What is Preventing us from Preventing Homelessness? A Review of the Irish National Preventative Strategy

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Introduction

It is now widely recognised that preventing households from becoming homeless must be a key component in any strategy to tackle homelessness effectively. Due to the high public and personal costs of providing emergency shelter, governments increasingly view preventative strategies as cost-effective and socially progressive (Mackie, 2014). This increased emphasis on prevention can be seen, alongside the attention to 'Housing First' and 'Housing Led' approaches, as a paradigm shift away from the large-scale provision of emergency shelter. Ireland's homelessness strategies have been positively regarded internationally due to a series of government policy publications from 2000 on, which emphasised the importance of prevention. This recognition led to the publication of a Homeless Preventative Strategy (Departments of Environment & Local Government, Health & Children and Education & Science, 2002), which FEANTSA described as 'one of the more advanced examples of prevention being integrated into the policy package/strategic approach to tackling homelessness' (FEANTSA, 2004). However, Culhane *et al.* (2011) have argued that investment in prevention, in contrast to Housing First, is being pursued without an adequate empirical and conceptual basis. This article looks at what impact the Irish Preventative Strategy has had on preventative practices in Ireland and what the lessons might be for other EU jurisdictions.

How we Understand the Prevention of Homelessness

While it is universally agreed that 'prevention is better than cure', the practical deployment of effective approaches to prevent homelessness is plagued with conceptual and methodological problems (Shinn *et al.*, 2001). Most authors use a three-stranded framework to conceptualise prevention strategies, but although this constitutes the general approach to prevention, deeper exploration shows this apparent consensus to be quite superficial. While Culhane *et al.* (2011, p.3) warn that 'these classifications should more be seen as ranges in a continuum', the approaches differ more fundamentally than simply where they set boundaries between the three strands, and different authors include very different forms of intervention in each. This has implications for both practice and research.

Busch-Geertsema and Fitzpatrick (2008, p.73) set out a three-tier model of prevention, drawing on the disciplines of both medicine and criminology:

1. Primary prevention measures: activities that reduce the risk of homelessness among the general population or large parts of the population. It is at this level of prevention that general housing policy (supply, access and affordability) and overall welfare settlement (such as the availability of income benefits, housing benefits and employment protection) are most relevant.

2. Secondary prevention: interventions focused on people at potentially high risk of homelessness because of their characteristics (for example, those with an institutional care background) or because they are in crisis situations that are likely to lead to homelessness in the near future (such as eviction or relationship breakdown).

3. Tertiary prevention: measures targeted at people who have already been affected by homelessness. From the analogy with medicine and criminology, it would make sense to subsume 'harm reduction' measures such as rapid re-housing here, so that homelessness is ended as quickly as possible.

While other authors tend to agree with the sort of issues that Busch-Geertsema and Fitzpatrick (2008) include in the first tier, considerable variation emerges when we look at the second. For example, Shinn *et al.* (2001), Culhane *et al.* (2011) and Montgomery (2013) are explicit in their view that secondary measures only apply to people who are already homeless. Culhane *et al.* (2011, p.3) comment that secondary measures 'do not reduce the number of new cases, but rather treat the conditions closer to their onset of homelessness'. For Shinn *et al.* (2001), 'secondary prevention efforts may reduce the prevalence of homelessness, but they do not reduce the number of new cases.'

In the German and English approaches described by Busch-Geertsema and Fitzpatrick (2008), however, the term 'prevention' only applies where people have not yet become homeless; 'secondary prevention' relates to people who are not yet homeless but are at 'high risk' or 'in crisis… likely to lead to homelessness in the near future' (2008, p.73). Quite aside from the simple confusion that can be caused by the deceptive similarity in frameworks, the different approaches reflect a divergent idea of what is in fact being 'prevented'. In the European approach, the intention is to prevent *any* experience of homelessness at all, while the US approach reflects a concern that any experience of homelessness should be short lived. In fact, in the US it appears to be *long-term* homelessness that is being prevented. To some extent this difference reflects a greater US emphasis on considerations of efficiency and effectiveness, as will be discussed.

