTERVENTION

GTP was designed on the basis of eclectic principles and a trial-and-error approach. Effective elements, principles and work methods that contribute to the counseling of homeless people were sought both in the literature and the practical field (and both within and outside SMO Breda). Parts of the intervention were then applied in practice with the goal of learning from these experiences, and these various parts were fused together to form a single intervention. The organizational embedding is integrated in GTP: aspects such as job autonomy, leadership style, organizational culture, work engagement and team performance are vital to the intervention. GTP consists of three layers and seeks to promote the societal participation and well-being of clients (see Figure 1) (Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019; SMO Breda, 2014).

Outline of the Intervention
The first layer consists of principles, which apply to both clients and co-workers. The goal is to create a social environment that offers maximum scope for personal development, by assuming and appealing to strengths and talents, a need for autonomy, an organizational culture that stimulates flexibility and creativity, and applying the principle that learning is best achieved through doing.

The second layer, consisting of methods, distinguishes between client-centered work methods and organization forms. The first component concerns the group approach ("I want to participate"), and it comprises various group activities in which clients can participate, depending on their preferences, talents and needs. The second component is an individual approach, and it pertains to the individual counseling (case management) of clients by a social worker. The third component concerns methodologies that are in line with the GTP principles and that provide workers with frameworks and tools with which to offer clients optimum support. The fourth component is leadership style, which consists of a combination of transactional and transformational (or, charismatic)

leadership. The last component is a horizontal organization structure and working with self-directed teams.

The third layer concerns the intended outcome, and here a distinction is made between the intended outcome for clients and for care workers; the notion of taking responsibility and self-management is important for both groups. The intended outcome for clients comprises three goals, namely finding and keeping long-term housing, building a supportive social network, and having a meaningful way of spending the day. For care workers, the intended outcome pertains to achieving work results (team performance) and feeling passionate about the work (work engagement).

The client's experience of the care or service provided deserves particular attention. The efforts made both by clients and by care workers aim to result in a positive client's experience. All activities are ultimately geared to the main goals of the intervention, which are to promote the client's societal participation and well-being (Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019; SMO Breda, 2014).

Figure 1. Visualization of Growth Through Participation (Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019)
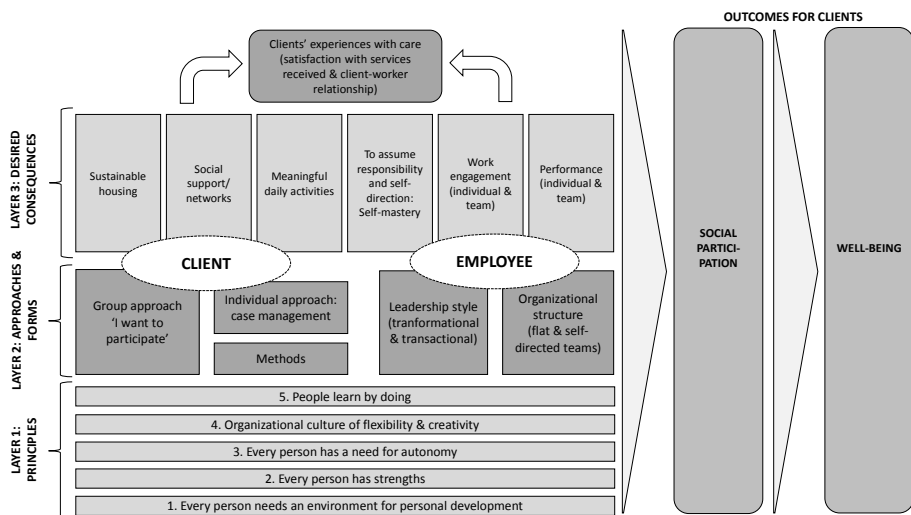

Specific Explanation of Organizational Aspects of GTP

It is a deliberately chosen aspect of GTP to focus on creating an organizational culture (layer 1) that stimulates flexibility and creativity. People should be able to act autonomously, and there's nothing wrong with making mistakes as long as they learn from

these mistakes. These cultural aspects are related to the dimension of 'flexibility and discretion' as described in the 'Competing Values Framework' by Cameron and Quinn (2011), where the culture types of clan and adhocracy are dominant (see Figure 2). As indicated, one of the intended outcomes (layer 3) is that care workers are dedicated to their work, which is captured by the concept of work engagement: "a positive work-related state of fulfillment that is characterized by vigor, dedication, and absorption" (Schaufeli & Bakker, 2004, p. 91).

Figure 2. The competing values framework (Cameron & Quinn, 2011)
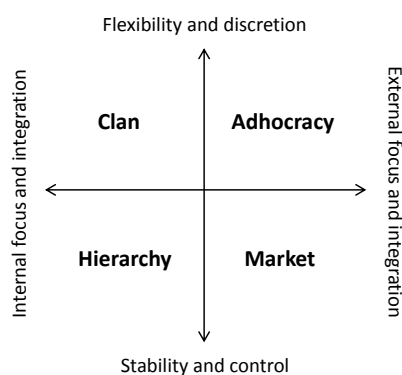
Care workers can be engaged at the individual and the team level (Tims, Bakker, Derks, & Van Rhenen, 2013), and this can be stimulated by a charismatic leadership style and, to some extent, by a transactional leadership style on the part of their manager (Strom, Sears, & Kelly, 2014; Tims, Bakker, & Xanthopoulou, 2011). This aspect is part of the second layer of GTP. Care workers can also increase their work engagement directly, because they are responsible for and have discretion (Schaufeli, 2015) with respect to their own performance and that of the team. For example, they can organize performance appraisal interviews and work meetings, or can assume responsibility for the recruitment and selection of colleagues, or by arranging training courses or other forms of education to improve their skills. Work engagement can lead to better team performance (Christian, Garza, & Slaughter, 2011).

Within GTP, work results mainly pertain to achieving results in terms of the three main goals for clients (housing, social network and daily activities), and in terms of client satisfaction regarding the support and the client-worker relationship. Subjective team performance (e.g., personal opinions on team performance and the achievement of results) is also important.

IMPLEMENTATION AND FIRST EVALUATION OF THE INTERVENTION

GTP was introduced in the spring of 2015, by means of a staged implementation. This implementation occurred hand in hand with a reorganization which gave virtually all workers in the primary process a new role. At the same time, changes were made to the management and supporting staff. The number of managers in the primary process was initially reduced from six to three, and finally to two. Additionally, two team coaches were appointed and a number of changes occurred in the supporting staff, resulting in a stronger focus on communication and result-based management. A number of employees (<5) left SMO Breda because they could not meet the demands of their new position (in good time) or because the organization could not offer them a suitable position.

During the first stage of implementing GTP, all employees were appointed to their new position. Next, a center was created, namely "Talentenfabriek de Faam", where clients are offered group counseling (implementation of the "I want to participate" offer). Care workers were allowed to choose the team that they wanted to be part of, based on a number of diversity-related criteria: distribution of male/female, (work) experience, and with regard to Kolb's learning styles (2015). Team coaches then engaged the teams in a dialogue on important processes, such as drawing up an activities plan, the result-centered approach to work, and the conditions this requires. During the course of the implementation process, a (digital) dashboard was set up enabling both the teams and the management to collect information on the results achieved.

There was particular attention for the organizational side of GTP, both during and after its introduction. Internal team coaches offered managers coaching with regard to their leadership style, and meetings were organized to focus on leadership style and associated topics. These meetings were devoted to, among other things: (1) identifying the personal values that are important for the managers, including attention for what leadership means to the manager, personally; (2) a training in "Non-violent Communication" aimed at building mutual bonds (among management staff, but also in relation to care workers); (3) applying methods in relation to personal leadership; (4) analyzing current leadership styles and personal views on leadership by means of self-tests and then sharing and discussing the results; and (5) interactively discussing the results of the current study at the team level, particularly addressing the (change in) leadership style by the managers.

SMO Breda has evaluated the implementation and results of GTP in several ways: (1) a process evaluation among employees, clients and chain partners, performed by an external agency (Dimensus, 2017); (2) a longitudinal study into the results among cli-

ents; (3) a longitudinal study into the organizational side of GTP (the present study). The process evaluation indicated that employees understand why GTP was introduced and that GTP is welcomed by both employees and clients. For teams and individual workers, the implementation does involve some effort to figure out exactly how to put GTP into practice (there is for instance a lack of clarity regarding certain tasks). People can also try to learn more from each other than learning only from one's own performance, and the group-centered offer can be deployed more effectively (Dimensus, 2017).

The longitudinal study, which concentrates on the results of the support provided by SMO Breda, revealed that after some time, clients did experience a better quality of life and spent more hours outside SMO Breda on work-related activities. However, they spent less hours on recreational activities outside SMO Breda. Overall, no changes were observed with respect to psychological or social functioning, and the clients' appreciation neither increased nor decreased. It also emerged that clients with comparatively more psychological issues benefited more from GTP than clients less affected by such issues (Rutenfrans-Stupar, Schalk, & Van Regenmortel, 2019).

Based on the two studies (process and results), we may conclude that the introduction of GTP does represent a positive development, but that there is certainly room for improvement. To use Sinek's terms (2011), the 'why' of the change is clear, but the 'how' is still unclear in places, leading to a partial achievement of good results with clients (the 'what').

THE PRESENT STUDY

The present study has two goals. On the one hand we examined whether the introduction of GTP has gone hand in hand with a change in organizational culture, leadership style, work engagement and team performance, respectively. On the other hand we investigated whether organizational culture, leadership style, job autonomy, work engagement and team performance display the relation that the GTP concept assumes (see 'Design of the intervention'). In accordance with the theoretical underpinning of GTP, we assumed that work engagement functions as a mediator between discretion, charismatic and transactional leadership styles, clan and adhocracy culture on the one hand (predictors), and team performance (as outcome) on the other. This is in line with the Job Demands-Resources (JD-R) Model (Bakker, 2003), in which engagement is a mediator between task requirements and energy resources on the one hand and organizational results on the other. Discretion, leadership style (in the sense of the support that a worker receives from a manager) and organizational culture (in the sense of the room a worker is given) can be seen as one of the energy resources, and team

performance as part of the organizational results (Bakker, 2003). The present study only examines the factors with explicit relevance within GTP, so not all the factors identified in the JD-R Model.

The above leads to the following research questions:

1. During the implementation of GTP, did the organizational culture and leadership style change in the desired direction, and did work engagement and team performance improve?
2. How are the variables of job autonomy, leadership style, organizational culture, work engagement and team performance correlated?

RESEARCH METHOD

Research Design and Participants

Questionnaires covering various subjects were fielded among all employees of SMO Breda at three measurement moments. The measurement moments were around 21 months apart. Table 1 shows which subject was investigated at what measurement moment. For the first measurement moment, 59% (n = 111) of the total workforce employed by SMO Breda at that time fully completed the questionnaire. At the second measurement moment, the response rate was again 59% (n = 96), and the third time it was 55% (n = 102). In the second and third measurement moment (these were measurements during the implementation and execution of GTP), we deliberately chose not to enquire after the respondents' demographic details (we only enquired after the team that the respondent is part of). This decision was taken with a view to the relatively small size of SMO Breda, which could make demographic details traceable to individuals, which would increase the likelihood of socially desirable response behavior. The questionnaires were completed anonymously at all three measurement moments. As a result, the overall study produced 'unpaired data', meaning that we do not have data available per individual respondent at all three measurement moments.

The first research question (changes in the different variables over time) was answered using the available data produced by the three different measurement moments (longitudinal research design). To answer the second research question (relationships between the variables) we used a cross-sectional research design, using the data obtained at the third measurement moment (October/November 2017).

