

**Help the Aged
Crisis**

Homeless Truths

Challenging the Myths about Older Homeless People

**By Maureen Crane
with contributions by Tony Warnes**

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Forward

Older homeless people are among the most vulnerable in society today. Street homelessness at any age is unacceptable, but to find men and women in their nineties sleeping rough, as we did in this survey, is truly disgraceful.

Yet there is currently little research available which describes their needs or can guide our responses in helping them into safe and secure housing. Furthermore, no reliable figures are available which can tell us the extent of the problem. This report seeks to begin to fill the gap. That it is a joint project between an older people's and a homelessness charity demonstrates a commitment to work for a more complete understanding of this group.

This report is intended to stimulate informed debate and help shape effective services to ensure older homeless people across the UK are given the help they need.

The author specialises in research on older homeless people, and indeed this report benefits from being able to draw on her recent work towards a doctoral thesis. In addition, we have asked her specifically to look at the extent of the problem, to identify features specific to older homeless people, and to identify examples of existing good practice.

In producing this report we have attempted to draw together a number of threads and take a much needed overview, all of which will be useful in guiding a practical response. Getting to the heart of the problem has involved challenging existing stereotypes, and indeed some surprising facts have emerged.

We welcome the report which is a valuable and timely reminder of what needs to be tackled.

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Summary

Homelessness is a problem which affects older people as well as younger people. This report focuses on older people who are homeless. Its aim is to improve our understanding of this group with a view to developing appropriate policies and effective services. The report discusses the distinct problems and needs of older homeless people, the prevalence of homelessness among older people, and the types of services which are needed, drawing on examples of good practice. It combines the results of new investigations by the main author, with material from her doctoral study of 225 homeless people over the age of 55 years in four cities. These are some of the facts which emerge from the research:

Circumstances and problems of the older homeless respondents

- **Significant numbers** of homeless people are over 55. Some have been homeless for many years.
- Over one-half of respondents reported **broken or disturbed childhood homes**. For some, this was the start of their homelessness.
- Many older homeless people are **isolated**. Those surveyed had no contact with their families nor with services. Seventy per cent of those sleeping rough stayed in isolated and hidden spots.
- **Mental illness** featured strongly, particularly among the women and those sleeping rough. Two-thirds reported or demonstrated current mental health problems, but many were receiving no treatment.
- **Transience** was a minority characteristic. Over 75 per cent of women and 50 per cent of men had remained in one town since becoming homeless.
- **Heavy drinking** was not a problem for many respondents in the study, and was rare among women. Only one-tenth of the women and two-fifths of the men were regular drinkers.
- **The respondents' histories prior to homelessness were diverse**. Some had married and worked, and had become homeless for the first time in later life. Others had experienced a lifetime of unsettled and marginal existence.
- Rarely did a single factor cause homelessness. It was often the outcome of **several stressful events intricately related to psychological and social problems**.
- **Homelessness has various triggers** among the older respondents. The survey found:
 - For the '**lifetime**' homeless, it was triggered by disturbed family homes, and discharge from orphanages or from the armed services.
 - For the '**mid-life**' homeless, triggers included the death of a parent, marital breakdown, and a drift to less secure work and housing by transient workers.
 - For the '**late life**' homeless, it followed widowhood, marital breakdown, retirement and the loss of tied accommodation, and the increasing severity of a mental illness.
- Just over one-half of the respondents who had been resettled **became homeless again because they could not cope at home**. Others stayed on **the streets all night** although they had accommodation.
- With an ageing population, **numbers may rise**. Further, an exacerbation of some of the conditions which were found to be associated with homelessness – such as an earlier history of job insecurity – does not bode well for the future.

Present interventions and services for older homeless people

- **No policies and few local homeless services** are targeted specifically at older homeless people.
- Older homeless people who sleep rough **have unmet health and social problems**, yet **do not use hostels and day centres** because they fear violence and intimidation from younger homeless users.
- Many older homeless people have **lived on the streets or in hostels for years** and have **never been resettled**.
- In cities where help is available, older homeless people with long histories of homelessness **are being successfully rehoused** through an intensive resettlement programme.
- Housing alone **does not** resolve the problem of homelessness. Many older homeless people **need support** once they are rehoused.
- Because they **lack support at home**, some older homeless people who have been rehoused continue to use day centres for homeless people.

