Interrogating the prevention approach of the Housing (Wales) Act 2014 for people with mental health needs who are homeless

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Abstract
Rates of homelessness and poor mental health present significant challenges across the globe. In this article, we explore how these intersecting issues have been addressed in Wales through Part 2 of the Housing (Wales) Act 2014 through a paradigm shift towards a prevention model. This article reports findings from a study (conducted between 2016 and 2018) which evaluated the processes and impacts of the Act against the backdrop of welfare reform and systemic changes taking place in Wales and the UK. Using new evidence, we offer a critical examination of how homelessness prevention policy operates in practice and how social values and power affect policy implementation. We offer new evidence of the translation of policy into practice through the experiences of two stakeholder groups: people with mental health needs and service providers. In doing so, we offer a critique of how policy and practice could be modified to improve outcomes for homeless people with implications for prevention policy in Wales and in other contexts and different welfare regimes.

Keywords: homelessness, housing, mental health, policy, prevention

Introduction

Globally, homelessness is an entrenched social and public health problem. It is, however, difficult to quantify or make global comparisons as definitions and measures are inconsistent. It is complex and connected to both individual and structural factors. In the developed world, poor mental health has long been debated as a cause and consequence of homelessness (Amore and Howden-Chapman, 2012). Disentangling mental illness from homelessness, however, is complex. The task of addressing either, or both together, is challenging for policy-makers. In the US, homelessness among individuals with severe mental ill-health has been described as 'the most pervasive manifestation of the failure of public policy' (Newman and Goldman, 2009: 299). Of concern, a systematic review of programmes aimed at supporting people with poor mental health to secure and retain accommodation, found that the extant, but modest, evidence-base had limited usefulness for policy-makers and service providers seeking empirical evidence to justify policy decisions (Benston, 2015).

Rates of mental ill-health are concerningly high and, like homelessness, rising resulting in 'significant impacts on health and major social, human rights and economic consequences in all countries of the world' (WHO, 2018: online). A report by the Mental Health Foundation (2016) suggests that every week one in six adults will experience symptoms of a common mental health problem, such as anxiety or depression. In the Welsh Health Survey (2015) 13% of respondents reported being treated for a mental health need in the preceding year, continuing a trend of annual increases since the survey was first conducted in 2003/4 (Welsh Government, 2015). In addition to other factors, housing and living conditions have long been recognised as social determinants for good mental health (Dahlgren & Whitehead, 1991). Indeed, the correlation between mental ill-health and homelessness is well established (Fox et al., 2016). It is unsurprising, therefore, that research has demonstrated a higher prevalence of mental health problems in the homeless population compared to the general population (Folsom et al., 2005).

The relationship between homelessness and mental health is complex and often mediated by additional risk factors such as adverse childhood experiences, links with the criminal justice system, intimate partner abuse, substance misuse and violent victimisation (Fox et al., 2016). An evidence review conducted by a UK government department found that the most prevalent health-related issues amongst the homeless population were substance misuse (62.5%), mental health problems (53.7%) or a combination of the two (42.6%) (DCLG, 2012). Described by Dai and Zhou (2018: online), a 'mutual causality' and reinforcing circularity exists between health and homelessness.

Within the homelessness field, a paradigm shift towards preventing homelessness is evident and this is reflected in the Housing (Wales) Act 2014 (hereafter 'the Act'). The Act placed a duty on local authorities in Wales to try to prevent or relieve homelessness for everyone seeking housing assistance and who is either homeless or at risk of homelessness. This makes Wales the only nation to have a specific 'prevention duty' integrated in law (Mackie et al., 2017). This pioneering Act has offered several opportunities for systemic change as in addition to heralding a prevention approach, it has sought to provide the foundations for a more person-centred culture which is rooted in partnership-working (across agencies, and between service providers and service users). The Act was introduced during a period characterised by austerity impacts and welfare reform in Wales and across the UK more generally.