Similar differences exist in the understanding of tertiary prevention, with interventions such as rapid re-housing of newly homeless people being classified as 'preventing' long-term homelessness in some countries, while being seen as 'resettlement' (i.e. not prevention at all) in others. Mackie (2014, pp.3-4), in his review of the Welsh experience of homelessness preventative strategies, puts these differences down to the varying definitions of homelessness on either side of the Atlantic*:*

> This means that policy-makers operating under a narrow definition of homelessness (e.g. the USA) are seeking to prevent people from sleeping on the streets, whilst policy-makers operating under a more liberal definition of homelessness (e.g. the UK) will be seeking to prevent households from occupying unfit or over-occupied housing.

The framework outlined by Gaetz (2013) comprises three tiers but is also distinct; all three strands refer to actions prior to the experience of homelessness. The second tier is named 'Systems Prevention' and focuses on transition from care institutions. Finally, the third strand is called 'Early Intervention', which he defines as 'identifying and addressing the physical, emotional, material, interpersonal, social and educational needs of people who are at imminent risk of, or who have just become homeless' (2013, p.482) – activities which fall into the second strand for Busch-Geertsema and Fitzpatrick (2008) and might fall into any of the three strands for Culhane *et al.* (2011).

Beyond these conceptual difficulties, Culhane *et al.* (2011) identify two fundamental practical problems: 1) effectiveness: assessing whether any particular intervention is successful; 2) efficiency: selecting those who would most benefit from intervention.

The problem of effectiveness

Assessing whether a preventative strategy is effective requires us to know both 1) what the impact of the intervention has been, and 2) what the outcome would have been in the absence of the intervention. Shinn *et al.* (2001) point out that to achieve any certainty on this issue would require substantial randomised, controlled studies. For ethical and methodological reasons, there were very few of these at the time and Shinn *et al.* reject the claims of a number of studies of cost-effective interventions, which attribute all positive outcomes to the intervention and contrast these with pessimistic assumptions about the outcome.

The problem is deeper than methodological weaknesses in the research, however, as the context in which homelessness is occurring is constantly in flux. Factors that might increase or decrease the risk of homelessness for particular groups or individuals are constantly changing, both as a result of outside factors and the impact of the adopted preventative strategies themselves. Pawson (2007) analysed the decline in homelessness in England after the introduction of preventative measures in 2002. He expresses concern that the decline resulted not from real changes in the circumstances of people, but rather due to the fact that local authorities changed the definition of homelessness to avoid having to supply the services set down in legislation. Mackie (2014) expresses similar concerns in the Welsh case. Stuart (2014) finds an even darker picture in Los Angeles, with a disciplinary model of policing using homelessness prevention as a pretext for coercing homeless people into rehabilitative programmes rather than tackling the underlying causes of homelessness.

The problem of efficiency

The most cost-effective method of delivering preventative measures would be to identify those individuals who are going to become homeless and target interventions only at those individuals. However, problems arise with this method – first, in reliably identifying those at risk of becoming homeless. A number of studies have been carried out to establish indices of risk factors for homelessness, but Shinn *et al.* (2001) demonstrate that even the best of these would, if used for recruitment to a programme, involve substantial expenditure on people who would not have become homeless in any case. They argue that such approaches would be further undermined as people would adapt their behaviour in order to qualify for the interventions. Based on this, Shinn *et al.* (2001) emphasise the risk of queue-jumping in any preventative strategy, where people who adopt behaviours that put their homes at risk receive greater rewards than those who make reasonable efforts to sustain their homes.

Shinn *et al.* (2001) and Culhane *et al.* (2011) differ on the extent to which at-risk individuals can be targeted for efficient interventions. Culhane *et al.* (2011) propose a practical response to this difficulty in a sliding scale of preventative responses.

Through this 'progressive engagement' approach, large numbers of households can benefit from inexpensive measures but resource-intensive measures are only deployed in the case of people who have already demonstrated they are at risk by actually becoming homeless. Montgomery develops this further in relation to services for people with mental health issues. On one side of the scale are relatively cheap interventions, which are widely available in the population, and at the other end of the scale are more expensive interventions, which are only available to a much smaller number of people in particular need.