Recommendations

Measures need to be taken to identify older people **at risk** and **prevent** homelessness. Vulnerable people may be affected by the breakdown of family and support networks, enforced independent living, and fragmented work patterns.

Specialist outreach workers are needed for older homeless people who are isolated, sleeping rough, and who have unmet health and social needs.

Intensive resettlement programme are needed for older homeless people, including **long-term support** for those who are unable to manage alone.

A range of permanent housing is needed for older homeless people, from independent accommodation with support to small high-care group homes. Direct access accommodation should only be used **as an interim measure**.

Chapter 1

Introduction

1.1 Aims and Purposes and Background to the Study

This report is about a neglected group of older people in Britain, whose problems and needs have rarely been studied and who lack services which are appropriate. Jointly commissioned by Help the Aged and Crisis, this report aims (a) to highlight the fact that homelessness is a problem which can affect older people as well as those who are young, and (b) to help improve our understanding of older homeless people with a view to developing appropriate policies and effective services.

In particular, the we were asked to:

- advise on the circumstances, problems and needs of older homeless people, reporting in particular on features which are distinct amongst this group, and which need to be accounted for in the development of policy and services for homeless people;
- consider the prevalence of homelessness among older people; and
- make recommendations as to the types of services which are needed, and report on examples of good practice.

There is no consensus as to the age that "older" homelessness begins. British studies and housing projects apply variously 50, 55 and 60 years as criteria. A New York study argued that the benchmark was 50 years because homeless men from that age were comparable to the housed population aged ten to twenty years older: they had physical disabilities and health problems, and "psychologically, many viewed their lives as over, and (they) had little sense of the future" (Cohen and Sokolovsky, 1989, p.26). Rigid cut-off points always pose dilemmas, but it is necessary to define the age range. For the purposes of this report, 55 year was considered to be the most appropriate lower age for our sample. By this age, homeless people often have severe health problems, there is little possibility of them returning to work, and their needs in relation to rehabilitation and reintegration within conventional society are similar to people in their 60s and older. Hence, "older" homeless people are defined as those aged 55 years and over.

In preparing this report, the author has drawn heavily on her doctoral thesis which comprises a field study investigating pathways into and through homelessness of people over the age of 55 years in London, Sheffield, Leeds and Manchester. This progressed from her two earlier studies of older homeless people in London (Crane, 1993; 1990). The latest study involved 225 individuals in hostels and other temporary accommodation, at day centres and soup kitchens, and on the streets. It included both long-term and recently homeless people. The data was collected using an "ethnographic" approach - based on lengthy participant observation and intensive interviewing over 15 months - a methodology which has rarely been used in studies of homelessness in Britain.

Additional new work for this report includes interviews with key providers working with older homeless people in London and Leeds, and statistical compilations and digests of the extent of older homelessness and of available services in Glasgow and Liverpool. The work benefits by drawing on the author's extensive experience in mental health nursing and eight years of research with older homeless people.

1.2 Homelessness: an overview

Homelessness is controversial and prompts emotive responses among politicians, the media, service-providers and the public. There is real concern about the situation of homeless people and efforts are made to help and support them. At the same time, homeless people are sometimes publicly attacked. Policy reflects this general ambivalence and is consequently complex. At times homelessness is regarded as criminal or antisocial and produces policies of restraint. Yet again, it is seen as a social welfare and medical problem, which stimulates treatment and rehabilitation programmes. It is also seen as a moral problem, and some religious bodies have developed services with salvation in mind. The complexity of homelessness can be seen in the following section on policies.