A growing body of evidence is emerging that explores how prevention policies are implemented (Mackie, 2014a; Brown et al., 2018). There are, however, clear challenges in policy analysis when it comes to exploring outcomes and the experiences of marginalised populations (Fitzpatrick and Stephens, 2014). A recent study of the policy responses to homelessness in the case of marginalised communities in six European countries revealed that a range of social values embedded in national cultures (for example, individuality, social cohesion and egalitarianism) influenced policy aims and

outcomes. This in turn problematised evaluation and the task of comparing different welfare regimes (Fitzpatrick and Stephens, 2014). Accordingly, in this article, whilst we provide a critical examination of how homelessness prevention policy operates in Wales, a focus on how social values and power affects policy implementation is retained to allow comparisons across contexts to be made. New evidence of the translation of policy into practice is offered using data which details the experiences of a marginalised group (homeless people with mental health needs) and service providers. By scrutinising how prevention practices were experienced by people with complex mental health in one context, this article offers a lens to explore the challenges of adopting a prevention paradigm in a range of different contexts.

Previous work has employed a public health model for conceptualising prevention identifying three levels of activity (Culhane et al., 2011). *Primary* prevention seeks to prevent new cases amongst the general population, whilst *secondary*, or targeted, prevention is aimed at people who are more at risk of homelessness due to a crisis or an identified characteristic (in this case, mental health need). This should offer a targeted approach addressing the risk of homelessness at the earliest stage. *Tertiary* prevention is targeted towards those who are already affected by homelessness and seeks to slow the progression or mitigate the impact of an established issue or condition. Whilst this model has been critiqued for lacking clarity about which activities fall into which categories (Culhane et al., 2011), in this article, the discussion illustrates the extent to which the Act has been successful in orienting secondary and tertiary prevention (which targets support towards people with identified mental health needs).

Methods

A mixed methods design underpinned the process and impact evaluation of the implementation of the Housing (Wales) Act 2014. This was undertaken between 2016 and 2018. A rigorous design embedded several complementary qualitative and quantitative research methodologies, as well as a longitudinal strategy. This resulted in the completion of the following workstreams:

- Quantitative analysis of secondary data taken from Statistics for Wales [2015-16/2016-17];
- Survey and review of all local authorities in Wales (*n*=22) [first wave: June–August 2016/ second wave: August – October 2017] collecting quantitative and qualitative data;
- Interviews with national stakeholders (*n*=15) including statutory, private and third sector representatives;
- Selection of six local authorities (case study sites) which involved:
    - One-to-one interviews with service users [first wave: October 2016–January 2017 (*n*=154)/second wave: June-July 2017 (*n*=57)];
    - One-to-one or group interviews with service providers (*n*=148) [March – June 2017] including frontline practitioners, service managers and directors;
- Focus group with the national Homelessness Network [January 2018].

Data in this article are taken from the case studies. The choice to have interviews conducted in Welsh or English was given to every participant. Individual and group interviews were digitally recorded and analysed thematically using software (NVivo). Informed consent was gained from all participants and data has been anonymised to preserve confidentiality. Ethical approval was gained from the University of Salford with all other permissions granted from Welsh Government.

Findings

This paper reports the study's qualitative findings as this data resulted in a detailed picture of homelessness and mental health in Wales at the time of data collection. However, some of the quantitative data helps to provide a snapshot of these two intersecting issues at that time. For example, in the first wave of service user interviews, of the 154 people interviewed, 59 reported

that they were receiving support for poor mental health as a primary issue and all other respondents reported that they were experiencing some level of anxiety, depression or deterioration in their mental health due to homelessness or precarious housing. This was the case for 25 out of the 57 respondents in the second wave. From the analysis of qualitative data, six themes are reported here to illustrate policy and practice continuities, changes or constraints resulting from the Act in relation to secondary and tertiary prevention. Themes include: managing complexity with limited resources; access to mental health support; the statutory sector; enablers to access; a person-centred model; and partnership-working. Excerpts from interviews are coded as LA to denote a local authority representative, TS which is a third sector employee and RSL (registered social landlord). Service users' excerpts are identified by SU.

Managing complexity with limited resources

A major theme was the increased prevalence of mental health needs amongst the homeless population and service providers identified this to the most significant problem for them in terms of capacity to deliver or source appropriate housing with support. The lack of resources in this regard was emphasised in addition to the geographical constraints of large rural areas in Wales:

> There's a lack of facilities for people to go[...] We're not geared up for people with such complex needs. (TS)

What was evident was that whilst the Act had widened eligibility and access to prevention support, without a corresponding increase in resources, the Act was having limited outcomes for people with mental health needs. So, whilst service providers described how the Act instigated a shift from enabling access to support on a *selective* basis under the old policy framework (Mackie, 2014b) towards a more universal approach, structural and systemic factors (bureaucracy, welfare reform and austerity, specifically) impeded targeted and appropriate support for people with mental health needs. In addition, diminishing mental health services were recognised as presenting 'a distinct challenge' for service providers.