Shinn *et al.* (2001) make a helpful distinction between 'Universal Strategies', 'Selected Strategies' (aimed at people because they are a member of an at-risk group) and 'Indicated Strategies' (targeted at people because of their individual characteristics). Indicated and Selected Strategies can operate at both the secondary and tertiary level. They also critique efforts to target measures, leading to the conclusion that the most effective preventative measure would be to ensure that affordable housing is readily available – which is essentially a first tier intervention.

Gaetz's (2013) approach is less based on statistical screening for risk factors and more concerned with service practices, which, he argues, are effective at directing resources to those who are genuinely at risk of homelessness. He identifies two such practices in particular: case management and common access. He also places a strong emphasis on building resilience and, particularly in the case of youth homelessness, the important role of family relationships.

The detailed analysis of over 11 000 families who were in contact with homeless services in New York City by Shinn *et al.* (2013) challenges Gaetz's (2013) position on the role of case-workers in some respects. Shinn's evidence shows that screening for risk factors (female-headed households, previous experience of homelessness, etc.) are better predictors of homelessness than the judgement of case-workers. In this way, the emphasis is on what she had termed 'Indicated Strategies'.

The concern about achieving efficiency in targeting preventative measures is closely related to two of the key critiques of preventative strategies: that they are selective in who they assist and that they emphasise individual rather than structural causes of homelessness (Parsell and Marston, 2012). As has been noted, the shift towards preventative intervention is strongly driven by concerns about cutting the cost of homelessness, so it is not surprising that such interventions can end up being 'restricted to those where a cost-saving can be made' (Mackie, 2014, p.5).

The two groups that are likely to be excluded as a result of cost-benefit analysis are those who are deemed likely to find their own solution to their problem, and those whose high support needs make the intervention expensive or likely to fail. Mackie shows that the Welsh Preventative Strategy tended to exclude certain groups, and

he argues in favour of the new approach adopted in Wales, which will create a universalist obligation on local authorities to make all reasonable efforts to assist anyone who is at risk of homelessness. However Mackie's (2014) critique appears to conflate a number of different issues. It seems to be quite a different matter to refuse someone a service because it would be too expensive and to refuse the service because the available evidence indicates that they do not need it. While we might argue, for example, that everyone who has cancer has a right to treatment irrespective of their prognosis, it is hard to sustain the case that everyone has a right to cancer treatment whether they have cancer or not. In the Welsh case, as presented by Mackie (2014), certain groups appear to have been excluded either through administrative inefficiency (prisoners) or prejudice (single men) – the prevalence of such arbitrary selection is an argument for all selections being made based on reliable evidence rather than an argument against targeting as such.

Significantly, Shinn *et al.* (2013) test the hypothesis that there are cases where the risk of homelessness is so severe that no intervention would be cost-effective, but they conclude that this argument is unsubstantiated. Shinn *et al.'s* (2001) earlier critique of the absence of empirical evidence in relation to prevention is particularly relevant in the context of the current emphasis across the EU on cost-benefit evaluations of social interventions, because the evidence of success in specific cases is hard to establish reliably. There is therefore a risk that – quite counter-intuitively – cost-benefit approaches will shift resources away from preventative measures.

However, it is striking that even where the literature is sceptical about the effectiveness of targeted interventions to prevent homelessness, there is an underlying recognition that many of these interventions are, in and of themselves, socially beneficial. This perspective can also be seen to inform the insistence of Culhane *et al.* (2011) that services targeted at people who are homeless (or at risk of becoming homeless) should be mainstream services so as not to create separate loops of provision that maintain people in a condition of homelessness. In other words, rather than designing a range of specific homelessness prevention measures and researching their cost-effectiveness, it might be better if mainstream (first tier) economic and social policy were designed to ensure they did not have any unintended consequences of increasing the risk of homelessness. This is the core of Parsell and Marston's critique (2012) of the Australian Homelessness Prevention Strategy. They argue that the focus on individual risk factors and service interventions to respond to these risks shifts attention away from the underlying functional causes of homelessness and suggest that if we can identify and 'fix' each individual considered at risk, we would be able to end homelessness. Genuinely effective preventative measures would be in the first tier and would seek to reduce the overall incidence of homelessness in society rather than simply transfer the experience of it from one group to another.