1.3 Background to Present Day Policies

Policies and interventions in response to homelessness date back centuries. As early as 1349 the first vagrancy statute aimed to curtail vagrant behaviour through punishment (Chambliss, 1964). But there is also a long history of constructive help. Both the Elizabethan and the *Poor Law Amendment Act* of 1834 made provision for relief of destitute people, and those in need received food and shelter in the casual wards attached to work-houses (Rose, 1988). The *National Assistance Act* of 1948 replaced the *Poor Law*, and policies changed in relation to homelessness. Local authority welfare departments had a duty to provide temporary accommodation for those in "urgent need". At the same time, casual wards became known as Reception Centres, and their responsibility was handed over to the *National Assistance Board* who had a statutory duty to resettle people 'without a settled way of life' (National Assistance Board, 1966, p. 263).

During the late 1960s and early 1970s, rising concern about the growing problem of homelessness led to the setting up of Committees and Working Parties to review housing provision, social services, and the situation of single homeless people (Clapham *et al.*, 1990; Archard, 1979). These construed homelessness as principally a problem of housing shortage, although a national survey of single homeless people at this time highlighted that many such people in Reception Centres, hostels and on the streets, had mental health and alcohol-related problems, and needed support and treatment (Archard, 1979; The Home Office, 1974; National Assistance Board, 1966).

In 1977 the *Housing (Homeless Persons) Act* placed the responsibility for finding secure accommodation for homeless people in "priority need" on local authority housing departments. This responsibility has been maintained in the 1985 and 1996 *Housing Acts* (discussed in next chapter). At the same time, large traditional hostels and Reception Centres (known as Resettlement Units from 1976) which housed large numbers of homeless people, particularly men, were seen to be institutional settings which achieved a low rate of resettlement (Drake, 1989; Eardley, 1989; CHAR (Campaign for the Homeless and Rootless), 1985). In 1980 the *Hostels' Initiative* was launched, and the aim was to close the large traditional hostels or reduce their number of beds, and replace them with smaller, special-needs housing and hostels.

1.4 Recent Policies on Single Homeless People

During the late 1980s the number of single homeless people on the streets in Central London grew rapidly. There was little secure, long-term accommodation for resettling homeless people, and thus the declining number of hostel beds became "blocked" (Spaul and Rowe, 1992; Eardley, 1989). A Social Security reform in the late 1980s exacerbated the situation, as board-and-lodging allowances were replaced by income support and housing benefit. This reduced benefits for those under the age of 25 years, and disqualified altogether those younger than 18 years (Hutson and Liddiard, 1994; Malpass and Murie, 1994). Neither voluntary agencies nor local authorities had the resources to cope with the increase in the number of rough sleepers in London (Department of the Environment (DoE, 1995).

In order to tackle the problem, the *Rough Sleepers' Initiative* (RSI hereafter) was launched by the Government in 1990, with the objective of "making it unnecessary to have to sleep rough in Central London" (DoE, 1995, p. 5). A sum of £96 million was allocated over three years for temporary and permanent accommodation, cold-weather shelters, and out-reach and resettlement workers, to help people sleeping rough in designated areas in London. The RSI was extended with an additional £86 million for a further three years to March 1996, but once

again this was exclusively for people sleeping rough in London (Randall and Brown, 1996). The aim had been to return the responsibility for housing rough sleepers to local authorities after the end of the second phase of the RSI in 1996. The problem of rough sleeping in London had not been resolved, however, and the RSI is to be continued to 1999 (DoE, 1995). It is also now acknowledged that rough sleeping is not just a problem within central London. The RSI has been extended to Bristol and Brighton, and a *Rough Sleepers' Revenue Fund* has been set up to provide services for people sleeping rough in towns and cities such as Manchester, Leicester, Bath, Nottingham, Cambridge and Oxford (DoE, 1996a).

In the late 1980s there was also concern about the increased number of people sleeping rough in Central London who were mentally ill (Craig, 1995). *The Homeless Mentally Ill Initiative*, initiated by the *Mental Health Foundation* and the *Department of Health*, was launched in 1990 and £20 million was made available for accommodation and for out-reach teams to work with mentally-ill homeless people (Craig, 1995). The objective was to provide short-term accommodation whilst resettling clients in conventional or supported housing (Department of Health, 1992). This scheme has recently been extended for another three years (DoE, 1996a).