Signposting to or offering secondary and tertiary prevention measures (for example, supported housing, or other forms of accommodation with housing-related support) were cited as requiring careful consideration:

> Supported accommodation is a valuable resource […] If you don't understand what the project is meant to do and who they're meant to be for, if you're putting somebody in who doesn't fit that profile, it can destabilise everybody else, especially if you're talking about people with mental health problems. (LA)

Meeting an individual's needs versus maintaining a community's equilibrium presents a double bind which reflects the conflict that arises for services when people present with higher mental health-related needs, but providers are simultaneously tasked with maintaining social cohesion (Fitzpatrick and Stephens, 2014). This problem was seen to be compounded by systemic problems (long waiting lists, availability and affordability of specialist accommodation). As such, there was a 'huge demand' for specialist support and accommodation with these services seen to be 'just touching the surface' (LA).

Having inappropriate or insufficient support resulted in unsustainable tenancies. This resulted in homelessness and contributed to the 'revolving door' for those individuals (a situation in which the same events recur in a cycle). The 'revolving door' phenomenon was linked to the limited way that the implementation of the Act had effected change for people with mental health needs and additional vulnerabilities.

As well as an increase in mental ill-health, co-existing issues (violent victimisation, for instance) and co-morbidity (mental ill-health coupled with physical disorders, or substance dependency) were recognised as complex, intersecting experiences for many service users. Yet, although the Act was intended to promote partnership-working to address multiple problems, silo working remained in some locales:

> I mean, mental health won't look at anybody if they're using substances. (LA)

> I've been trying since November for one of my clients. … He's got severe mental health issues. Again, he's got a criminal history, he's got a drug past, he's been evicted from a number of properties. The issue we have is partly with the mental health team; they are not prepared to do assessments on him. … We had the police actually take him up there for an assessment one day, but because he was under the influence, they refused to do anything. They're saying he's got no mental health issues. He's being medicated for mental health. But no landlord will take him because of the history. But this gentleman is street homeless, severe mental health issues, and there's nothing we can do for him. (LA)

Silo thinking reflected a long-standing obstacle (Montgomery et al., 2013) and provides evidence of the ongoing need for interdisciplinarity and interagency protocols for secondary and tertiary prevention to be developed when working with people with mental health and additional needs.

Access to mental health support

Providers drew attention to issues of access for people with lower-level mental health need:

> I definitely think that the people that we tend to work with […] are already engaged with services. Then, there's probably an even bigger population of people who have mild to moderate mental health issues, like depression and anxiety, and social phobias, who probably don't fit so well within mental health services, but actually they have quite a big need in terms of the housing community. (TS)

This highlights the ways in which thresholds and eligibility criteria for mental health services impeded implementation of the Act and, specifically, the aim of a wider reach for homelessness prevention. The ongoing barriers to access, shortage of specialist support and gatekeeping in primary care (General Practitioners (GP) surgeries and community-based services) or hospital-based care were recognised by providers. If people did not meet the threshold, they were not deemed to be vulnerable nor in need of being referred onto therapeutic or psychological treatment. The complexities of access were frequently articulated:

> If we want to access mental health services […] you have to go through the GP surgery […] Yes, but how does that work if you don't know which GP surgery somebody's with? How does that work if they're not engaging with us? […] What happens if actually they've chosen not to be with their local GP surgery or because of their mental health they've actually been excluded from their GP surgery? So, access and mental health is a huge problem for us, increasingly so. (LA)

Overall, service providers noted similar access difficulties faced by all people with mental health support needs whether low, medium and severe in nature.