Table 1. Subjects per measurement moment

March/April 2014 (*n* = 111)	Dec 2015/Jan 2016 (*n* = 96)	Oct/Nov 2017 (*n* = 102)
Organizational culture	Organizational culture Leadership style Work engagement Team performance	Organizational culture Leadership style Work engagement Team performance Team engagement Job autonomy

Since the data was unpaired, we were unable to determine whether the independent variables in one measurement moment had any influence on the dependent variables in the subsequent measurement moment. There were two reasons to use the data from the third measurement moment: (1) GTP had been implemented for some time at that point (2.5 years) and (2) it was the most expansive measurement: all the variables mentioned above were included in this measurement.

Measures

To measure the organizational culture we used the Organizational Culture Assessment Instrument (OCAI) (Cameron & Quinn, 2011). The OCAI measures an organization's status quo in terms of six dimensions of organizational culture (also referred to as content dimensions) (Cameron & Quinn, 2011): (1) dominant organizational characteristics; (2) leadership style; (3) management of employees; (4) organizational glue; (5) strategic emphasis; and (6) criteria for success. The OCAI applies an ipsative assessment scale: respondents are asked to distribute 100 points across four statements, where the first statement relates to the clan culture type, the second to the adhocracy culture type, the third to the market culture type, and the fourth to the hierarchy culture type. By means of the OCAI, both the current and the desired culture can be measured (two times six questions, once about the current culture and once about the desired culture). In the present study, the OCAI was only used to measure the current culture. To answer the first research question we used the separate scores per sub-scale. To answer the second research question we added together the scores of the clan and adhocracy sub-scales.

Leadership style was measured using the Charismatic Leadership in Organizations (CLIO) questionnaire. This tool distinguishes the following four leadership styles (De Hoogh, Den Hartog, & Koopman, 2004):

1. Charismatic (transformational) leadership: implies formulating an inspiring vision that gives the employees a sense of purpose and meaning in their work.

2. Transactional leadership pertains to the social exchange process between the leader and the employees.
3. Autocratic leadership is about giving orders and making clear who's the boss.
4. Laissez-faire leadership: the absence of leadership and avoiding interventions.

The questionnaire consists of 27 items and uses a 7-point scale that runs from "Disagree completely" (1) to "Agree completely" (7). To answer the first research question we used the separate scores per sub-scale. To answer the second research question we added together the scores of the charismatic and transactional leadership sub-scales.

Work engagement at the individual level was measured using the abbreviated version of the 'Utrechtse BEvlogenheids Schaal (UWES; the Utrecht Work Engagement Scale). This questionnaire comprises three sub-scales, namely that of vigor (energy, feeling fit and strong, resilience), engagement (dedication to one's work), and absorption (being immersed in the work in a pleasurable way) (Schaufeli & Bakker, 2004). The questionnaire consists of nine items and answers can be scored on a 7-point scale ranging from "Never" (0) to "Always/Daily" (6). In line with Tims, Bakker, Derks, & Van Rhenen (2013), to measure team engagement we used an item for each dimension that was derived from the UBES.

Team performance was measured using the scale for team performance by Zellmer-Bruhn and Gibson (2006). This is a questionnaire consisting of five items with a 7-point scale ranging from "Disagree completely" (1) to "Agree completely" (7). This questionnaire contains questions like, 'This team achieves its goals' and 'This team completes its tasks'.

Job autonomy was measured using the scale by Peccei and Rosenthal (2011). This scale consists of three items, which are scored on a 5-point scale ranging from "Disagree completely" (1) to "Agree completely" (5).

RESULTS

The following section discusses first the changes over time, and then the relationship between the variables.

Changes over Time
First, the means of the different (sub-)scales were calculated using SPSS (version 24) (see Table 2). This revealed that, at the time of the first measurement moment, the dominant culture type was the clan type, directly followed by adhocracy and hierarchy. At the

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last measurement moment, the clan culture type was still the dominant type, followed by adhocracy. At the second measurement moment (this scale was not measured at T1), employees assigned the highest score to the transactional leadership style of their manager. At the third measurement moment, the charismatic leadership style scored highest. Regarding work engagement, dedication scores highest at the second and third measurement moment.

Next, we investigated whether the average score changed significantly over time. To calculate this for the subscales of the OCAI, namely clan, adhocracy, market and hierarchy, we used SPSS to perform a one-way MANOVA. Since we only had data collected over two measurement moments for the other variables, we used the summary independent-samples t-test in SPSS to determine the significance of the differences over time. Additionally, we calculated the effect size by means of the indices Partial Eta Squared (η_p^2) (recommended ≥ .02) and Cohen's *d* (recommended ≥ .20). These tests indicated that the clan culture type increased significantly ($F(2, 306) = 3.95$, $p < .05$, $\eta_p^2 = .03$) and that hierarchy culture type decreased significantly ($F(2, 306) = 21.13$, $p < .001$, $\eta_p^2 = .12$). The adhocracy culture type was almost significant ($F(2, 306) = 2.44$, p = .09, $\eta_p^2 = .02$), while the other variables did not show a significant increase or decrease.

To determine at what measurement moment the scores for the clan and hierarchy culture types differed significantly, we performed post hoc tests. Regarding the clan culture type, a Gabriel post hoc test[5] indicated that the values of the third measurement moment (M = 30.87, SD = 8.39) were significantly higher than those of the first measurement moment (M = 27.68, SD = 7.95). There were no significant differences between respectively the first (M = 27.68, SD = 7.95) and the second measurement moment (M = 29.34, SD = 8.57) and between the second (M = 29.34, SD = 8.57) and third measurement moment (M = 30.87, SD = 8.39). Regarding the hierarchy culture type, a Games-Howell post hoc test[6] indicated that both the first (M = 25.80, SD = 9.24) and the third measurement moment (M = 19.62, SD = 4.92), the first (M = 25.80, SD = 9.24) and the second measurement moment (M = 22.09, SD = 5.78), and the second (M = 22.09, SD = 5.78) and third measurement moment (M = 19.62, SD = 4.92) differed significantly from each other: per measurement moment, the average values decreased significantly.

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5   A Gabriel post hoc test was applied because the sample size at the three measuring moments differed only slightly, and Levene's test for homogeneity of variance was not significant for the clan culture type (*p* > .05), which means that the variances within the clan culture type did not differ across the three measuring moments (Field, 2018).

6   A Games-Howell post hoc test was applied because Levene's test for homogeneity of variance was significant for the hierarchy culture type (*p* < .001). This means that the variances within the hierarchy culture type did differ from each other, so that using the Games-Howell test is recommended given the strong statistical power of this test (Field, 2018).

Table 2. Means (and standard deviations) of the different (sub)scales

	T1 Mean (SD) (n = 111)	T2 Mean (SD) (n = 96)	T3 Mean (SD) (n = 102)	Partial Eta Squared/ Cohen's d[1]
Organizational culture				
Clan	27.68 (7.95)	29.34 (8.57)	30.87 (8.39)	.03*
Adhocracy	26.21 (7.16)	27.11 (6.09)	28.21 (6.45)	.02
Market	20.30 (7.51)	22.04 (8.47)	21.30 (8.50)	.01
Hierarchy	25.80 (9.24)	22.09 (5.78)	19.62 (4.92)	.12***
Leadership style				
Charismatic		5.04 (1.01)	5.13 (.78)	.10
Transactional		5.09 (1.00)	4.97 (.89)	.13
Autocratic		4.50 (.95)	4.56 (.85)	.07
Laissez-faire		4.48 (.98)	4.56 (.93)	.08
Work engagement (individual)				
Vigor		4.68 (.77)	4.50 (.99)	.20
Dedication		4.84 (.90)	4.71 (1.11)	.13
Absorption		4.35 (.94)	4.24 (1.10)	.11
Team performance		5.43 (.82)	5.46 (.91)	.03
Team engagement				
Vigor			3.85 (1.20)	n.a.
Dedication			4.11 (1.16)	n.a.
Absorption			4.10 (.98)	n.a.
Job autonomy			3.94 (.55)	n.a.

[1]Partial Eta Squared is a common measure of effect size when there are three measurement moments (culture types clan, adhocracy, market, and hierarchy) and Cohen's d is a common measure of effect size when there are two measurement moments (other variables, with the exception of team engagement and job autonomy, since these do not include repeated measurements). *$p < .05$; ***$p < .001$

Relationships between Variables

As the second main part of the analysis, we examined how the variable relate to each other. As mentioned previously, GTP assumes that a relationship between job autonomy, the combination of a charismatic and transactional leadership style, and finally the combination of the clan and adhocracy culture types will contribute positively to work engagement (individually and as a team). A higher work engagement will in turn contribute to better results (team performance).

To verify this, we used Amos (version 22) (Arbuckle, 2013) to test a model in which job autonomy, charismatic and transactional leadership style and clan and adhocracy culture are predictors of team performance via the mediators of work engagement (in-

dividual) and team engagement, and in which individual work engagement is a predictor of team engagement (see Figure 3). We treated both variables – work engagement and team engagement – as latent variables. The analysis revealed that the tested model showed a good fit; the χ^2/df was 1.467 (recommended <3.0; Awang, 2012), the Comparative Fit Index (CFI) was .975 (recommended >.90; Awang, 2012) and the Root Mean Square Error of Approximation (RMSEA) was .068 (recommended <.08; Awang, 2012). It also emerged that job autonomy and the combination of charismatic and transactional leadership shows a significant positive relation with individual work engagement (as expected) but not with team engagement (not expected). Also contrary to expectations, the combination of clan and adhocracy did not show a significant relation with individual or team engagement. Individual work engagement did turn out to be positively correlated with team engagement, as expected, but negatively correlated with team performance, completely contrary to expectations. Team engagement was positively related to team performance, as expected. For work engagement, team engagement and team performance, the proportions of explained variance in this model are .23, .37 and .34, respectively.

DISCUSSION AND CONCLUSION

The results indicate that the organizational culture has developed in the desired direction to some extent: the clan culture type has increased significantly, and the hierarchy type has decreased significantly. The adhocracy culture type has developed in the right direction, but not significantly. We may conclude that a cultural change appears to be underway within SMO Breda: the development is in the right direction, but the process is not yet complete. Given how cultural change processes usually take years and how culture is often very difficult to influence (Cameron & Quinn, 2011), this is understandable.

The other variables, such as leadership style, work engagement, and team performance, have remained steady. Since the scores for individual work engagement were already high at the second measurement moment (late 2015/early 2016) compared to the benchmark scores with respect to work engagement (Schaufeli & Bakker, 2004), the management mainly sought to develop the leadership style, also because influencing the leadership style lies directly within the managers' own sphere of influence. However, the analyses show that this effort has not yet been successful. This may be attributable to the fact that individual people have their own leadership style, which is difficult to change. Despite all that is said and written about changing leadership style in the world of coaching and consultancy, there are theories that indicate that a person's leadership style is directly related to his or her personality (Cable & Judge, 2003).