Until the late 1970s, religious and long-established voluntary sector organisations played a key role in providing shelter and food for homeless people in large hostels and in soup kitchens, alongside the Resettlement Units managed by statutory providers. Since the early 1990s, the provision of resettlement and professional help, by a new generation of "special-needs" agencies, has been encouraged, and there has been decreased provision within large hostels and soup kitchens to "contain" the problem. Specialist outreach teams working on the streets and intensive resettlement programmes have grown. Increased and more appropriate services have undoubtedly developed, but few specifically for older people.

1.5 The Structure of the Report

The following chapter describes the current understanding of older homeless people in a literature review of the small number of specialised studies currently available. Chapter 3 turns to the subject of enumeration, and in observing the inadequacy of current methods of assessment, proposes guidelines for a protocol for assessing the extent of homelessness in a city. Chapter 4 describes the characteristics of the older homeless people who were included in the field study, and in describing their backgrounds, their conditions of health and daily activities, paints a picture of considerable diversity within this group, which challenges many popular assumptions. Chapter 5 concentrates on the in-depth experiences of the homeless individuals in the field study, describing their various pathways into homelessness and their experiences of resettlement. This chapter also looks at conditions prior to homelessness, and at the events which triggered homelessness.

The remaining two chapters deal with meeting the needs of older people. Chapter 6 focuses on current services and interventions, in relation to older people. This chapter also describes a number of schemes which are successfully meeting the needs of older homeless people. These, combined with other material in the report, and drawing on the author's very wide experience, culminate in a series of recommendations in Chapter 7. The recommendations are aimed at prevention, as well as the development of more appropriate services. Action is needed at all levels: national, regional and local; by national and local government departments, and by the voluntary sector. This report illustrates that appropriate action can lead to high rates of success: a joint approach is needed now.

Chapter 2

Understanding Older Homeless People

2.1 Introduction

This chapter describes the current state of knowledge of this comparatively neglected group of older people, drawing particularly on the small number of specialised studies in Britain and America. The chapter focuses on the elusiveness of clear definitions, and the current living arrangements, social contacts, health problems and morale of older homeless people, and on their histories of homelessness.

2.2 Defining older homelessness

There is no single definition of homelessness (Rossi *et al*, 1987). It is defined in different ways by policy-makers, service-providers, academic researchers, the media and the public. This inconsistency produces varying estimates of the scale of the problem. Some studies and initiatives concentrate on people who are literally “roofless” and sleeping rough, others include people in temporary accommodation such as hostels and night-shelters, and in insecure housing such as lodgings and digs. In Britain, homeless people are seen as either those who come within the statutory definition (and local authority statistics) or those who are homeless but who are not officially recorded as such.

The United Kingdom Statutory Definition of Homelessness

As defined by the *Housing Act 1985* (Sections 58(2) and 58(3)), a person is homeless if, “there is no accommodation which he, together with any other person who normally resides with him as a member of his family, (is entitled to occupy) by virtue of an interest in it or by virtue of an order of a court, or has an express or implied licence to occupy”; or if a person has accommodation but “cannot secure entry to it, or it is probable that occupation of it will lead to violence from some other person residing in it,... or it consists of a movable structure, vehicle or vessel designed or adapted for human habitation” and there is nowhere permissible to place it. A person is threatened with homelessness if “it is likely that he will become homeless within 28 days” (Section 58(4)). This definition has been maintained in the *Housing Act 1996*.

Statutory duties are imposed upon local authorities to house groups of people who are considered to be homeless or at risk of homelessness, provided that they are in “priority need”, and they have not made themselves intentionally homeless (*Housing Act, 1985*, Section 65(2)). Those in “priority need” include people with dependent children; pregnant women; people who become homeless following a fire, flood or similar emergency; and those who are vulnerable because of old age, mental illness, or physical disability. Hence, older homeless people are one of the priority groups. If an unintentionally homeless person in priority need does not have a “local connection”, then the local authority has an interim duty to accommodate that person but can refer the application to another local council (*Housing Act, 1985*, Sections 63 and 97).

The DoE's *Homelessness Code of Guidance* (1994, Sec 6.9, p.24) advises local authorities to look not just at whether people are old, but at the extent to which their age has made it hard for them to fend for themselves. There is no guidance or consensus as to an age at which people become vulnerable and in priority need (Wilson, 1995; Niner 1989). Some local authority housing departments accept men and women aged 60 years and over, whilst others only accept men aged at least 65 years.