The statutory sector response

Both service users and providers outside of the statutory framework perceived that mental health needs were not sufficiently considered by local authority practitioners despite the drive towards person-centred working. This is highlighted in the following excerpt:

> Took [service user] to [the local authority] but, of course, one of the workers there [said] 'no, no duty of care to him', even with his [severe mental health issues, learning and physical disability, substance misuse problem]. He ended up going back on the street, stole from [supermarket], got arrested and then sent [to prison]. Came back out again after six weeks, I took the case up again, took him again over to [the local authority], the same person, [said] 'why should we look after him?'[…] Three times he ended up going back to prison to get a roof over his head because [the local authority] had no duty of care to him. Whereas [Third Sector organisation] actually got the proof that he should have been. They had a duty of care to him. (TS)

This underlines the continued inadequacy of responses for some people with mental ill-health despite the Act's thrust towards power-sharing through partnership-working and a person-centred ethos (which should orient staff towards individualised responses and solutions). One respondent reflected on practices prior to the Act where the requirements for evidence and proof were driving forces in eligibility assessment. Some service users stated that staff still did not appear to be satisfied with a diagnosis and production of a prescription for medicine as frequently people were asked for more detailed information about their mental health condition. One person reported struggling with instructions to gather evidence requested by local authority staff. In this context, some frontline operators continued to reflect the former process-driven policy of 'investigating and processing decisions' rather than the approach of 'problem solving and dialogue with the household' advocated by the Act (Mackie, 2014b, 15-16).

Enablers to access

Conversely, data from the first wave suggested that most people with the more severe mental health conditions were accessing formal and specialised support. Some indicated that their condition was managed and most appeared to be knowledgeable about the kind of support they needed. What was not explicit was that this access to support was a direct result of changes associated with the Act. What is more likely is that widening eligibility under the prevention duty served to illuminate the scale and nature of mental health need amongst the homeless or at risk population, drawing attention to the burgeoning demand on existing services to meet that need.

Across the six case study sites, structures did exist that sought to help bridge the gap between an individual's needs and appropriate support. For example, the role of a support worker as an 'enabler' was seen to counter the barriers to accessing homelessness and/or mental health services:

> I think when you're on your own, you don't seem to get anywhere but when you do have the support worker with you, you do. (SU)

Some local authorities already had this type of support in place (demonstrating continuity for service users), but subsequent to the Act, others had made specific changes to structures introducing enabling roles by offering secondary and tertiary prevention support for people with housing/homelessness and mental health needs. For example, one authority had created a new post of Mental Health Liaison Officer. Similarly, other authorities had strengthened or introduced Gateways (structures that offer a more streamlined pathway to specialised support for specific issues, for example, through a Mental Health Gateway):

> All referrals were supposed to go through the one point. That's the main ethos behind having the Gateway. (LA)

Yet, as before, in discussing the specific roles of Gateways, whilst policy had changed, resources did not necessarily match demand. Notwithstanding, where Gateways had been introduced, they were thought to offer specific benefits through enhanced co-ordination, better information-sharing and streamlined processes (enabling efficiencies and timelier access). Overall, therefore, Gateways that were either restructured or introduced subsequent to the Act facilitated more targeted prevention work.

Person-centred working

The Act sought to change cultures through value-driven, person-centred practice. The implementation of a new process and tool that was introduced, the Personal Housing Plan (PHPs), exemplifies this. Whilst PHPs were designed to encourage person-centred working through the co-construction of the plan itself with individuals, in doing so they had the potential to address power imbalances. There were divergences in their usage across local authorities reflecting various social values and approaches to power-sharing (Fitzpatrick and Stephens, 2014). Specifically, some local authority officers took responsibility for the creation of PHPs and subsequent actions (reflecting *paternalism*), others placed the responsibility on service users (reflecting the values of *personal responsibility* and *empowerment*), and some took a shared approach (a value of *partnership*). This resulted in service users having quite varied experiences, which is antithetical to one of the objectives of the Act which was to address inconsistencies across local authorities (Mackie, 2014b). A service user highlighted the challenges facing people with mental health needs:

> The last time I had a homelessness experience was right at the beginning of the millennium […] At that point, I found that there was real, practical help. I mean, I suffer with learning difficulties and mental health issues, so to find myself in that situation and being fed, 'Yes, you're at risk of homelessness, we want to help you'. [Now], what you need to do is do all of the help for yourself, and what you're getting in support is somebody reminding you to help yourself. (SU)

This person highlighted the onus conferred to service users when given responsibility to be active in taking a lead role to implement their PHP.