Figure 3. Relationships between job autonomy, leadership style, organizational culture, work engagement (individual and team) and team performance (*n* = 102)
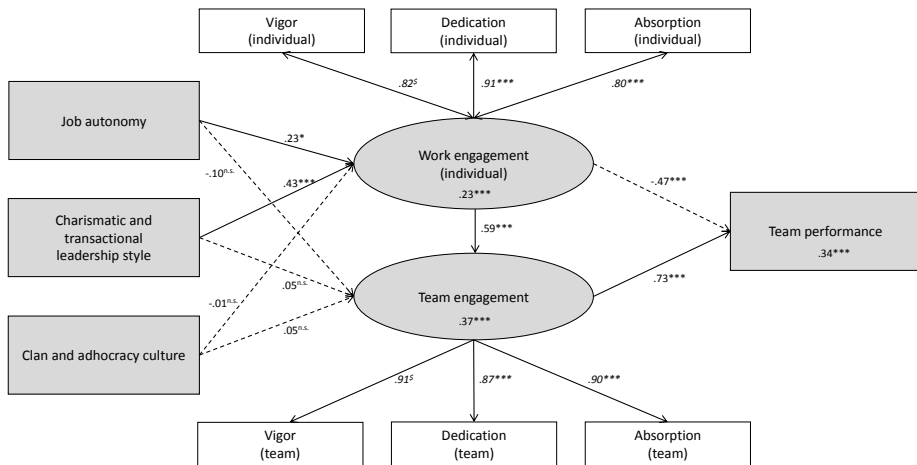
Note. Standardized regression coefficients are shown next to the arrows, and factor loadings are printed in italics. Proportions of variance explained are reported below construct names. Ovals represent latent variables and rectangles represent observed variables. *p<.05. ***p<.001. [n.s.] *p=non-significant. [$]Loading fixed at the value of 1 in the non-standardized solution.

As a result, managers are not inclined to adjust their leadership style to the (changing) organizational context. It is moreover known that a person's personality is fairly stable, so that an adjustment of leadership style is very difficult to achieve, if at all possible. Another possible explanation for not finding any change with respect to the scores on leadership style pertains to the change in management staffing that occurred: two managers (in supporting processes) were newly hired, and the number of managers in the primary process was reduced by one (i.e., first, there were six managers, then three, and finally two). At the time of the measurement, the two new managers had been with SMO Breda for just a few months. This made it hard for employees to assess their manager (scoring the questionnaire for these items), which may have led them to choose the midway category (score 4).

The present study furthermore shows that only job autonomy and the combination of the charismatic and transactional leadership styles correlate positively with individual work engagement, and not with team engagement. The items regarding the concept of job autonomy pertain to individual performance. This might explain the lack of a relationship with team engagement. Regarding leadership style, we may speculate that at the time of the measurement, the managers were not so much focused on managing team processes, but were concentrating their attention on the individual employee. It can therefore be formulated as a recommendation for managers of SMO Breda to focus

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more on work processes in teams.

Higher scores on the combination of clan and adhocracy culture (both characterized by a high degree of flexibility and discretion) do not seem to lead (directly) to more individual and team engagement. Work engagement may possibly be influenced by other factors which we did not measure, such as the mental, emotional and physical work requirements associated with the position fulfilled by the employees (Bakker, 2003). Moreover, the items regarding the clan and adhocracy culture types do not aim to directly measure job autonomy activities; after all, the items consisted of statement about the organizational culture. This culture does form the context within which discretion can be increased, but it does not directly measure discretion. The scale that we used for discretion does measure this directly, and we have already concluded that there is in any case a positive relationship between discretion and individual work engagement.

Team engagement correlated positively with team performance, as expected. However, completely contrary to expectations, we found a negative relationship between individual work engagement and team performance. One explanation could be that individually engaged employees take a much more critical view of team performance; so perhaps this group is harder to please with respect to achievements.

Implications

On a general note, we may conclude that the practical field is a lot more obdurate than the theory. GTP assumes a certain relationship (as described on the basis of literature, see the section on "Design of the intervention") between job autonomy, leadership style, organizational culture, work engagement and team performance, but the present study has found limited evidence to demonstrate this relationship. At the same time, it is clear that changing organizational culture and leadership style takes time and effort, and is not easy to achieve. We nevertheless advise SMO Breda to persist with the development process, but with a few changes; for example, that managers should focus more on managing teams rather than individuals. We also recommend that management seriously consider further coaching to help them adopt the charismatic and transactional leadership style, or to see whether other measures are required.

Other organizations can certainly draw lessons from the case study presented here as well. Numerous organizations are currently seeking to implement interventions comparable to GTP. Based on the present study and the experience we have acquired during the change process, we can offer the following recommendations:

- First communicate mainly about the 'why' of the change, and subsequently also

about the 'how' of the change. Act with a clear vision and provide for clarity and involvement. Leading by example is essential.

- Involve employees and clients in developing an intervention. Try things out to discover what works, and be prepared to adjust the intervention if something does not work. Always keep the client center-stage; in this way, conflicts of interest can be resolved more easily.
- When developing an intervention, make use of effective elements found in both literature *and* the practical field.
- Ensure that employees can act with discretion, as this increases the individual work engagement.
- As manager, seek to combine a charismatic and transactional leadership style, as this contributes to individual work engagement among employees.
- Seek to promote team engagement, as this contributes to better team performance.
- Take the time it takes to achieve a change to organizational culture.
- Also take time to achieve a change in leadership style, but be prepared to make changes to the management staffing as well.
- Managers who are expected to provide leadership to teams: focus especially on how the team performs, rather than on how individuals perform.
- Monitor the results of the intervention: examine both the organization-related and client-related outcomes, and how these two relate.

Recommendations for Future Research

Given how change processes take time, it is important to continue to monitor them. That is why we advise SMO Breda to perform a follow-up measurement to determine whether the organizational culture and leadership style have developed (further) in the desired direction.

It would also be advisable to further consolidate the organizational aspects of GTP. This could be done by conducting a qualitative study to explain both effective and ineffective mechanisms. The present study did not include attention for the "survivor syndrome", for example: an attitude and feeling that may emerge among employees following an organizational change (Brockner, 1988). Despite the fact that only a few employees were made redundant during the change process, the change nevertheless had a strong impact on the employees. This was revealed for instance by perceptions of unsafety within the organization. A qualitative research design could yield further insight into these aspects, so that managers can better adjust their actions to their employees' behavior.

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Further, we defined the outcomes of the care workers' work (see Figure 3) as team performance, which is a very narrow and subjective measure of outcome. For this reason, it is advisable to also examine individual employee performance and more objective outcomes, for instance using the individual and team performance indicators included in the SMO Breda's dashboard.

To examine the relationships between the variables, we moreover made use of a cross-sectional analysis. A longitudinal research design would offer more insight into causality. In the present study we were unable to use longitudinal data to test for causality, since the data was unpaired and we only included all the variables in the third measurement moment. For future research we recommend testing the model as presented in Figure 3 by means of a longitudinal study.

Finally, GTP centers on the clients' experience in the form of satisfaction regarding the care and support provided and regarding the client-worker relationship. It emerged from previous research that the clients' experience is a strong predictor of better outcomes (in terms of clients' social participation and well-being) (Rutenfrans-Stupar, Van Regenmortel, & Schalk, 2018). Any follow-up measurement should therefore integrate the client and employee experience. This could take the form of a measurement aimed at determining whether a higher employee satisfaction (and possible higher work engagement as well) leads to a higher client satisfaction.

Finally

The current research literature generally focuses on the outcomes for clients (consider for instance effect research in the research fields of psychology and social work), *or* on the outcomes for employees (consider the extensive range of research conducted within employment and organization psychology). Interventions are only effective if they are implemented well within the organizations that execute them. For any future (intervention) study, we would therefore advocate integrating these two research domains more closely, and to not focus only on the outcomes for either clients or employees.

Chapter 7

General Discussion

BACKGROUND

The current thesis aimed to evaluate GTP, including the factors that enhance the primary outcomes of GTP (i.e., social participation, self-mastery, quality of life/well-being), through examining the following five research questions:

1. What factors enhance or impede social participation, self-mastery, and well-being?
2. How are all these variables related to each other?
3. What are the outcomes of the GTP intervention?
4. How did organization-related variables change during the implementation of GTP?
5. How are these organization-related variables related to each other?

Five studies were conducted in order to answer these questions. The first study (Chapter 2) described two qualitative studies ($n = 10$ and $n = 6$) that investigated clients' experiences with participation in educational, recreational, and labor activities (i.e., activities that are part of the "I want to participate" program) in relation to their physical, social, and mental well-being. Chapter 3 presented the results of a cross-sectional quantitative study ($n = 225$) in which a mediation model was tested where social participation is considered as a mediator between care-related and demographic (i.e., client-related) predictors on the one hand, and well-being on the other hand. Chapter 4 described a mixed-method study ($n = 97$ and $n = 36$) of associations between person-related and care-related variables as predictors of both social participation and quality of life through the mediator of self-mastery. Chapter 5 revealed the outcomes of a longitudinal quantitative study ($n = 172$) on GTP. Finally, Chapter 6 presented the outcomes of a quantitative study ($n = $ approx. 100) on the organization-related variables that play a fundamental role in the GTP intervention. Here, we examined whether these organization-related variables changed during the implementation of GTP by applying a longitudinal study design and we explored the relationship between these variables by applying a cross-sectional study design. In the current chapter the main findings, a reflection on the main findings, research limitations and strengths, and finally, recommendations for future research, policy, and practice are presented.

MAIN FINDINGS
In this section the main findings are presented clustered around the five research questions.

1. What factors enhance or impede social participation, self-mastery, and well-being?
In Chapters 2, 3, and 4 we examined which factors enhance or impede social participation, self-mastery, and well-being (research question 1). The findings are reported in

line with the distinction between care-related and person-related variables presented in Chapter 1.

Social participation: The findings regarding factors that enhance social participation are summarized in Table 1. The research described in Chapter 3 and 4 showed the following predictors of social participation: Education level, the level of self-mastery (defined as a combination of self-efficacy, intrinsic motivation, and internal locus of control), and optimism as person-related predictors, and experiences with care as a care-related predictor. Notably, analysis of the data of the study described in Chapter 4 did not show a relationship between education level and social participation. All these predictors had a positive relationship with social participation, meaning that the predictors were enhancing factors of social participation. Additionally, the studies described in Chapter 2 showed that the supervisor of a group activity can, next to enhance, also hinder clients' participation in activities (i.e., a specific type of social participation, level 4 in the taxonomy of Levasseur et al. (2010) as described in Chapter 1). However, in the research described in Chapter 4, it was expected that age (person-related) and participation in activities organized by the shelter facility (care-related) also would lead to an enhancement of well-being, but analysis of the data did not reveal these relations among the study sample.

Table 1. Enhancing factors of social participation found in the current thesis

Enhancing factors	Chapter
Person-related	
Education level[a]	3
Self-mastery	4
Optimism[b]	4
Care-related	
Experiences with care[c]	3 + 4

[a] The research described in Chapter 4 did not show a relation between education level and social participation.
[b] Through the mediator self-mastery (Chapter 4)
[c] Including the role of the social worker. The research described in Chapter 2 showed that the supervisor can hinder or facilitate clients' participation in activities.

Self-mastery: Table 2 provides a summary of enhancing and impeding factors of self-mastery found in the research described in the current thesis (i.e., outcomes of the mixed-method study described in Chapter 4). Person-related enhancing factors include age squared (i.e., self-mastery increases as formerly homeless clients get older until a certain age, then self-mastery decreases), social participation, optimism, physical

and psychological health. Care-related enhancing factors include experience with care, daily structure, the autonomy to decide how to spend the day, and privacy. A note has to be made regarding experiences with care. The quantitative analysis did not reveal an association between experiences with care and social participation. However, the qualitative analysis indicated that this relationship might exist, but it became not fully clear how self-mastery was influenced through experiences with care. A care-related impeding factor is non-supportive house rules, and person-related impeding factors are a lack of financial resources and a sense of not feeling at home. Furthermore, contrary to the hypothesis in Chapter 4, we did not find a relationship between education level (person-related) and self-mastery, nor between duration of support (care-related) and self-mastery.