Unofficial or “single” homelessness

Some homeless people are not officially recognised as being homeless. They include people who have never approached local authority housing departments, and others who have applied for rehousing but have been rejected. They are accommodated by relatives or friends, stay in hostels and night-shelters, or sleep rough. Although older people as a priority group should not fall into this category, there are many who do sleep rough or live mostly in hostels and temporary shelters.

Older people sleeping rough

Sleeping rough describes sleeping at night on the streets, in doorways (usually in town centres) and in railway stations, bus terminals, parks, subways, abandoned buildings and any accessible but unconventional and inappropriate setting (Baxter and Hopper, 1981). In New York, the hundreds who sleep in abandoned railway tunnels deep under Manhattan have been called the *mole people*. In Britain, there are older homeless people sleeping on the streets, in parks, and in derelict buildings. Some “rough-sleeper” older homeless people do not “bed down” at night but roam the streets or travel on buses, and sleep during the day in libraries and other public facilities (Crane, 1993).

Vagrancy has been associated with homelessness in Britain since at least AD368, and describes an unsettled or wandering lifestyle, sleeping in the open or unconventional setting (formerly often barns), and destitution and begging (Home Office, 1974; Ribton Turner, 1887). Many older people who sleep rough do not demonstrate vagrancy, but instead remain in one town and sometimes at one site for years.

Older people in hostels and temporary shelters

The DoE's *Code of Guidance* accepts that bed-and-breakfast hotels, direct-access hostels and night-shelters “are not designed to be lived in long-term” and that people in such accommodation are homeless (Sec 5.8c). Yet in some British towns, many older people live in hostels, hotels and night-shelters, and some have done so for years and never been rehoused. In February 1996, a survey of 49 direct-access hostels in London found 362 hostel residents were over 60 years of age (Harrison, 1996).

Older people staying in hostels, hotels, and temporary shelters have no control or rights over their accommodation. They normally have no written tenancy agreement, but only a licence to stay which can be revoked at any time. In one London hostel, the written licence to stay can be revoked after 28 days or less, “provided that the period specified is reasonable in the circumstances”. In effect residents can be evicted immediately and peremptorily if their behaviour is deemed inappropriate. They have limited control over their facilities, rules dictate how they behave, and they are sometimes forced to share rooms (as in dormitories). Some hostels and night-shelters require the residents (including older people) to vacate the premises during the day.

Apparently homeless older people

Some older people have conventional housing but regularly congregate with homeless people and present themselves at soup kitchens, street handouts and day centres. They are on the streets for long periods, some through the night, and go home rarely or for just a few hours. The majority have experienced true “rooflessness” and, although rehoused, continue “homelessness behaviour”. Many are isolated, lonely and vulnerable, have mental health or alcohol problems, and experience difficulties in coping alone at home. Although they have been resettled, they have not acquired conventional social roles and relationships. Their response indicates the complexity of their problems and that they go far beyond a simple lack of housing.

2.3 Working towards a more complete understanding

Homelessness is often therefore a manifestation of complex underlying problems. It has been associated with “disaffiliation” or estrangement from conventional social and work roles: “when the web (of human relationships) is shredded...a person is homeless even if he or she has an anonymous room” (Caplow *et al*, 1968; Harrington, 1984, p.101). Homeless older people are often isolated from their families and relatives, they seldom work or participate in community groups, and have few social roles. But most homeless people were once affiliated and had conventional social roles. Some have owned property or sustained tenancies, many have maintained employment, and some have married and brought up children. In many cases, homelessness is a radical change in their circumstances, and one which severs their connections within society.

To understand older homeless people's circumstances and needs, we must consider rough sleepers, those in hostels, those and those in secure accommodation and conventional homes, but who nonetheless show homelessness behaviour.