Partnership-working

The Act aimed to influence a culture change through an emphasis on partnership-working across different sectors and areas of practice as well as between service providers and service users. Partnership principles were interpreted differently across the six sites with diverse approaches to the provisions contained within the Act. In terms of inter-agency working, again there were mixed reports. Some providers noted that successful partnerships already existed, but the need for improvement in this area was a common feature of service provider feedback. A small number of local authorities responded to the Act by revising their information and advice service ‘for people leaving hospital after medical treatment for mental disorder as an inpatient’. The driver for this was the desire for improved partnerships with hospitals and relevant agencies and this had led to some closer working relationships. Where successful partnerships had been forged, this was seen to be contingent on individual (operational) relationships rather than strategic partnerships. One authority described improvements to efficiencies and more targeted support:

> ‘Historically service providers […] have supported a client for three to four hours per week whether there was a housing-related support need at that time or not. The new model allows the three/four hours to be used where the support is needed most that week. (LA)

A mechanism to manage this involved appointing dedicated housing officers. Where such officers existed, they supported 'customers to return home or to alternative accommodation in a much more structured way'. Yet, given the increased prevalence of mental ill-health, the need for improved engagement with mental health services was described by service providers from all sectors. Concerns were voiced around the tendency for some hospitals to discharge individuals with limited information or pre-planning for their housing needs, placing a considerable burden on local authorities.

The *Supporting People* Programme is a national framework providing housing-related support to vulnerable people to help them to live as independently as possible (Welsh Government, 2018). This includes people experiencing mental ill-health. Across Wales, intra-agency working was evident with homelessness teams collaborating with *Supporting People* teams to provide support to vulnerable people. In some authorities collaborative working between these teams was established before the Act; for instance, one authority employed a Housing Advice Worker, provided by *Supporting People* funding, to bridge housing support with the hospital mental health team. In others, the Act had provided the impetus to explore channelling resources as another authority was planning to introduce a new discrete post to "support people with mental health and complex needs" to ensure that mental health and well-being assessments were better targeted towards housing-related support. Only one service user mentioned *Supporting People*:

> Between the last time I spoke to you I've taken a dip, I haven't been so well. The doctor has helped me access some help with that…. I'm supposed to be receiving the support from the *Supporting People*…so hopefully I'm going to be getting some help with that. I've received paperwork to say that I'm in there, I just haven't been contacted yet. So hopefully that's going to help with some of the practicalities. (SU)

Again, this evidence does not indicate whether this was brought about by changes subsequent to the Act or represents continuity in this particular area.

Discussion and concluding thoughts

This article presents a critical discussion of new evidence that demonstrates how policy is translated into practice through the experiences of two stakeholder groups: a marginalised community (people with mental health needs as a subset of homeless people); and service providers. What is apparent is that the relationship between homelessness and mental health remains complex. Congruent with empirical literature, this study found that this relationship is also often entwined with other factors such as intimate partner abuse, substance misuse, victimisation and poor physical health (Fox et al., 2016; Gilfoy et al., 2016). Indisputably, the complex entanglement of any combination of these factors serves to increase risk and vulnerability, exacerbating existing problems, or resulting in new ones, for individuals and service providers. There were several examples of this for homeless people with mental health needs and additional vulnerabilities. For example, challenges to effective secondary and tertiary prevention were highlighted as the enduring and competing social values in service delivery and performance management (for example, in seeking to identify person-centred solutions whilst maintaining social cohesion) (see also Fitzpatrick and Stephens, 2014). In addition, service user testimonies drew attention to how the value-driven policy objectives of partnership and person-centred working had been ineffective in addressing the power imbalance in the service-user/service provider relationship. In some cases, the balance had shifted considerably resulting in an onus on people to be demonstrably active in finding their own solutions. This was problematic for people who were vulnerable and who were trying to manage their mental health in addition to being homeless or risk of homelessness.

There were two frequently cited implications relating to policy implementation. First, the need for a coherent and joined-up policy responses was lacking as providers described the ways in which various structures, such as Universal Credit and the Bedroom Tax, and policies that were introduced at the same time as the Housing (Wales) Act 2014 (specifically, the Social Services and Well-being (Wales) Act) were not aligned. This was represented as a missed opportunity. Mackie (2014a: 45) described this lack of alignment as a barrier to successful prevention activity which resulted from 'the piecemeal way in which prevention has emerged alongside existing systems of services'. Mackie noted how policy frameworks have not been comprehensively reviewed nor revised to incorporate the prevention agenda whilst accounting for overlapping or divergent policy directives. This lack of whole system approach is a major critique of the prevention approach.