Table 2. Enhancing and impeding factors of self-mastery found in the current thesis

Enhancing and impeding factors	Chapter
Person-related enhancing factors	
Age squared	4
Social participation[a]	4
Optimism	4
Physical and psychological health	4
Care-related enhancing factors	
Experiences with care[b]	4
Daily structure	4
Autonomy to decide how to spend the day	4
Privacy	4
Person-related impeding factors	
Lack of financial resources	4
A sense of not feeling at home[c]	4
Care-related impeding factors	
Non-supportive house rules	4

[a] In this table categorized as person-related factor, because the concept is in the current thesis examined from clients' perspective (i.e., self-reports). However, social participation is also related to environmental factors (such as social relations), and can also be considered a society related factor (see Chapter 1).

[b] Quantitative analysis did not reveal the relationship between experiences with care and self-mastery. Qualitative data indicated that clients' experiences with care can affect self-mastery. However, based on the qualitative data, we were unable to draw a conclusion on how experiences with care influences quality of life and social participation.

[c] In this table categorized as a person-related impeding factor, because it concerns feelings of clients. However, this variable can also be categorized as a care-related impeding factor, because social workers of the shelter facility also have a responsibility in arranging the conditions of making the residence feel like home.

Well-being: Table 3 presents the enhancing factors of well-being (including quality of life) that were found in the research described in Chapter 2, 3, and 4. Person-related predictors include education level, age squared, social participation, optimism, and self-mastery. Care-related predictors include participation in activities in the shelter facility and experiences with care. Only enhancing factors were found, except for the finding regarding poor group cohesion when participating in group activities. Clients experienced that a lack of group cohesion negatively influenced their social and mental well-being. Importantly, the research described in Chapter 4 showed that age squared was positively associated with quality of life, but the research described in Chapter 3 did not confirm a relation between age and well-being. Besides, the research in Chapter 3 showed a relationship between education level and well-being, but the analysis of the data of Chapter 4 did not reveal this relationship.

Table 3. Enhancing factors of well-being/quality of life found in the current thesis

Enhancing factors	Chapter
Person-related	
Education level[a, b]	3
Age squared[c,d]	4
Social participation[e]	3
Optimism[b]	4
Self-mastery	4
Care-related	
Participation in activities in the shelter facility[f]	2 + 3
Experiences with care[a]	2 + 3 + 4

[a] Through the mediator social participation (Chapter 3).
[b] In the research described in Chapter 4, no relationship was found between education level and quality of life.
[c] Through the mediator self-mastery.
[d] The relationship between age and well-being was not confirmed in the research described in Chapter 3.
[e] In this table categorized as person-related factor, because the concept is in the current thesis examined from clients' perspective (i.e., self-reports). However, social participation is also related to environmental factors (such as social relations) and can also be considered as a society related factor (see Chapter 1).
[f] The research described in Chapter 2 showed that when clients experienced a bad group cohesion this has a negative influence on their social and mental well-being.

2. How are all these variables related to each other?

Chapters 2, 3, and 4 contained information on the relationships between variables such as person-related and care-related variables, social participation, self-mastery, and well-being/quality of life. Chapter 2 showed that clients experienced that participation in educational, recreational, and work activities led to an improvement of important

components of physical, social, and mental well-being. In general, clients reported that due to participation in activities, their social support improved, their mental and physical health (i.e., mood and physical condition) increased, and their self-esteem and personal growth enhanced. Moreover, Chapter 3 showed that client's experiences with care (care-related) and education level (person-related) are predictors of well-being with a mediating role for social participation, and that participation in activities at the shelter facility (care-related) is a direct predictor of well-being. Furthermore, the quantitative analysis in Chapter 4 showed that (1) self-mastery is related to social participation and quality of life, (2) optimism predicts social participation and quality of life through self-mastery, (3) age squared predicts social participation through self-mastery, and (4) clients' experiences with care is directly related to social participation and quality of life. Additionally, qualitative analysis revealed that (1) both social participation and aspects of quality of life can be considered as predictors of self-mastery; 2) clients' experiences with care is associated with self-mastery; and (3) additional promoting factors for self-mastery include daily structure, the autonomy to decide how to spend their day, and privacy; while impeding factor include, non-supportive house rules, a lack of financial resources, and a sense of not feeling at home.

3. What are the outcomes of the GTP intervention?

The longitudinal study presented in Chapter 5 evaluated the outcomes of GTP. This study showed that the total score of quality of life (including the subscales social relationships and environment) increased over time. Additionally, the amount of time clients spent on labor activities outside the shelter facility also increased over time. However, the amount of time clients spent on recreational activities outside the shelter facility decreased over time, and no changes were found in the scores of the subscales physical and psychological health, nor in the scales psychological distress, self-esteem, social support, participation ladder, and experiences with care. (Formerly) homeless clients with above-average psychological distress scores experienced more improvements over time in quality of life (subscales physical health and environment), self-esteem and psychological distress compared to those with lower levels of psychological distress. However, the amount of time these clients spent on labor and recreational activities outside the shelter facility remained unchanged, as did the scores on other variables.

4. How did organization-related variables change during the implementation of GTP?

The research described in Chapter 6 examined changes of organization-related variables (i.e., organizational culture, leadership style, work engagement, and team performance) during the implementation of GTP. This research showed that organizational culture has partly changed in the intended direction: There is a significant increase in the clan culture and a significant decrease in the hierarchy culture. Although the adhocracy

culture has changed in the right direction, it was not a significant change. It can be con-
cluded that there seems to be a cultural change within SMO Breda: the right direction
has been taken, although the process has not yet been completed. The other variables,
namely leadership style, work engagement, and team performance, remained stable.

5. How are these organization-related variables related to each other?

Chapter 6 examined the relationships between organizational culture (combination
of clan and adhocracy culture), leadership style (i.e., combination of charismatic and
transactional leadership), job autonomy, work engagement (at the individual and team
level), and team performance. This research showed that both job autonomy and a
combination of charismatic and transactional leadership were positively related to
individual work engagement, but not to team engagement. Individual work engage-
ment was positively related to team engagement, but negatively to team performance.
Moreover, a positive relationship between team engagement and team performance
was found. Finally, the combination of clan and adhocracy culture was not related to
team engagement.

## REFLECTION ON THE MAIN FINDINGS

A New Proposed Model of Predictors of Self-Mastery, Social Participation, and Well-Being

Based on the main findings related to the first two research questions, a new model of
predictors of self-mastery, social participation, and well-being is proposed. Although
this model is largely reliant on the empirical findings of the current thesis, it should be
tested more comprehensively, because it is not fully based on the current empirical
findings. The new model includes person-, care-, and society/community-related vari-
ables. Although the first two types of variables were examined in the current thesis,
Chapter 1 stated that the current research did not focus on society-/community related
variables. For future research, it is recommended to include these variables. Aside
from the aforementioned predictors, the model includes the relationships between
self-mastery, social participation, and well-being (Figure 1).

Regarding person-related variables, we found that demographics might play a role as
indicators of self-mastery, social participation, and/or well-being. However, the find-
ings from Chapter 3 and 4 on age and education level were contradictory regarding
the influence of these demographics. Therefore, a solid conclusion whether age and
education level can be considered predictors of self-mastery, social participation, and
well-being could not be drawn. However, it is plausible that these factors, especially
education, play a role, because in today's society we see that position is strongly de-

termined by education level and the related level of income and wealth (e.g., Van den Muijsenbergh, 2018).

Figure 1. A new proposed model of predictors of self-mastery, social participation, and well-being.
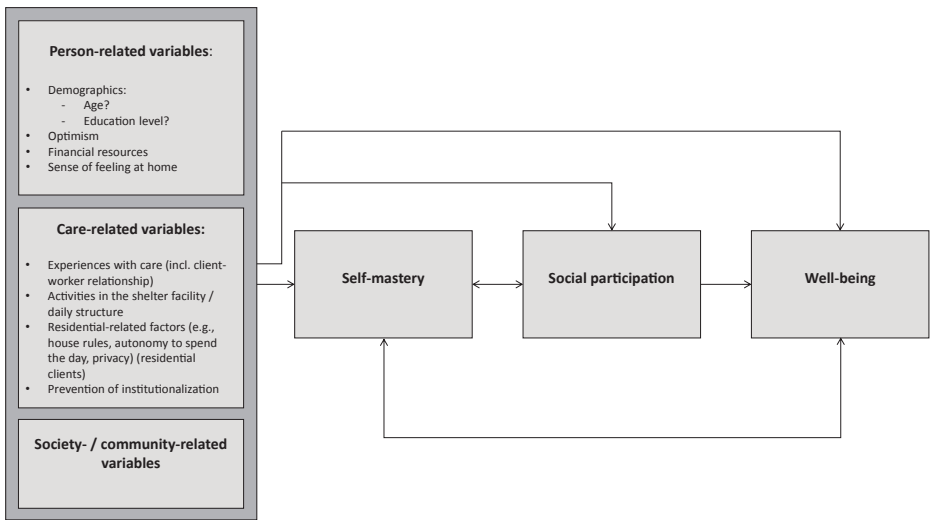
Three other variables, namely (1) optimism, (2) financial resources, and (3) the sense of feeling at home, were determinants of self-mastery according to the research described in Chapter 4. Although the impact of these variables on well-being and social participation has not been examined in the current research, they likely also influence well-being and social participation. For example, other research shows that optimism is positively related to quality of life (Applebaum et al., 2013; Gruber-Baldini, Ye, Anderson, & Shulman, 2009; Schou, Ekeberg, & Ruland, 2005) and to social support or social functioning (Applebaum et al., 2013; Schou et al., 2005), which are all aspects of social participation. Additionally, several other studies showed an association between (lack of) financial resources and well-being or related aspects (Rijken & Groenewegen, 2008; Smith, Langa, Kabeto, & Ubel, 2005; Van Straaten et al., 2016); these studies stress the negative effect of low income on the access to social participation (Bittman, 2002; Rijken & Groenewegen, 2008). Finally, other researchers emphasize the importance of feeling at home in relation to people's well-being (De Veer & Kerkstra, 2001; Easthope, Liu, Judd, & Burnley, 2015) and to social participation (Cuba & Hummon, 1993).

Regarding care-related predictors, we found in the studies described in Chapters 2, 3, and 4 that experiences with care play a role in enhancing self-mastery, social par-

ticipation and/or well-being. However, the quantitative analysis presented in Chapter 4 did not show a relationship between experiences with care and self-mastery, but experiences with care was directly related to social participation and quality of life. Qualitative findings indicated that clients experiences influences experiences with care on self-mastery. Another care-related predictor is activities in the shelter facility and daily structure. Chapters 2 and 3 revealed the relationship between participation in these type of activities and well-being. However, despite the respondents in Chapter 2 reporting that their participation in activities enhanced their social functioning and enlarged their social network, a relationship between activities in the shelter facility and social participation was not found in the study described in Chapter 3. This is probably due to the low participation rate of the clients in that study sample, which could be related to the implementation of the "I want to participate" program (the study was conducted at the same time as the implementation of the broader GTP intervention of which group activities, i.e., "I want to participate", form one of the key aspects). Besides, we did not examine the impact of participation in activities in the shelter facility on self-mastery; however, clients indicated the importance of a daily structure in enhancing self-mastery. We assume that a relationship between participation in activities in the shelter facility including a daily structure and self-mastery exists, as other authors have shown that, for example, self-efficacy (one aspect of self-mastery) can be developed through performance achievements, such as participation in (sports) activities (Feltz & Weiss, 1982). Previous research has also shown that a daily structure is related to one's mastery of daily life (Punamäki & Aschan, 1994). Additionally, the qualitative research from Chapter 4 showed that clients experienced that residential-related factors, such as house rules, autonomy to spend the day, and privacy, enhance self-mastery. Although we did not examine the influence of these factors on social participation or on well-being, we suspect the existence of this relationship because of the importance of environmental factors on people's well-being and social functioning mentioned in Chapter 1 (e.g., Rapp & Goscha, 2012). Finally, Chapters 2 and 3 paid explicit attention to the prevention of institutionalization (Goffman, 1961): In the institutionalization process, the enabling niche of the "I want to participate" program can become an entrapping niche when the environment becomes too safe for people. Therefore, the prevention of institutionalization is added as a care-related predictor.