Prevention in the Irish Strategy

The national Homeless Preventative Strategy (Departments of Environment & Local Government, Health & Children and Education & Science 2002) was drawn up in response to recommendations in the general Integrated Homelessness Strategy (Department of Environment & Local Government, 2000). This Integrated Strategy represented 'the beginnings of a coherent national policy approach to the needs of homeless households' in Ireland (O'Sullivan, 2008a, p.211) and identified the fact that is was 'essential that action be taken to identify and assist those at risk of becoming homeless' (p.7). It situated this risk primarily with people moving out of or between state institutions such as prisons, hospitals or care institutions and recommended a further, specialised plan to set out 'preventative strategies across identified relevant agencies' (p.7).

After a brief report of this recommendation and the history of its implementation, we will discuss how the recommendations relate to the concerns outlined in the literature.[1] The 2002 national Homeless Preventative Strategy included fourteen recommendations, categorised under three institutional settings: 1) adult and youth offenders leaving detention; 2) people leaving psychiatric institutions and acute hospitals; and 3) young people leaving care.

1) Adult and youth offenders leaving detention

The first two recommendations place the responsibility for ensuring that prisoners do not become homeless upon release with the prison authorities, recommending the establishment of a 'specialist unit in the probation and social welfare service to deal with offenders who are homeless' (2002, p.34) and that the Prison Service should build and operate 'transitional housing units'.

The implementation of these recommendations establishes a pattern that soon becomes familiar. The recommended specialised unit was set up in 2002 but was dissolved in 2006 and later replaced by a different approach – a cross-agency team. While the Prison Service initially indicated it would build transitional housing units, this objective was dropped in an internal review and does not appear in the most recent Prison Service Strategic Plan (Irish Prison Service, 2012), as it is not considered part of their core function. There has been patchy progress on the third recommendation: to enable prisoners to continue educational courses after their release.

In relation to youth offenders, the report recommended that step-down units at two youth detention centres should be staffed and made operational as a priority. This happened in 2006. However, when responsibility for youth detention moved to the

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[1]   A more detailed description of the implementation of the Irish Prevention Strategy was presented by Catherine Maher at a conference in September 2012 and can be accessed at bit.ly/prevhomeless

Department of Justice, the units were closed as the Department considered that this fell outside their remit. Recent reports by the Inspection Authority (HIQA) indicate that the risk of homelessness on discharge of juvenile offenders remains an unresolved problem (Health & Information Quality Authority, 2010; 2011).

2) People leaving psychiatric institutions and acute hospitals

Recommendations 5 to 10 essentially stated that psychiatric and general hospitals should have written policies for discharging people who are homeless, that there should be a dedicated staff member responsible for these policies and that records should be kept of the outcome of psychiatric discharges. Seven years after this recommendation, The Mental Health Commission (2009) published a *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*. This required that approved centres work with homeless organisations and other relevant service providers when an in-patient is identified as being homeless or at risk of homelessness. The Mental Health Commission (2011) reported that 58 approved centres were fully or substantially compliant with the Code of Practice; seven had initiated compliance; and two were not compliant. However, this code also deals with other matters of admission and transfer, and there is no published breakdown of compliance with the homelessness section of the code. In any case, this measure only relates to patients who are involuntarily admitted to mental health institutions; patients who are voluntarily admitted may discharge themselves at any time and such patients continue to feature strongly in reports from homeless services. The recommendation that the form of accommodation to which patients are being discharged be recorded has not been implemented and there is no plan to do so (Parliamentary Question, 2012).

In relation to General Hospitals, a *Code of Practice for Integrated Discharge Planning* (HSE, 2008) was published in 2008 and revised in 2010. This noted that homeless people should be identified on admission and that primary care services should be notified on their discharge. However, the experience of homeless services is still that the discharge of patients from acute hospitals is uncoordinated and unplanned.

3) Young people leaving care

Recommendations 11 and 12 called for the development of aftercare protocols and their implementation within 6 months. Ten years after this recommendation, National Guidelines for Aftercare were drafted after consultation with voluntary and statutory bodies, are expected to be published in 2014. The Irish Government has now agreed to give these guidelines a legislative basis.

Recommendation 13 proposed that education services for homeless adults be extended across the country. Since 2002 the number of adult courses has tripled and the percentage of those allocated to homeless adults has increased from 0.35 percent to 0.46 percent, so that 146 homeless adults benefited from such courses in 2011.