Second, whilst service providers did indicate changing cultures, better and more effective partnerships and frontline practices that are becoming more person-centred (which reflected the wider social care policy agenda), there are enduring constraints limiting the advances made in preventing or relieving homelessness for people with mental ill-health and complex, intersecting problems. These restrictions were frequently characterised by the disconnect between policy objectives and existing resources. The need for adequate levels of resources to support policy implementation in terms of affordable housing, housing-related support, human resources and resources to meet additional (non-housing) need, such as those relating to mental health, were highlighted frequently.

Evidently, austerity measures have had long-lasting effects and welfare reform in the UK offers uncertain contexts for policy implementation where homelessness was concerned. As such, the evaluation uncovered implications for prevention policy in Wales with relevance for other contexts and different welfare regimes where social change and policy review are ongoing. Furthermore, neoliberal principles already embedded in policy and practice responses (such as strict funding requirements and performance indicator mechanisms) were not sufficiently transformed following the implementation of the Act and were cited by RSLs as limiting the ways in which they supported people with mental health needs to manage and sustain tenancies. Overall, it was suggested that the translation of policy into practice was hampered by a complex amalgam of structural and local factors.

Unsurprisingly, the data reported in this article demonstrated that securing accommodation and the appropriate type and level of support for people with mental health needs in Wales was the most challenging problem faced by service providers. The bi-directional nature of homelessness and mental health (where mental ill-health can be a cause and consequence of homelessness) was stated by many participants reflecting the global literature (Guy and Chamberlain, 2011). These circumstances were characteristic of the field prior to the Act. What the findings do highlight is the complex nature of intersecting problems and the difficulties for insightful and empowering responses in all relevant fields of practice; an example being the identified lack of homelessness awareness amongst healthcare practitioners. This results in barriers to effective secondary and tertiary prevention work. Additionally, resulting from insufficient resources, thresholds and eligibility criteria, not all people with homelessness and mental needs were able to access appropriate and adequate support. As such, the principle of selectivity remained operational in some instances (Maher and Allen, 2014).

In the short term, there are various recommendations for improving the service response for people at risk or who are homeless who have mental health needs. On a statutory level, the knowledge, skill, empathy and confidence exhibited by local authority practitioners in relation to mental health would improve people's everyday experiences if there was a better level of mental health awareness. Similarly, training for healthcare practitioners in issues of homelessness would assist

service users to experience a more holistic, person-centred response. Earlier in this article, we explored how notions of social values influenced policy implementation for marginalised groups (Fitzpatrick and Stephens, 2014) and without a coherent and united multi-agency response for people with mental health needs (reflecting values which recognise heterogeneity in the homeless population as well as across the subset of people with mental ill-health), constraints to prevention work will continue at secondary and tertiary levels. This recognition also needs to consider some of the value-driven principles of the Act, specifically that of partnership, may not work for marginalised people with specific, entrenched and complex needs.

In the medium and longer term, there are various recommendations for policy-makers including the need for a mental health and homelessness strategy to align agendas, address the chasm in prevention and service provision, and to reflect the scale and nature of mental health needs. The continued development of the Welsh *Housing First* approach to address the shortages in provision may well be a strategy that accommodates the specific, entrenched and complex needs that people with mental health needs often articulate. A *Housing First* approach embeds social values which prioritise basic needs (that is, permanent shelter) as well as support that is flexible, user-led and ongoing moving away from service-led, timebound interventions (Patterson et al., 2013). Research on *Housing First* has documented improved stability, community integration and high levels of satisfaction for residents (Field, 2011; Patterson et al., 2013). Recently, a random controlled trial study found that despite the multiple health and social challenges faced by homeless individuals with mental ill-health, *Housing First* results in significantly greater outcomes compared to individuals who do not receive *Housing First* services even after a relatively short period of time (Patterson et al., 2013). Therefore, the evidence-base for the *Housing First* model for people with mental health should be considered in future homelessness policy that addresses the gap in support for people with mental health needs. This offers possibilities and hope in the desire to reduce the 'revolving door' experience and continued complex support needs for this community of people.

References

Amore, K. and Howden, Chapman, P.L. (2012) 'Mental health and homelessness', *International Encyclopaedia of Housing and Home,* 268-273.