Finally, the research described in the current thesis revealed a positive relationship between self-mastery and social participation (Chapter 4), self-mastery and quality of life (Chapter 4), and social participation and well-being (Chapter 3). However, it seems that not only self-mastery and social participation are predictors of well-being/quality of life; aspects of quality of life (i.e., physical and psychological health) also influence self-mastery. People with health problems are hindered in their capacity of mastering

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their lives (Chapter 4). Additionally, lower levels of social participation likely influence self-mastery (Chapter 4). More specifically, having a job or a social network gives people more opportunities which in turn can cause an increase of their mastering capacity (e.g., Rapp & Goscha, 2012; Scheffers, 2015; Wolf, 2016). Lastly, person-, care-, and society-/community-related factors may also directly influence social participation and well-being, aside from, self-mastery. Although self-mastery is a key-concept in taking control over one's life, other factors also play a role. For example, in Chapter 1 the importance of environmental factors was emphasized (e.g., Rapp & Goscha, 2012).

The new proposed model presented in Figure 1 provides more insights in enhancing the well-being of (formerly) homeless people. Interventions, such as GTP, can benefit from these new insights. In other words, person-, care-related, and society-/community-related predictors should be taken into account by social and health care workers and their organizations (explanation, see Introduction). Some of these factors are easy to influence, others more difficult or are not influenceable at all. From the perspective of social workers and their organizations, the care-related variables in particular are the first category to promote. Another new insight is the importance of self-mastery and social participation in enhancing well-being of (formerly) homeless clients. Consequently, these two components should play a crucial role in interventions; fortunately, they do so in GTP and in strength-based and recovery methods and approaches (e.g., Den Hollander & Wilken, 2013; Korevaar & Droës, 2016; Wolf, 2016).

Outcomes of GTP

In Chapter 5 the outcomes of GTP were evaluated through a longitudinal study design. The finding that the total quality of life (including subscales social relationships and environment) increased over time is relevant, because it is supposed to be the main outcome of GTP. The results on the other crucial outcome, namely social participation, were measured by a combination of questions/questionnaires (i.e., time spent on labor and recreational activities outside the shelter facility, participation ladder, and social support); however, they were ambiguous. The time spent on labor activities outside the shelter facility increased, but the time spent on recreational activities decreased, and the scores on the participation ladder and social support remained stable during the three measurement points. The data of the study did not provide an explanation for the unexpected outcomes. A possible explanation for the decrease in recreational activities outside the shelter facility, is that clients have been spending more time on recreational activities of the "I want to participate" program, which is contradictory to the objective of GTP (social participation). However, future research is needed to investigate this finding. Notably, the other main indicator, self-mastery, was not assessed in the longitudinal research.

Another conclusion was that clients with above-average psychological distress experienced more improvements over time in total quality of life (subscales physical health and environment), self-esteem and psychological distress (i.e., psychological distress decreased) compared to those with lower levels of psychological distress. However, other variables did not change over time as those variables related to social participation remained stable. This leads to the question whether it is more difficult to enhance social participation among people with psychological distress. Another study, that evaluated the effectiveness of the Comprehensive Approach to Rehabilitation (CARe) methodology, among people with severe mental illness showed that quality of life increased, but social functioning (which is closely related to social participation) did not change over time (Bitter, Roeg, Van Assen, Van Nieuwenhuizen, & Van Weeghel, 2017), which implicates that it is especially hard to change social participation. Another remark that needs to be made on the research described in Chapter 5 is that it cannot be concluded whether the significant changes that were found are related to GTP, because the study design did not include a control group. The study of Bitter et al. (2017) described the results of a Randomized Controlled Trial, and revealed significant changes in quality of life in both the intervention and control group. This also indicates that quality of life can change over time as a result of factors other than intervention alone. Consequently, more research is required to examine the efficacy of GTP. Nonetheless, GTP seems to be a promising intervention, because it is in line with Dutch government policy in that it promotes labor activities and quality of life. In addition, the intervention has the potential to reduce costs.

Organization-Related Variables

Chapter 6 assessed whether the organizational aspects during the implementation of GTP changed and how they are related. This research showed that the organizational culture did change, but leadership style, work engagement, and team performance did not; it also found that the variables did not fully show the coherence they were assumed to have based on previous literature. It can be concluded that practice seems to be more complex than theory; however, change processes take time (e.g., Cameron & Quinn, 2011). The main lesson learned in Chapter 6 is that it is necessary to study the connection between client-related and organizational outcomes during the development and implementation of interventions, and while the research is being conducted.

RESEARCH STRENGTHS AND LIMITATIONS

The research described in the current thesis has strengths and limitations that will be discussed in the current section.

Strengths

The first strength is that the thesis consists of both quantitative and qualitative research designs. The qualitative studies (Chapters 2 and 4) provided more insight in the experiences of homeless people on participation in activities in relation to their well-being and on self-mastery in relation to their social participation and quality of life. The quantitative studies focused on the relationships between variables through testing a model (Chapters 3, 4, and 6) and on testing changes in client- and organization-oriented variables in time (Chapters 5 and 6). Additionally, the research included studies among clients and employees to gain a better understanding of GTP. This all contributed to the thoroughness of the current research regarding the topic of social participation of homeless people.

Second, this research is the first to examine social participation through a comprehensive approach from the perspective of homeless people. As mentioned in Chapter 2, although the relationship between participation and well-being in the general population has often been examined (e.g., Eurostat, 2010; Wallace & Pichler, 2009), only a few studies explored this relationship in the homeless population. Besides, most of the studies focus on the requirements and barriers to participate (e.g., Bradley, Hersch, Reistetter, & Reed, 2011; Zuvekas & Hill, 2000) instead of the often positive outcomes of participation. Furthermore, although strength-based and recovery-oriented approaches included concepts such as self-mastery and social participation, only a few studies focus on these aspects among homeless people and even less on the relationship between these two variables. To our knowledge, no empirical model has been developed regarding the relations between self-mastery, social participation, and well-being including predictors among the homeless population.

Third, the researcher was involved in the development of GTP and in SMO Breda. Although some scholars would consider this as a limitation, it can also be acknowledged as a strength. Hence, the researcher was aware of the details of the intervention, and had extensive knowledge of the target group, organization, and context which enabled to investigate the intervention in depth. Additionally, this reduces the risk of type II error. It is important to emphasize that conditions were created to guarantee the independence of the research, such as connection with the academic collaborative center Social Work (Tranzo, Tilburg University) including a written agreement allowing for the research to be conducted according to scientific guidelines under supervision of two independent supervisors. As a result of the researcher's involvement in the intervention and in SMO Breda, results of the research were applied directly in practice, which allowed SMO Breda to learn from the research. Finally, the researcher could also easily involve clients to participate in the research: Clients were directly involved in the research process

through participating in a taskforce and, when necessary, the official client board was involved in the research decision making process and was informed about results of the research. This enabled them to advise the management board on issues related to the research and GTP.

Limitations

The first limitation is that the research was conducted in the context of one organization (SMO Breda) in the Netherlands. Therefore, we did not examine social participation of homeless people that are not a client of SMO Breda (for example, homeless clients of other facilities or homeless people who are living on the streets and not yet a client of any organization). Consequently, the external validity and transferability are threatened. This implies that carefulness is needed when generalizing results to other populations in- and outside the Netherlands. Nevertheless, we did not have indications that the examined samples were not a good representation of the target group of Dutch homeless people and most Dutch homeless people are client of an organization. The samples of the current research were diverse, existing of different age categories, education level, gender, and contained both residential clients and clients who had ambulatory support.

Second, although a longitudinal study design was used to test the outcomes of GTP, we did not use a control group and we did not include process indicators to measure whether the intervention was fully and adequately implemented. Therefore, we do not know whether the outcomes of the longitudinal study are caused by GTP or by other factors. As argued previously, other studies also revealed an enhancement of quality of life among comparable target groups (e.g., Bitter et al., 2017); it is therefore possible that, for example, the enhancement of quality of life is the result of a natural process. Additionally, the model fidelity of the implementation of GTP was not assessed, meaning that no evidence is available on the thoroughness of implementation of the intervention. The study described in Chapter 6 showed that regarding the organizational-related variables, GTP was not fully implemented. However, an independent process evaluation showed that in general GTP was adequately implemented (Dimensus, 2017).

Third, society-/community-related variables (examples are provided in the Introduction) were not included in the research described in the current thesis. In Chapter 1, the relevance of these variables was mentioned, but it was decided to examine social participation on the level of the client and the shelter facility (i.e., person- and care-related variables were included) as the current research intended to contribute to implications for interventions like GTP. Therefore, we could examine the person- and care-related variables more in depth, but to fully understand the concept of social participation, it is necessary to consider the big picture. In relation to this limitation, it is also necessary

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to address that the current research did not include implications on how clients' social network can be strengthened. In the current research we included social support and social contacts as a part of social participation, but for example, in the qualitative parts of the research, clients did not mention how their social network can be expanded. To investigate this more thoroughly, it is needed to focus on this topic and to examine this from a broader perspective (e.g., to include clients' social contacts in future research).

Fourth, in Chapters 3, 4, and 6 models were tested (using a cross-sectional study design) and based on these models, the current chapter proposed a new more comprehensive model of predictors of self-mastery, social participation, and well-being. In relation to these models, two limitations needs to be reported. First, the models intend to examine causal relationships between variables. Although techniques like Structural Equation Modeling are commonly used to test causal processes (Byrne, 2016), one has to be careful with drawing solid conclusions on the causality between variables. Second, the presented models are, like every model and theory, a simplification of reality. Hence, other mechanisms also play a role in social participation which means that, despite our intention to provide more comprehensive insights in the concept of participation, we have not fully captured all the processes related to social participation.

Finally, we did not report results of subgroup analyses regarding ambulatory versus residential clients, male versus female clients, and clients with lower levels of social economic status versus clients with higher levels of social economic status. This has several reasons: (1) The principles of GTP can be applied to different type of target groups and GTP does not make an explicit distinction between subgroups; (2) In several of the reported studies we have conducted additional analyses and these analyses showed that the groups did not differ on outcome variables; and (3) Sometimes it was not possible to conduct subgroup analyses, because the sample sizes of the groups differed too much or where too small.

RECOMMENDATIONS

In this section recommendations for future research, policy and practice are presented.

Recommendations for Future Research
The aforementioned limitations of the current research lead to the following recommendations for future research:

1. *Conduct a multi-site research on social participation including predictors and outcomes.* This means that clients of other shelter facilities can be involved. Additio-

nally, it is also interesting to examine cross-cultural differences on the processes related to social participation of homeless people. This implies that also foreign homeless people should participate in future research.

2. *Conduct a cost-effectiveness study on offering group activities and on GTP.* For example, in Chapters 2, 3, and 5 it was stated that offering group activities (instead of only individual support) can save money and that the saved money and time can be used to support the clients more intensively, resulting in an increased quality of the support. However, the current research did not aim to examine the cost-effectiveness. Future research should include cost-related aspects.

3. *Examine the (full) proposed model including society- and community-related variables, presented in Figure 1 in the current Chapter, through a longitudinal design.* As stated previously, the model is largely though not completely based on empirical findings of the current thesis. Besides, these empirical findings are based on cross-sectional data. To examine society- and community-related variables (see Chapter 1 General Introduction), other target groups need to be investigated, such as citizens and social contacts of homeless people. This is also relevant in relation to the concept of the participation society (see Chapter 1 General Introduction). Additionally, the research should investigate whether and how societal structures (i.e., economic, social, and cultural institutions) can encourage homeless people to participate in society.