4) Monitoring the implementation of the Strategy

The final recommendation relates to having 'monitoring systems in place to ensure that the measures in this strategy that are relevant to them are implemented and that they contribute to the overall aim of preventing homelessness' and to having monitors 'report regularly to the Cabinet Committee on Social Inclusion' through the Cross Department Team on Homelessness (2002, p.31).

This Cross Departmental Team on Homelessness has been meeting for a number of years and frequently engages in joint sessions with the National Consultative Committee on Homelessness. It met only once between the end of 2010 and the end of 2012 but is now meeting on a quarterly basis once again. However, given the poor track record of implementation of the report recommendations outlined above, the effectiveness of the meetings that were held can certainly be questioned.

Analysing the Irish Measures

Because of the failure to consistently implement most of the recommendations and the absence of consistent, regular and robust data on homelessness in Ireland, analysis of the recommendations may seem an empty exercise. However, we believe that there are a number of useful lessons that can be taken from the Irish experience.

All the proposals are of one type, falling into Busch-Geertsema's and Fitzpatrick's (2008) second and Culhane's *et al.* (2011) tertiary tier: a focus on groups of people where there is a known high incidence of homelessness, such as ex-prisoners, care leavers, etc. All the measures in the Strategy respond to the situation of people who are homeless under Category 6 of the ETHOS definition: people due to be released from institutions. In the terms of Shinn *et al.* (2001), they are generally not 'selective' measures (targeting all people released from institutions) but rather 'indicative' measures, utilising a basic risk factor: whether the individual within the cohort leaving an institution has accommodation to return to upon discharge. While the proposed mechanism for targeting is not sophisticated, there can be little doubt as to the efficiency of this approach. It is hard to think of a more precise targeting than individuals living in our state institutions who we know to have nowhere to live when they are released. The proposals would be more likely to miss people at risk of homelessness than provide an unnecessary service for people who would be able to resolve their own problems.

Effective Systems Prevention

Most of the measures can be characterised fairly comfortably within Gaetz's (2013) 'Systems Prevention' approach, and the Strategy's identification of the institutional pathways into homelessness is one of its stronger aspects. The systems approach recommended is not case management, nor is it ensuring a supported pathway for the individual as advocated by Gaetz (2013); the major recommendations essentially propose that the discharging institutions continue to take responsibility for people beyond the legally required period. This can be done by the prison or youth detention centre providing transitional homes or by agreeing protocols with other state institutions, so smoothing out the manner in which responsibility for the individual is transferred from one state agency to the next.

One of the lessons here is that while the Strategy sought to intervene in the institutional interactions at a functional level, it did not attempt to alter the underlying legal responsibilities. For instance, although in the Strategy the justice institutions agreed to *act* differently, the underlying legal position for all juvenile justice institutions is (and remains) that when the young people in their care have completed their sentence or reached adulthood, the institutions have a legal obligation to release them – but to do nothing further. Instead of proposing to change this legislative fact, the Strategy proposed to bypass it by agreeing protocols concerning discharge. However, when the officials and Ministers who were party to that agreement moved on, their successors simply returned to what the legislation requires and does not require. An approach more concerned with creating social rights for those facing homelessness might have created a more sustainable framework than a protocol.

Further, Gaetz (2013) places information sharing and a case management approach as practices essential to Systems Prevention. While these are now central to the delivery of the Irish system (Downey, 2012) they were not in place in 2002. The community and voluntary sector were recognised as full 'social partners' during the period in which the Strategy was drafted. Nevertheless, the homeless strategy documents are only concerned with the question of how different arms of the state, at local and national level, should interact with each other. This misses the reality that every pathway into (or out of) homelessness involves complex transitions back and forth between various state agencies and voluntary organisations. The omission of voluntary organisations from the framework means that some of the preventative approaches that have since demonstrated the greatest successes were also overlooked.[2] These come about when

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[2]   To a large extent these practices have come about since the implicit adoption of a Housing-Led approach following the major evaluations of Dublin services in 2008 (Brooke, 2008), which heralded a shift from managing homelessness towards ending it. They also coincided with a stronger integration of voluntary sector actors, such as the NHCC and the Implementation Advisory Group in Dublin, into governance structures.

voluntary sector case-workers are able to work with the at-risk citizen to integrate the necessary complex range of state services around the specific needs of that individual. In this way the integration of services does not come about by written protocols from above, but through front-line collaboration of public service and voluntary sector staff.