2.4 Literature review

British studies

Several 1960s and 1970s surveys of people sleeping rough and living in hostels and resettlement units produced similar findings (Digby, 1976; Lodge Patch, 1971; Crossley and Denmark, 1969; National Assistance Board, 1966). The majority of older homeless people were men; approximately two-thirds were single and most others divorced or separated; most were unemployed or working in unskilled jobs; the majority either had no living relatives or they were estranged from their families; one-quarter to one-half had histories of mental illness; and one-fifth were heavy drinkers.

An early British study to concentrate on older homeless people was based on 55 men who used a night-shelter in Plymouth (Blacher, 1983). It showed that most men were single and had physical health problems, over two-fifths were heavy drinkers, and that the majority had worked in unskilled or semi-skilled jobs as kitchen porters, labourers or merchant seamen. Some were long-term residents of the night-shelter, but others left after one or two nights without indicating their destination.

More recent reports have investigated the health and accommodation needs of homeless people aged over 50 years in London, the characteristics of older homeless people in contact with local authorities in four areas of Scotland, and service provision in Britain, Sweden, Denmark and America for this group (Wilson, 1995; Lipmann, 1995; Kelling, 1991). The Scottish study found the majority to be less than 65 years of age, and that many were living in secure accommodation or with adult children, with only a few living in hostels or sleeping rough. Marital breakdown was a common reason for homelessness; others included family disputes between older people and their children; eviction from privately-rented accommodation; and the loss of tied accommodation on retirement (Wilson, 1995).

The only British study which has collected in-depth information about older homeless people who are sleeping rough was by the main author of this report in the early 1990s (Crane, 1993). This exploratory study interviewed 54 older homeless men and 21 older homeless women who were sleeping on the streets in London. Another 55 people either refused to be interviewed or could not provide information because of severe mental health problems. A quarter of the respondents were aged at least 70 years, a majority had physical health problems, and many, particularly women, had mental health problems. The men presented as depressed, whereas the women were more commonly psychotic, deluded or had severe memory problems. Many respondents slept in hidden places and were not in touch with either their families or services. These findings are comparable to those of American investigations which also report that older homeless people tend to be isolated and hidden, they are not in contact with their relatives, and they have high rates of mental illness, which are particularly severe among older homeless women (Gelberg *et al.*, 1990; Douglass *et al*, 1988; Rossi *et al.*, 1986).

Many of the older rough sleepers in London could not say how long they had been homeless (Crane, 1993). Ten had been sleeping rough for less than one year, and fourteen for more than five years. The majority had once been owner-occupiers or had had secure tenancies: some had been evicted and others had abandoned their accommodation. The dominant expressed reasons for becoming homeless were widowhood, marital breakdown, eviction, redundancy and mental illness (Crane, 1993). Another study of 73 homeless ex-servicemen in London, including 45 who were aged over 50 years, found a connection between discharge from the armed forces and homelessness. Two-fifths of the respondents had never settled after being discharged (Randall and Brown, 1994).

Older people have also been included in British studies which have examined the health needs of homeless people. Physical health problems are much worse among the homeless than domiciled older people. Common problems include respiratory conditions, tuberculosis, hypertension, arthritis, oedema and peripheral vascular disease, gastrointestinal complaints, alcohol-related problems, and trauma. Poor health is exacerbated by dire living conditions, hazardous lifestyles and the decreased physiological reserves of advanced age. Malnutrition, inadequate clothing and shelter, prolonged standing, walking and exposure, and unhygienic and unsanitary habits all contribute. In London, high rates of active tuberculosis have recently been reported among homeless people, the most vulnerable being middle-aged and older rough-sleepers, hostel clients and heavy drinkers (Citron et al 1995). Of 114 homeless people over the age of 60 years, five percent were found to have active tuberculosis.

Few older homeless people are registered with a general practitioner and they are often reluctant to seek health care (Kelling, 1991; Williams and Allen, 1989). Mortality rates among homeless people are high. The average age of death of homeless people is reported variously at 42 to 51 years of age (Grenier, 1996; Keyes and Kennedy, 1992; Wright, 1989). This implies that many long-term homeless people die before they reach old age, and that older homeless people are either a minority of survivors or those who become homeless late in life.