4. *Investigate the efficacy of GTP by applying a Randomized Controlled Trial and include measurement of the model fidelity in which also organizational aspects are included.* It is needed to examine GTP through a longitudinal design using a control group (with randomization), using process indicators to determine whether GTP is implemented fully and adequately. These process indicators should also include GTP's fundamental organizational aspects, such as organizational culture, leadership style, work engagement, job autonomy, and team performance.

5. *Investigate GTP in relation to the current paradigm shift in homeless policies from a shelter-led system to a housing-led approach.* Chapters 2 and 3 paid explicit attention to a possible side-effect of GTP, namely institutionalization of clients (Goffman, 1961), which can be caused by staying too long in shelter facilities. Institutionalization can be prevented by applying more housing-led approaches, such as Housing First (Tsemberis, 2010). Housing First is based on the fundamental principle that homeless people should live like other citizens in regular houses and it also leads to positive outcomes such as housing retention. However, Housing First also has

Chapter 7

negative side-effects such as loneliness (Busch-Geertsema, 2013); higher levels of loneliness are correlated with lower levels of social participation (Newall, McArthur, & Menec, 2015) and with lower levels of well-being (Rew, 2002). Therefore, we argue that housing alone is not enough to promote social participation and well-being of homeless people. Consequently, it is recommendable to examine whether housing programs, such as Housing First, and GTP can be integrated in order to achieve the best results for clients.

The aforementioned types of research can preeminently be conducted in collaboration with or by an academic collaborative center, such as Social Work, where the current research also is carried out. This because the infrastructure of academic collaborative centers bridges the gap between research and practice (Garretsen, Bongers, De Roo, & Van de Goor, 2007). The recommendations for future research include the need for health care institutions and social services to play an active and equal role in research (i.e., equality between researchers and professionals). This increases the likelihood that the research can be carried out adequately and can be of significance for practice (Garretsen, et al., 2007).

Recommendations for Policy and Practice

Invest in Group- and Participation-Based Interventions
The current research showed that group- and participation-based interventions have several benefits for clients. Unfortunately, some (mental health care) institutions have been making cost-saving policy changes related to group interventions. It is recommended that organizations invest in these type of interventions and that the local and national governments facilitate these type of investments. Although a cost-effectiveness study is necessary to examine the costs of such interventions in relation to the quality of care, it seems that these types of interventions improve quality without extra costs. The saved money could then be invested in the quality or intensity of the support.

Implement GTP In Other Organizations
Although more research is needed, the main conclusion is that GTP seems to be a promising intervention for the support of homeless people: The current research showed positive outcomes which are especially relevant in relation to the government policy (i.e., quality of life and labor). Besides, it includes variables that are relevant in enhancing social participation and well-being of homeless people, such as the concept of self-mastery, the role of clients' experiences with care, and group activities ("I want to participate"). Therefore, it is recommended that other organizations implement the GTP intervention.

Proposed Interventions and Implications for Practice

Based on the main findings regarding the predictors of self-mastery, social participation, and well-being, a model is proposed on interventions and implications for practice (Figure 2). This model is based on a combination of the actions and interventions that should be applied by managers and social workers and can be applied independently of GTP. Therefore, it has relevance for organizations that are not working with GTP as well as organizations that already use GTP, who can use it as an extension.

Figure 2. A proposed model of interventions and implications for practice

Managers

(Social) workers

Faciltate through

a charismatic and transactional leadership style:

1. Job autonomy
2. An organizational culture of flexibility and creativity
3. Work engagement

Person-related actions & interventions:

1. Work on a positive attitude among clients, e.g., through enhancing strengths and talents
2. Support clients by making arrangements on debts and financial resources
3. Facilitate creating an environment in which people feel home

Care-related actions & interventions:

4. Work on a good client-worker relationship (e.g., respect, equality, and stimulate autonomy), be clear about expectations (i.e., expectation management)
5. Facilitate a supportive daily structure, e.g., through offering group activities (e.g., "I want to participate")
6. Facilitate a supportive residential climate. Involve clients in creating house rules, including agreements about privacy and daily activities (residential clients)
7. Create enbling niches, but avoid creating entrapping niches, e.g., through facilitating clients to accomplish their goals

Team and individual performance of (social) workers

Clients

Self-mastery

Social participation

Well-being

Organization

Monitor organization-related variables

Monitor process-indicators

Monitor client-related outcomes

Note. Society- and community-related actions and interventions are not included in this model, because they were not included in the current research. However, future research should focus on these aspects and include interventions on the macro-level so that an integral approach can be developed.

The model includes actions and interventions for managers, social workers, and the organization.

1. Managers should facilitate job autonomy, an organizational culture of flexibility and creativity, and work engagement through a charismatic and transactional leadership style. Although the current research did not yet confirm all hypothesized relationships between organization-related variables and team performance, other research show that a charismatic and transactional leadership style, job autonomy, an organizational culture of flexibility and creativity, and work engagement improve team performance (see Chapter 6). The latter also refers to accomplishing the best results for clients in terms of enhancing self-mastery, social participation, and well-

being. Therefore, it is recommendable that management bodies implement these organizational-related aspects.

2. Social workers should perform the following actions that are based on the empirical findings regarding person-related and care-related predictors. First, since clients' optimism is found to enhance self-mastery, social participation, and well-being, it is recommended to work on a positive attitude among clients. This can be accomplished through a focus on strengths and talents. Second, financial resources and especially a lack thereof seemed to play a role; therefore, social workers should support their clients by making arrangements on debts and financial resources. Third, to enhance clients' sense of feeling of at home, it is necessary to create an environment in which people feel at home, both for clients who live in their own dwelling and for clients who live in a residential shelter. Fourth, because experiences with care (including the client-worker relation) form a key component in enhancing self-mastery, social participation, and well-being, it is recommended to work on a good client-worker relationship that is based on respect and equality, stimulating the autonomy of the client. Besides, expectations about the shelter facility must be clear (expectation management). Fifth, social workers should create a supportive daily structure for their clients, for example through offering group activities. In the current study, the "I want to participate" program seemed to accomplish good outcomes of clients, especially in terms of enhancement of well-being. Sixth, because residential-related variables were found as a predictor of self-mastery and are likely also related to social participation and well-being, social workers should maintain a supportive residential climate, for example through involving clients in decisions on house rules, including agreements about privacy and daily activities for residential clients. Finally, in order to prevent institutionalization, social workers should create enabling niches and avoid entrapping niches through encouraging clients to accomplish their goals related to housing, social contacts, and daily activities. In relation to the sixth and seventh point, it is also recommended to expand the current actions regarding housing programs, such as Housing First (Tsemberis, 2010) (see Paragraph Recommendations for Future Research). Consequently, all the aforementioned seven actions should lead to team and individual performance of (social) workers and finally to self-mastery, social participation, and well-being of clients.

3. Organizations should monitor organization-related variables, process-indicators and client-related outcomes. Regarding the recommendations for future research, it is advised to evaluate client-related outcomes of GTP through including monitoring process-indicators and organization-aspects. Next to future research, these type

of evaluations should also be made frequently in practice. Relevant outcomes can be monitored in an organization dashboard.

Recommendations for SMO Breda

Finally, it is recommended for SMO Breda to implement GTP more thoroughly, especially its organizational-related aspects. Chapter 6 showed that change and innovation processes take time, especially regarding organizational culture, leadership style, work engagement, and team performance. The implementation of these aspects is in the interest of the social workers and other care workers. They must be encouraged to perform the work as well as possible and they must be fully supported by their management and organization. It is a challenge to change these organization-related aspects, especially during a reorganization, which was also part of implementation of GTP. However, it is necessary to continue on the chosen path, to adjust when necessary, and especially to keep the final goals in mind in the interests of accomplishing the best for homeless people.

Summary

SUMMARY

The current thesis aims to evaluate Growth Through Participation (GTP), a participation-based intervention for homeless people, as well as the factors that enhance the primary outcomes of GTP (i.e., social participation, self-mastery, and well-being).

Chapter 1 provided general information that is relevant in the context of the current thesis. First, information is provided on different definitions on homelessness and on the size and composition of the homeless population in the Netherlands. In the current thesis, homeless people are defined as "all people who receive support from an organization providing shelter and ambulatory care". This definition includes people who live in a residential shelter and people who receive ambulatory care from a shelter facility. In the Netherlands, between approximately 30,000 to 60,000 people are homeless (the figures differ because of the use of different definitions) with a relative majority of these people being male, unmarried, younger than 30 years, and possessing a lower education level. Second, information on social participation is provided, which in the current research is defined as: "a person's involvement in activities providing interactions with others in society or the community" (Levasseur et al., 2010, p. 2146). Additionally, the relevance of social participation is illustrated as a high priority issue for both the European Union and the Dutch government policy, due to economic and ideological reasons. Social participation can be influenced by several factors, such as person-, care-, and society- or community-related variables, and it leads to an enhancement of well-being. Third, a brief description of the GTP intervention is given, including its relation with strength-based and recovery-oriented approaches. GTP, developed by SMO Breda, is based on these approaches and includes organizational-related variables, with its main objective as the promotion of well-being among homeless people through social participation. Finally, Chapter 1 ends with an explanation of the aim and outline of the present thesis, where the following five research questions are presented:

1. What factors enhance or impede social participation, self-mastery, and well-being?
2. How are all these variables related to each other?
3. What are the outcomes of the GTP intervention?
4. How did organization-related variables change during the implementation of GTP?
5. How are these organization-related variables related to each other?

Chapter 2 described qualitative research that investigated clients' experiences with participation in group activities in relation to their well-being. We examined this relationship by conducting two studies among clients of a Dutch shelter facility (SMO Breda). The first study, consisting of 10 semi-structured interviews, explored homeless

clients' experiences with participation in educational, recreational, and labor activities in relation to their reported well-being. The second study, consisting of six semi-structured interviews, focused on the homeless clients' experiences with taking part in a sports intervention (i.e., Sports Surprise) and its influence on two aspects of well-being, namely the sense of coherence and social support. The group activities, including Sports Surprise, are a part of the "I want to participate" program, which is one of the key components of GTP. The findings showed that clients experienced that participation had led to an improvement of physical, social, and mental well-being. In general, clients reported that due to participation in activities, they strengthened their social support network, improved their (mental and physical) health, self-esteem and personal growth. It was concluded that in order to facilitate long-term positive outcomes of participation in practice, it is necessary to focus on group cohesion and on the social worker's behavior and attitude.

Chapter 3 presented the results of a cross-sectional quantitative study in which we examined care-related (namely participation in various group activities and clients' experiences with care) and demographic predictors (i.e., person-related predictors, namely age and education level) of well-being among 225 homeless clients of a Dutch shelter facility (SMO Breda). In this study, the role of social participation as a mediator was considered. Results from Structural Equation Modeling showed that the client's experiences with care and education level are predictors of well-being with a mediating role for social participation, and that participation in activities at the shelter facility is a direct predictor of well-being. However, age is not significantly related to social participation or well-being. We suggested that interventions for homeless people should be based on a combination of individual and group approaches and that special attention should be given to the client-worker relationship. We also recommended that vulnerable children are provided with solid education, and we called for research into the cost-effectiveness of group-based interventions.