One current example of this involves the delivery of preventative services in Dublin by voluntary organisations, working with and on behalf of the local authorities. In this model, certain emerging problems with social housing tenancies trigger local authority staff to request an intervention by voluntary sector staff. For institutional reasons, the voluntary sector staff, working to some extent outside the system but authorised by it, are able to engage a wider range of appropriate support services than the local authority staff working alone. Written protocols are, of course, an essential part of this as they permit and prioritise action. But they are not the starting point. The failure to recognise that Systems Prevention can be built upon an effective, professional, person-centred voluntary sector seems to be one of the weaknesses of the programme set out ten years ago.

How to Integrate the Work of Different Agencies?

The second lesson lies not in the realm of homelessness, as such, but rather in the broader question of the challenges faced by governments in implementing social programmes that require the engagement of a number of state actors over a prolonged period of time. Because homelessness is a classic example of such a social problem, the implementation problems faced by the Irish Strategy are likely to be of some relevance to other jurisdictions and are worth some consideration.

One of the causes of the failure to implement relates to the extent to which state agencies that previously had core responsibilities ceased to exist, or were amalgamated, split-up or renamed over the intervening decade. O'Sullivan (2008, p.228) draws attention to this phenomenon when he identifies the formation of the Health Services Executive (HSE) as one of the factors slowing the progress of the Irish Strategy.

Burt *et al.* (2007) identify the fact that a system for feedback and continuous improvement is one of the key elements of successful strategies at community level, and this appears to be important at national level too. Many of the dead ends in the implementation of the Preventative Strategy might have had a different outcome if they had been referred back to the Consultative Committee or the Cabinet Sub-Committee, as had been envisaged. Indeed, the cross-departmental monitoring system, with reference to the highest political authority in the state (the cabinet), would appear to be the ideal institutional arrangement to avoid any loss of momentum when institutional changes take place. Of course, the scale of Ireland's economic crisis accounts for the effective absence of monitoring in recent

years, but there is no evidence that earlier changes in the plan (e.g., the Prison Service's decision not to build step-down units in 2005, or the Juvenile Justice system's decision to close step-down units that it had opened) were brought back to the monitoring committee so that an alternative approach could be agreed upon.

One explanation of why the monitoring process failed to operate effectively was the growing number of recommendations that were outlined in subsequent reports. To understand how policy and practice in Ireland developed over the period from 2002, it is important to recognise the extraordinary numbers of specialised and generalised, national and regional, strategies, action plans and implementation plans that were published. All of these documents included further recommendations on the prevention of homelessness (Table 1).

Table 1: Prevention recommendations per report (2002 – 2010)

Strategy Document	Number of recommendations on prevention
Homelessness Preventative Strategy (Departments of Environment & Local Government, Health & Children and Education & Science, 2002)	14 Recommendations
Comprehensive Strategy to Prevent Homelessness in Dublin (Pillinger, 2005)	104 Actions
National Adult Homeless Strategy 'The Way Home' (Department of Environment & Local Government, 2008)	10 National recommendations 6 Local recommendations 15 Actions
National Implementation Plan (Department of Environment & Local Government, 2010)	8 Approaches 6 Priority Actions 36 Specific Actions 6 Further Key Actions
A Key to the Door (Homeless Agency, 2007) Dublin	15 Recommendations
8 x Regional Homeless Strategies (2010)	Up to 50 Actions in each of 8 regions.

This was happening at a time when detailed strategies were being published to tackle a whole range of intractable social problems in addition to homelessness. This era also saw a Youth Homelessness Strategy (Department of Health & Children, 2001), an Anti-Poverty Strategy, The National Drugs Strategy 2001-2008, The National Health Strategy 2002, the National Children's Strategy 2000 and many others.

It could be argued that the various social inclusion strategies were more concerned with referencing each other than relating to the emerging reality. Perhaps the most extreme example of this is the decision to commission a 'poverty proofing' evaluation of the 2008 homeless strategy 'The Way Home'. Poverty proofing was a process agreed in social partnership to assess the impact that government decisions *not directly related to poverty* might have on the incidence of poverty.