Recent American studies

Since the early 1980s, the most penetrating and influential investigations of older homeless men have been in New York City (Cohen and Sokolovsky, 1980, 1983, 1989). The respondents had been homeless from a few days to many years. Several traits of their lives were shared, including disrupted childhoods, poor education, low-skilled jobs such as casual labouring, moderate to heavy alcohol consumption, mental and physical health problems which prevented employment, and emotional distress following widowhood or relationship breakdown.

Two further studies of older homeless people carried out in Chicago demonstrated that mental illness, the loss of family support and poor coping skills at home were often the reasons why people first became homeless in later life (Kutza 1987; Keigher et al, 1989).

2.5 Summary

There is insufficient information about older homeless people in Britain, for only a few mostly small-scale and short-term studies have, so far, been carried out. The evidence is poor on the extent of homelessness among older people, and on their histories of homelessness and present circumstances and needs. From the few studies which have been conducted it is possible to form hypotheses about common characteristics and antecedents: older homeless people are often isolated and estranged from their family and they have high rates of mental and physical illness. No work has been done which compares those who have been homeless for years and those who first became homeless in later life.

Homelessness is a complex phenomenon and homeless people are difficult to study, to assess and to understand. As the following chapters show, however, they can and are being helped. However, our support and rehabilitation work would be more effective if we took more trouble to understand the problems that have led to their current circumstances.

Chapter 3

Assessing the Extent of Older Homelessness

3.1 Introduction

Older homeless people are one of the most difficult groups to enumerate. Those who sleep rough are often not known to “officialdom”: they are not on electoral rolls, many are not in receipt of benefits and therefore are unknown to Social Security; they are often not registered with a general practitioner; and they are unknown to local authority housing and social services departments. They are often not in contact with their immediate family or other relatives, and they are socially isolated. Because of the fear of danger and harassment, some older homeless people “live” in hidden locations, such as sheds and cellars, which are inaccessible even to agencies who help and support homeless people. They are therefore an isolated group even in relation to other homeless people.

The paucity of data and the consequential lack of knowledge about older homeless people creates a vacuum within which stereotypes develop. Misconceptions may then lead to inappropriate responses from policy-makers and helping agencies. In order for the response to the problem to be pertinent, it is important that reliable good-quality data is available about the extent of older homelessness, and the circumstances and needs of the client group. One of the aims of this report is to begin to develop a method of enumeration which informs *Help the Aged* and *Crisis*, as well as other interested groups and individuals, about the scale of the problem of older homelessness, and enables them to make appropriate responses with regard to policy-making and service-development.

3.2 Present ways of enumerating homeless people

Because of the problems referred to above, only partial figures exist of the number of older homeless people in British cities and towns and they are an extremely unreliable guide to the actual numbers. At present, information available is obtained through three main sources.

Statistics of households officially accepted as being homeless

The DoE collects quarterly statistics from local authority housing departments of the number of households who are officially accepted as being homeless, including those who are in priority need because of old age. The statistics indicate that from 1991 to 1995, between 5,800 and 6,200 households each year were accepted as being homeless on the grounds of old age - around 4.5 per cent of all acceptances (DoE, 1996b). These totals, however, exclude older homeless people who are sleeping rough, and those in hostels and who have not approached local authorities and applied for rehousing. These figures have other shortcomings. The DoE had a non-response rate of 7 per cent from local authorities for their figures for the third quarter of 1996, and hence they had to estimate the number of households accepted as being homeless for 24 out of 358 local authorities (DoE, 1996b). This included 4 of 14 Inner London boroughs. Furthermore, the figures are flawed because there is no consistent eligible age criterion (Wilson, 1995; Niner, 1989).

Counts of people sleeping rough

Attempts have been made to enumerate homeless people who are sleeping rough, but the extent and frequency of such counts vary between locations. The 1991 Official Census included a count of people sleeping rough, although its accuracy has since been questioned. For example, no people were found sleeping rough in Birmingham yet local agencies were aware of regular rough sleepers (Randall, 1992). Six-monthly street counts of homeless people sleeping rough in London are conducted through *Homeless Network*. In May 1996, a reported 54 people aged 50 to 59 years, and 29 people over the age of 60 years, were sleeping rough (*Homeless Network*, 1996). This count excluded 25 rough sleepers whose age was not known, and it only included designated areas of Central London, the City, and East End. Although counts of people sleeping rough are regularly conducted in Central London, this is not necessarily the case in other towns and cities.