Chapter 4 discussed the results of a mixed-method study on self-mastery among homeless clients of a Dutch shelter facility (SMO Breda). This study investigated associations between person-related variables (optimism, age, education level) and care-related variables (experiences with care, duration of support) as predictors of both social participation and quality of life with self-mastery as a mediator. Quantitative analysis (Structural Equation Modeling; n = 97) showed that (1) self-mastery is related to social participation and quality of life; (2) optimism predicts social participation and quality of life through self-mastery; (3) age squared predicts social participation through self-mastery, but is not related to quality of life; (4) the variable of clients' experiences with care is not related to self-mastery, but directly to social participation and quality

of life; and (5) education level and duration of support do not predict self-mastery, social participation or quality of life. Qualitative analysis (semi-structured interviews; n = 36) revealed that (1) both social participation and aspects of quality of life can be considered as a predictors of self-mastery; (2) clients' experiences with care is associated with self-mastery; and (3) additional promoting factors for self-mastery include a daily structure, the autonomy to decide how to spend the day, privacy, while additional impeding factors include non-supportive house rules, a lack of financial resources, and not feeling at home in a residential shelter. Based on these results, we formulated guidelines for social and mental health-care workers to enhance their clients' self-mastery, like focusing on a positive attitude among clients, creating an environment that makes the clients feel at home, and providing a daily structure in clients where clients are enabled to make their own choices.

Chapter 5 examined the outcomes of GTP through a longitudinal study. This study was conducted among 172 (formerly) homeless clients of a Dutch shelter facility (SMO Breda) and was comprised of three measurement time points. It examined whether (1) quality of life increased during the GTP intervention; (2) social participation (e.g., labor/recreation outside the shelter facility), self-esteem, clients' experiences with care, and psychological distress improved during GTP; and whether (3) clients exhibiting psychological distress benefit more from GTP than others. Results from Latent Growth Modeling showed that quality of life and the amount of time clients spent on labor activities increased significantly, but the amount of time clients spent on recreational activities decreased over time. Clients with psychological distress experienced increased quality of life and self-esteem and reduced psychological distress. Other variables did not significantly change during GTP. Although not all hypotheses were confirmed, we concluded that GTP seems to be a promising intervention. Additionally, we recommended to conduct a multi-site Randomized Controlled Trial (RCT) to determine the efficacy of GTP.

Chapter 6 presented the outcomes of a quantitative study on the organization-related variables that play a fundamental role in the GTP intervention. Approximately 100 employees of a Dutch shelter facility (SMO Breda) participated in this study at three different time points. We examined whether these organization-related variables changed during the implementation of GTP by applying a longitudinal study design and the relationship between these variables by applying a cross-sectional study design. First, this research indicated that organizational culture has partly changed in the intended direction: There is a significant increase in the clan culture and a significant decrease in the hierarchy culture. Although the adhocracy culture has changed in the intended direction, it was not a significant change. It can be concluded that there seems to be a

cultural change within SMO Breda: The right direction has been taken, but the process has not yet been completed. The other variables, namely leadership style, work engagement, and team performance, have remained stable. Second, this research showed that the variables did not show the coherence they were assumed to have based on previous literature. Hence, both job autonomy and a combination of charismatic and transactional leadership were positively related to individual work engagement, but not to team engagement. Individual work engagement was positively related to team engagement and negatively to team performance. Moreover, a positive relationship between team engagement and team performance was found. Finally, the combination of clan and adhocracy culture was not related to team engagement. We concluded that practice seems to be more complex than theory; however, change processes take time. In the context of follow-up research, we would advise to study the connection between client-oriented and organizational outcomes.

Finally, Chapter 7 presented the main findings, a reflection on the findings, research strengths and limitations, and recommendations for future research and practice. In this chapter a new comprehensive model of predictors of self-mastery, social participation, and well-being was proposed. In this model, person-, care-, and society-/community-related variables are predictors of self-mastery, social participation, and well-being. Additionally, self-mastery, social participation, and well-being are related to each other. Based on this model, an additional model of interventions and implications for practice was proposed, which also integrates organization-related actions. This model illustrates that (1) managers should facilitate job autonomy, an organizational culture of flexibility and creativity, and work engagement through a charismatic and transactional leadership style; (2) social workers should apply person- and care-related actions and interventions, such as supporting their clients to make arrangements on debts and financial resources of clients, working on a good client-worker relationship, and facilitating a supportive daily structure; and (3) the organization should monitor organization-related variables, process-indicators, and client-related outcomes. The general conclusion is that GTP seems to be a promising intervention for the support of homeless people, because the current research showed positive outcomes which are especially relevant in relation to the government policy (i.e., quality of life and labor). Additionally, GTP includes variables that are relevant in enhancing social participation and well-being of homeless people, such as self-mastery, clients' experiences with care, and group activities. Furthermore, we concluded that follow-up research is needed, such as a multi-site research on social participation; cost-effectiveness study on group activities and GTP; a longitudinal study on causality between predictors, self-mastery, social participation, and well-being; and a RCT to examine the efficacy of GTP. These research activities can preeminently be conducted in collaboration with or by an aca-

demic collaborative center, such as Social Work, where the current research also is carried out. Furthermore, we recommended that, although more research is needed, other organizations should implement GTP.

Samenvatting
(Dutch Summary)

SAMENVATTING

(Dutch Summary)

In het huidige proefschrift is een interventie voor de ondersteuning en participatie van dak- en thuislozen, Verder Door Doen (VDD), geëvalueerd. Tevens is onderzocht welke factoren van invloed zijn op de primaire uitkomsten van VDD (namelijk maatschappelijke participatie, zelfregie, en welzijn).

In Hoofdstuk 1 is algemene informatie gegeven over de context van het onderzoek. Het eerste deel van het hoofdstuk gaat in op de verschillende definities die gehanteerd worden ten aanzien van dak- en thuislozen en vervolgens is de omvang en de samenstelling van de dak- en thuislozen populatie in Nederland besproken. In het huidige proefschrift zijn dak- en thuislozen gedefinieerd als: "alle personen die ondersteuning ontvangen van een instelling voor maatschappelijke opvang". In deze definitie zijn mensen die wonen in een residentiele opvangvoorziening èn mensen die ambulante begeleiding ontvangen van een instelling voor maatschappelijke opvang geïncludeerd. In Nederland zijn ongeveer 30 tot 60 duizend mensen dakloos. De schattingen lopen uiteen vanwege het gebruik van verschillende definities. Een relatief groot deel van deze mensen is man, ongehuwd, jonger dan 30 jaar, en heeft een laag opleidingsniveau. Het tweede deel van Hoofdstuk 1 heeft betrekking op maatschappelijke participatie dat in het huidige onderzoek is gedefinieerd als "de betrokkenheid van een persoon bij activiteiten waarbij er interactie is met anderen in de maatschappij of in de gemeenschap" (Levasseur et al., 2010, p. 2146). Daarnaast is ingegaan op het belang van maatschappelijke participatie, wat een belangrijk speerpunt is voor het beleid van zowel de Europese Unie als de Nederlandse overheid vanwege economische en ideologische redenen. Maatschappelijke participatie kan beïnvloed worden door verschillende factoren, waaronder persoons-, zorg-, en maatschappelijk-gerelateerde factoren; en het kan leiden tot een verbetering van welzijn. Het derde deel van Hoofdstuk 1 betreft een korte beschrijving van de interventie VDD, waarbij de relatie tot kracht- en herstelgerichte benaderingen is beschreven. VDD is gebaseerd op de uitgangspunten van deze benaderingen en daarnaast maken organisatie-gerelateerde variabelen integraal onderdeel uit van de interventie. VDD is ontwikkeld door SMO Breda en heeft tot doel om welzijn van dak- en thuislozen te vergroten door middel van maatschappelijke participatie. Tot slot is in Hoofdstuk 1 een uitleg gegeven ten aanzien van het doel en de opzet van het huidige proefschrift. Daarbij zijn de volgende vijf onderzoeksvragen gepresenteerd:

1. Welke factoren bevorderen of belemmeren maatschappelijke participatie, zelfregie, en welzijn?
2. Hoe hangen deze factoren met elkaar samen?
3. Wat zijn de uitkomsten van de interventie VDD?
4. Hoe zijn organisatie-gerelateerde variabelen veranderd gedurende de implementatie van VDD?
5. Hoe hangen deze organisatie-gerelateerde variabelen met elkaar samen?

In Hoofdstuk 2 zijn de resultaten van kwalitatief onderzoek naar de ervaringen van cliënten inzake hun deelname aan groepsactiviteiten in relatie tot hun welzijn weergegeven. We hebben deze relatie onderzocht door middel van twee studies onder cliënten van een Nederlandse instelling voor maatschappelijke opvang (SMO Breda). De eerste studie, welke bestond uit 10 semigestructureerde interviews, exploreerde de ervaringen met betrekking tot deelname aan educatieve, recreatieve, en werk-gerelateerde activiteiten in relatie tot welzijn. De tweede studie, welke bestond uit zes semigestructureerde interviews, focuste op de ervaringen van de cliënten met betrekking tot deelname aan een sportinterventie (Sportsurprise) en de invloed hiervan op twee aspecten van welzijn, namelijk de sense of coherence en sociale steun. De groepsactiviteiten, waaronder Sportsuprise, zijn een onderdeel van het "Ik wil meedoen" programma en vormen een hoofdonderdeel van VDD. Uit de resultaten kwam naar voren dat cliënten ervaarden dat hun deelname heeft geleid tot een verbetering van hun fysieke, sociale, en mentale welzijn. Over het algemeen gaven cliënten aan dat als gevolg van deelname aan activiteiten hun sociaal netwerk is verbeterd, hun mentale en fysieke gezondheid is verbeterd, en hun eigenwaarde en persoonlijke groei is toegenomen. Om deze resultaten te bestendigen op de lange termijn is het nodig om de groepscohesie te bevorderen en te focussen op het gedrag en de attitude van de sociaal werker.

In Hoofdstuk 3 zijn de resultaten gepresenteerd van een cross-sectionele kwantitatieve studie waarin we zorg-gerelateerde (namelijk deelname aan verschillende groepsactiviteiten en ervaringen met de hulpverlening) en demografische voorspellers (namelijk leeftijd en opleidingsniveau, beide zijn persoons-gerelateerde factoren) van welzijn hebben onderzocht bij 225 cliënten van een Nederlandse instelling voor maatschappelijke opvang (SMO Breda). In deze studie is maatschappelijke participatie als een mediator geïncludeerd. Analyses gebaseerd op Structural Equation Modeling toonden aan dat de ervaringen van cliënten met de hulpverlening en opleidingsniveau voorspellers zijn van welzijn, waarbij maatschappelijke participatie deze relatie medieert. Tevens is deelname aan groepsactiviteiten een directe voorspeller van welzijn. Echter, leeftijd is geen significante voorspeller van maatschappelijke participatie of welzijn. Op basis van deze resultaten adviseerden we dat interventies voor dak- en thuislozen gebaseerd

dienen te zijn op een combinatie van individuele en groepsbenaderingswijzen en dat er in het bijzonder aandacht dient te zijn met betrekking tot de cliënt-werker relatie. We deden ook de aanbeveling dat kwetsbare kinderen een degelijke opleiding dienen te krijgen. Tot slot adviseerden we dat een kosten-effectiviteitsstudie uitgevoerd dient te worden naar groepsinterventies.