After poverty proofing the homeless strategy, it was concluded – unsurprisingly – that, if implemented, the reduction in homelessness would have a positive impact on the incidence of poverty.

Processes for monitoring and review are essential for the delivery of any successful strategy. Such structures appear to be well considered in the Preventative Strategy, but they did not function effectively. We can draw two tentative explanations for this, which may be relevant for other jurisdictions; first, that the subsequent deluge of detailed recommendations clogged up the system and resulted in the underlying issues being lost; and second, that linking monitoring to the highest level of government (the cabinet) may give an impression that an issue is being taken seriously, while the reality is that such high levels of government are the most likely to be distracted by other immediate and urgent problems.

It is worth noting that the absence of overall resources is not a plausible explanation for the failure to implement so many of the recommendations in the Preventative Strategy, as funding for homeless services increased substantially over the eight years after its publication (O'Sullivan, 2012).

A Broader Understanding of Prevention

A more fundamental critique of the Preventative Strategy is that, as in Parsell and Marston's (2012) critique of the Australian strategy, it is far too restricted and fails to address any of the causes of homelessness. While the Irish strategy mentions structural causes of homelessness, the recommendations are confined to second tier measures. There is no exploration of the structural causes of a high risk of homelessness even among the high-risk groups identified. In this sense it is open to the criticism of framing homelessness as an individual problem.

If we look at the wider context at that time, the case made by both Shinn *et al.* (2001) and Parsell and Marston (2012) becomes very relevant – that the most effective way to prevent homelessness is to increase the availability of affordable housing. In the period immediately after the publication of the Preventative Strategy, Ireland experienced a house price bubble. This resulted in a massive increase in house prices, a collapse in the proportion of social housing being built and the growth of waiting lists for social housing (Drudy and Punch, 2005). All of this led to a property crash which, coinciding with the international financial crisis, left tens of thousands of people in negative equity, mortgage arrears or facing rising rents. All these factors significantly increased the numbers at risk of losing their homes. These factors were slowly building from 2002 onwards, yet were overlooked throughout all policy documents on homelessness prevention. While the homeless strategy was being 'poverty proofed', no poverty proofing was considered for the lending policies of

banks or general housing policy. In this sense, Shinn *et al.*'s (2001) conclusion is illuminating: a genuine homelessness prevention strategy must (among other things) be a realistic sub-strategy together with the provision of affordable housing.

Conclusion

To test the effectiveness of a prevention strategy, one must primarily consider how its measures have impacted on those at risk of homelessness. However, the lack of data on this means that we have had to focus on whether proposals for specific policy instruments have been implemented. This review has demonstrated not only that the progress on the 2002 proposals has been slow, but even more strikingly, that the progress made during the first four years was not sustained, and was in many cases lost. Recent work on homelessness prevention suggests that, if situated in the context of affordable housing policies, the limited focus of the Irish Preventative Strategy may not have been misplaced. The targeting was precise and the proposed interventions involved elements of what Culhane *et al.* (2011) would recognise as 'shelter diversion' and Gaetz (2013) would see as 'systems prevention'. The fundamental problem was a failure to implement or sustain the implementation of these recommendations.

We have argued that this loss of impetus arose in part because the Strategy was excessively focused on state institutions and their formal interactions. The inevitable shifting geography of state institutions and departments means that arrangements between departments have a limited lifespan. This highlights the need for regular review, best carried out through collaborative arrangements. It is striking that reviews and evaluations became less frequent as the strategies and implementation plans got more numerous and included ever more proposed actions. This suggests that an effective review is best achieved where there are a limited number of objectives; these objectives need to be re-allocated to different institutions as governance arrangements change, so that responsibility for achieving the objectives can remain clear.

A final conclusion is that while inter-agency protocols are useful, effective systems prevention requires early intervention through person-centred case management. More recent experience in Ireland suggests that voluntary agencies can play a key role in assisting state institutions integrate their services through a case management approach. Notwithstanding Pawson's (2007) concerns about diversionary responses to legislative changes, conferring positive legal rights on citizens and legal obligations on institutions also has a key role to play.

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