Benston, E.A. (2015) 'Housing programs for homeless individuals with mental illness: Effects on housing and mental health outcomes', *Psychiatric Services*, 66, 806-16.

Brown, A., Klebek, L. Chodzen, G., Scartozzi, S., Cummings, C., and Raskind, A. (2018) 'Housing status among single adults following Homelessness Prevention and Rapid Re-housing Program participation in Indianapolis', *Evaluation and Program Planning*, 69, 92-98.

Culhane, D.P., Metraux, S. and Byrne, S. (2011) 'A prevention-centered approach to homelessness assistance: a paradigm shift?' *Housing Policy Debate*, 21, 2, 295-315.

Dai, L. and Zhou, P. (2018) 'The health issues of the homeless and the homeless issues of the ill-health', *Socio-Economic Planning Sciences*, https://doi.org/10.1016/j.seps.2018.12.004 [accessed 03.07.2019].

Dahlgren, G., and Whitehead, M. (1991) *Policies and Strategies to Promote Social Equity in Health*, Stockholm: Institute for Futures Studies.

DCLG (2012) *Evidence review of the costs of homelessness*, London: Department Communities and Local Government, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf [accessed 03.07.2019].

Field, D. (2011) 'Emotional refuge? Dynamics of place and belonging among formerly homeless individuals with mental illness', *Emotion, Space & Society,* 4, 258–267

Fitzpatrick, S. and Stephens, M. (2014) 'Welfare regimes, social values and homelessness: Comparing responses to marginalised in six European countries', *Housing Studies,* 29, 2, 215-234.

Folsom, D.P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan, S….. and Jeste, D.V. (2005) 'Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system', *American Journal of Psychology*, 162, 2, 370-76.

Fox, A.M., Mulvey, P., Katz, C.M. and Shafer, M.S. (2016) 'Untangling the relationship between mental health and homelessness among a sample of arrestees', *Crime & Delinquency,* 65, 5, 592-613.

Guy, J. and Chamberlain, C. (2011) 'Are the homeless mentally ill?' *Australian Journal of Social Issues*, 46, 1, 29-48.

MacKie, P. (2014a) 'Homelessness Prevention and the Welsh Legal Duty: Lessons for International policy', *Journal of Housing Studies,* 30(1): 40-59.

Mackie, P. (2014b) 'The Welsh homelessness legislation review: delivering universal access to appropriate assistance?' *Contemporary Wales,* 27, 1, 1-20.

MacKie, P., Thomas, I. and Bibbings, J. (2017) 'Homelessness prevention: Reflecting on a year of pioneering Welsh legislation in practice', *European Journal of Homelessness*, 11,1, 81- 107.

Maher, C. and Allen, M. (2014) 'What is Preventing us from Preventing Homelessness? A Review of the Irish National Preventative Strategy', *European Journal of Homelessness,* 8, 2, 119-135.

Mental Health Foundation (2016) *Fundamental facts about mental health 2016,* London: Mental Health Foundation.

Montgomery, A.E., Cutuli, J.J., Evans, Chase, M., Treglia, D. and Culhane, D.P. (2013) 'Relationship among adverse childhood experiences, history of active military service, and adult outcomes: Homelessness, mental health, and physical health', *American Journal of Public Health*, 103, 2, S262-S268.

Newman, S. and Goldman, H. (2009) 'Housing policy for persons with severe mental illness', *Policy Studies Journal* 37, 2, 299–324.

Patterson, M., Moniruzzaman, A., Palepu, A., Zabkiewicz, Frankish, C.J., Krausz, M. and Somers, J.M. (2013) 'Housing First improves subjective quality of life among homeless adults with mental illness: 12-month findings from a randomized controlled trial in Vancouver, British Columbia', *Social Psychiatry and Psychiatric Epidemiology,* 48, 8, 1245–1259.

Welsh Government (2015) *Welsh Health Survey*, https://gov.wales/statistics-and-research/welsh-health-survey/?lang=en [accessed 03.07.2019]

Welsh Government (2018) *Supporting People Programme,* https://gov.wales/topics/housing-and-regeneration/services-and-support/supporting-people/?lang=en [accessed 03.07.2019].

WHO (2018) *Mental disorders: Key facts*, https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders [accessed 03.07.2019].