Hoofdstuk 4 gaat in op de resultaten van een mixed-method studie naar zelfregie van dak- en thuisloze cliënten van een Nederlandse instelling voor maatschappelijke opvang (SMO Breda). In deze studie zijn relaties tussen persoons- (optimisme, leeftijd en opleidingsniveau) en zorg-gerelateerde (ervaringen met de hulpverlening, duur van de ondersteuning) voorspellers van maatschappelijke participatie en kwaliteit van leven met zelfregie als mediator onderzocht. Uit de kwantitatieve analyses (Structural Equation Modeling; n = 97) kwam naar voren dat (1) zelfregie gerelateerd is aan maatschappelijke participatie en kwaliteit van leven; (2) optimisme een voorspeller is van maatschappelijke participatie en kwaliteit van leven via zelfregie; (3) leeftijd in het kwadraat maatschappelijke participatie voorspelt via zelfregie, maar leeftijd in het kwadraat niet gerelateerd is aan kwaliteit van leven; (4) ervaringen van cliënten met de hulpverlening niet gerelateerd is aan zelfregie, maar direct aan maatschappelijke participatie en kwaliteit van leven; en (5) opleidingsniveau en ondersteuningsduur geen voorspellers zijn van zelfregie, maatschappelijke participatie of welzijn. Uit de kwalitatieve analyses (semigestructureerde interviews; n = 36) kwam naar voren dat (1) zowel maatschappelijke participatie als aspecten van kwaliteit van leven beschouwd kunnen worden als een voorspellers van zelfregie; (2) de ervaringen van cliënten met de hulpverlening gerelateerd is aan zelfregie; (3) aanvullende bevorderende en belemmerende factoren, namelijk bevorderende factoren die werden genoemd hadden betrekking op dag structuur, de vrijheid om zelf te bepalen hoe de dag wordt besteed en privacy; en belemmerende factoren hadden betrekking op niet-ondersteunende huisregels, een gebrek aan financiële middelen, en het ontbreken van een gevoel thuis te zijn in de residentiële opvangvoorziening. Op basis van deze resultaten deden we aanbevelingen aan hulpverleners om zelfregie van cliënten te bevorderen, zoals het focussen op een positieve attitude van cliënten, het creëren van een omgeving waarin cliënten zich thuis voelen, en het aanbieden van een dagelijkse structuur waarin cliënten gestimuleerd worden om hun eigen keuzes te maken.

In Hoofdstuk 5 zijn de resultaten van een longitudinale studie naar VDD gepresenteerd. Aan deze studie namen 172 cliënten van een Nederlandse instelling voor maatschappelijke opvang (SMO Breda) deel en de studie bestond uit drie meetmomenten. Onderzocht is of (1) kwaliteit van leven verbeterde gedurende de VDD interventie; (2) maatschappelijke participatie (arbeid en recreatie), eigenwaarde, ervaringen met de

hulpverlening, en psychische klachten verbeterden gedurende VDD; en of (3) cliënten met bovengemiddelde psychische klachten meer baat hebben bij VDD dan anderen. Uit de resultaten (Latent Growth Modeling) kwam naar voren dat kwaliteit van leven en de hoeveelheid tijd die cliënten besteedden aan werk-gerelateerde activiteiten significant toenamen, maar de hoeveelheid tijd die cliënten besteedden aan recreatieve activiteiten nam af gedurende de meetmomenten. Cliënten met bovengemiddelde psychische klachten ervaarden een verbetering in kwaliteit van leven en eigenwaarde en een afname van hun psychische klachten. De overige variabelen veranderden niet gedurende VDD. Ondanks het feit dat niet al onze hypothesen bevestigd werden, is de conclusie dat VDD een veelbelovende interventie lijkt te zijn. We raadden wel aan om een multi-site RCT uit te voeren naar de effectiviteit van VDD.

In Hoofdstuk 6 zijn de uitkomsten gepresenteerd van een kwantitatieve studie naar de organisatie-gerelateerde variabelen die een fundamentele rol spelen in de VDD interventie. Circa 100 medewerkers van een Nederlandse instelling voor maatschappelijke opvang (SMO Breda) namen deel aan dit onderzoek op drie verschillende meetmomenten. We hebben door middel van een longitudinale studie onderzocht of deze organisatie-gerelateerde variabelen veranderd zijn gedurende de implementatie van VDD. Tevens is middels een cross-sectionele studie de samenhang tussen deze variabelen onderzocht. Het longitudinale onderzoek toont aan dat de organisatiecultuur gedeeltelijk is veranderd in de beoogde richting, namelijk een significante toename van de familiecultuur en een significante afname van de hiërarchiecultuur. Ook de adhocratiecultuur is veranderd in de gewenste richting, maar deze verandering was niet significant. Op basis hiervan is geconcludeerd dat er een cultuurverandering lijkt plaats te vinden binnen SMO Breda: De juiste weg is ingeslagen, maar het proces is nog niet voltooid. De andere variabelen, namelijk leiderschapsstijl, werkbevlogenheid, en teamprestaties, zijn niet veranderd. Op basis van het cross-sectionele onderzoek concludeerden we dat de variabelen niet de samenhang vertoonden zoals verwacht op basis van literatuur. Werkautonomie en de combinatie van charismatisch en transactioneel leiderschap hangen positief samen met individuele werkbevlogenheid, maar niet met teambevlogenheid. Daarnaast werd een positieve relatie gevonden tussen teambevlogenheid en teamprestaties. Bovendien was de combinatie van familie- en adhocratiecultuur niet gerelateerd aan teambevlogenheid. Op basis hiervan concludeerden we dat de praktijk meer complex is dan de theorie, maar veranderprocessen vergen tijd. In het kader van vervolgonderzoek is het raadzaam om de relatie te leggen tussen cliënt- en organisatie-gerelateerde uitkomsten.

Tot slot zijn in Hoofdstuk 7 de belangrijkste bevindingen, een reflectie op deze bevindingen, de sterkten en zwakten van het onderzoek, en aanbevelingen voor vervolgon-

derzoek en de praktijk besproken. In dit hoofdstuk is een nieuw veelomvattend model van voorspellers van zelfregie, maatschappelijke participatie, en welzijn gepresenteerd. In dit model zijn persoons-, zorg-, en maatschappelijke-gerelateerde variabelen geïncludeerd als voorspellers van zelfregie, maatschappelijke participatie en welzijn, waarbij zelfregie, maatschappelijke participatie, en welzijn ook aan elkaar gerelateerd zijn. Op basis van dit model is een aanvullend model van interventies en implicaties voor de praktijk gepresenteerd, waarin ook organisatie-gerelateerde activiteiten zijn opgenomen. In dit model is aangegeven dat (1) managers autonomie en werkbevlogenheid van medewerkers dienen te stimuleren, alsook een organisatiecultuur waarbij flexibiliteit en vrijheid van handelen voorop staan; (2) sociaal werkers persoons- en zorg-gerelateerde acties en interventies dienen toe te passen, zoals het ondersteunen van cliënten bij het treffen van regelingen omtrent schulden en financiële middelen, het werken aan een goede cliënt-werker relatie, het faciliteren van een ondersteunende dagstructuur; en (3) de organisatie de organisatie-gerelateerde variabelen, proces-indicatoren, en cliënt-gerelateerde uitkomsten dient te monitoren. De algemene conclusie is dat VDD een veelbelovende interventie lijkt te zijn voor de begeleiding van dak- en thuislozen. Het huidige onderzoek heeft immers aangetoond dat er positieve uitkomsten (namelijk inzake kwaliteit van leven en werk) zijn in relatie tot het beleid van de overheid. Daarnaast zijn binnen VDD variabelen geïncludeerd die relevant zijn in het bevorderen van maatschappelijke participatie en welzijn van dak- en thuislozen, zoals zelfregie, ervaringen van cliënten met de hulpverlening, en groepsactiviteiten. Tevens concludeerden we dat er vervolgonderzoek nodig is, zoals het uitvoeren van een onderzoek naar maatschappelijke participatie waaraan meerdere instellingen deelnemen; een kosten-effectiviteitsstudie naar zowel groepsactiviteiten als VDD; een longitudinale studie naar de causale verbanden tussen voorspellers, zelfregie, maatschappelijke participatie, en welzijn; en een RCT waarin de effectiviteit van VDD wordt onderzocht. Dergelijke onderzoeksactiviteiten kunnen bij uitstek uitgevoerd worden in samenwerking met of door een academische werkplaats, zoals Sociaal Werk, waar het huidige onderzoek ook is uitgevoerd. Ondanks het feit dat vervolgonderzoek nodig is, is het raadzaam dat andere organisaties VDD ook invoeren.

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Dankwoord

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DANKWOORD

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"Een proefschrift binnen ongeveer 2 jaar voltooien, kan dat?" was de vraag die ik prof. Tine Van Regenmortel stelde tijdens het eerste kennismakingsgesprek dat ik ongeveer 2,5 jaar geleden met haar had. Op 1 april 2017 begon ik aan mijn promotie-onderzoek bij de werkplaats Sociaal Werk van Tranzo, onder supervisie van Prof. dr. René Schalk en Prof. dr. Tine Van Regenmortel. Op 10 april 2019 leverde ik mijn proefschrift in bij Tilburg University. In deze 2 jaar en 10 dagen ben ik wijzer geworden wat betreft onderzoek, in het bijzonder met betrekking tot het analyseren en rapporteren van onderzoeksbevindingen, het publiceren van artikelen inclusief het daarmee gepaard gaande 'spel', het presenteren op internationale conferenties, etc. Tevens heb ik een bijzonder mooie ervaring opgedaan: ik heb de kans gehad om 2 jaar lang bezig te zijn met een zeer interessant en relevant onderzoeksproject in opdracht van SMO Breda e.o. Wat zijn deze 2 jaren enorm snel gegaan. Aan de ene kant is het fijn om dit resultaat nu al te hebben, maar aan de andere kant is het jammer dat het af is. Ik mis het onderzoek nu al…

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Miranda Rutenfrans-Stupar
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Curriculum Vitae

CURRICULUM VITAE

Miranda Rutenfrans-Stupar was born on 1 March, 1980 in Apeldoorn. She lived in Klarenbeek, a small village in the Veluwe, till 1999 when she went to study Health Sciences at Maastricht University where she completed two Masters: Healthcare Policy and Management and Health Education and Promotion. In 2016 she also completed a professional Master of Culture and Change (MCC) which provided her with knowledge on organization culture and change management processes. In 2005 Miranda started her career as a policy worker in the field of quality management at a mental health care institution and a nursing home. Since 2006 Miranda worked at SMO Breda, first as a policy worker, later on as a manager, and finally as a researcher. Throughout her entire career Miranda has frequently conducted research activities, supervised graduate students, and she has been project leader of a variety of innovative project, under which the development and implementation of the Growth Through Participation intervention. In 2017 Miranda started to work as a science practitioner at the Academic Collaborative Center Social Work at Tranzo (Tilburg University). During her PhD trajectory Miranda has published four empirical papers and presented her research findings at several international conferences (e.g., United Kingdom, Ireland, Croatia, Hungary, the Netherlands, and Russia). Since August 2018 Miranda has been working as a lecturer first at HAN and currently at Avans University of Applied Sciences where she is teaching courses related to social work and (innovation) management with use of her knowledge and experiences from practice and research.

Social participation is a strong predictor of well-being and happiness. Homeless people do not always feel welcome to participate in society, and therefore, they often experience social isolation and loneliness. Hence, organizations providing shelter services and ambulatory care (shelter facilities) have been developing participation-based interventions. An example of such an intervention is Growth Through Participation (GTP; in Dutch "Verder Door Doen") which is developed by a Dutch shelter facility (SMO Breda e.o.). GTP focuses on enhancement of social participation and well-being by offering a combination of group and individual approaches. A key element of GTP is the I want to participate program (in Dutch "Ik wil meedoen") in which homeless people are enabled to join educational, recreational, and labor activities. This PhD-thesis is based on five empirical studies and aims to evaluate GTP, including factors that enhance the primary outcomes of GTP such as social participation, self-mastery, and well-being. The general conclusion is that GTP seems to be a promising intervention for the support of homeless people, because the outcomes are especially relevant in relation to government policy. The studies also showed that GTP includes variables that are relevant in enhancing social participation and well-being, such as self-mastery, a focus on client's experiences with care, and group activities. The research led to useful recommendations for practice, policy, and future research.