One of the main problems of counting rough sleepers, particularly those in the older age groups, is finding them. For safety reasons, enumerators tend not to search in dangerous or inaccessible places. The six-monthly street counts in London do not attempt to include people sleeping rough in parks, basements, or other inaccessible areas (Homeless Network, 1996). Yet an inaccessible spot is often the place where older homeless people “hide”. In Glasgow, for example, an older homeless man was known to sleep in a rubbish skip. Older homeless people therefore are highly likely to be missed during counts of rough sleepers.

Records by service-providers

The types of records which service-providers keep about homeless people vary greatly. Hostels tend to have up-to-date records of their residents, and they are generally able to provide details of older homeless residents, their age, and their date of admission. These figures are not forwarded, however, to the DoE and collated with the statistics on statutory homeless people. Many day centres and soup kitchens do not maintain lists of users, and the staff are sometimes unaware of the number of older users, and whether they are staying in hostels, sleeping rough, or whether they are housed. Attempting to enumerate older homeless people through day centres and soup kitchens is further complicated by the fact that some move around centres, and duplication may occur.

3.3 The Complexity of Enumerating Homeless People

Besides a lack of reliable information about the number of people who are homeless, further complexities arise. Apart from the DoE which collects quarterly statistics and the *Homeless Network Street Monitor* which is conducted in London every six months, most counts provide only a snapshot (one-night) figure of the number of people who are sleeping rough and few penetrate the full extent and nature of the problem. The number of homeless people and the number on the street in any area can fluctuate seasonally and from night to night. A survey on one night might mislead as to the “average” scale of the problem in a city. There are many “entries” and “exits” during one month, and a few people shuttle in and out of homelessness. During one year, the *Over Fifty-Fives Accommodation Project*, in Leeds, received referrals for 87 new older clients who were homeless or threatened with homelessness (see Chapter 7). Similarly, at the local authority men’s direct-access hostel in Liverpool, 78 men over the age of 55 years were resettled over eleven months from January 1996. The majority of these men were new clients.

The importance of assessing an “average” scale of the extent of homelessness in a city is further indicated because some older homeless people alternate between hostels and sleeping rough, whilst others move between towns. For example, at a men’s hostel in Liverpool, only four men aged over 55 years were resident on 4th December, 1996, but 50 men of that age were discharged from the hostel between January and November 1996. Nearly one-half (24 men) had not been resettled when they left the hostel, but had either moved to another hostel or their destination was unknown. Similarly, at a women’s hostel in Liverpool, 13 women over the age of 50 years were resident on 30th December, 1996, but in that year 28 women in that age group had been admitted to the hostel and discharged. The destination of 17 of these women was unknown. An assessment of the scale of homelessness is therefore most useful when it describes the “turnover” or flow of cases over a period. “Flow data” enables transition patterns to be identified and it begins to allow estimates to be made of the requirement for rehabilitation and intensive support, as recent American investigations demonstrate (Burt, 1995; Link et al, 1995; Culhane et al, 1994).

This report offers a suggested basis for the development of a system of enumeration. There follows an account of an attempt which was made by the author to assess the number of homeless people in Glasgow during early January 1997, followed by a description of the model which was used.

3.4 The Scale of Older Homelessness in Glasgow

The complexities of enumerating older homeless people are demonstrated in this section using Glasgow as an example. Neither the number of homeless people aged over 55 years in Glasgow nor the “flow” of entrants to and exits from that state is precisely known, although David Wilson (1995) has published a substantial review of the available statistics. He found that 74 homeless older people were permanently housed each year from 1991/92 to 1993/94 by Glasgow City Council.¹ One complication, which occurs in any large conurbation and for any study of incidence and prevalence, is that the metropolitan area is governed by several local authorities. All parts of the city will “generate” homeless people, but hostels and services for homeless people are often in the central areas. In order to examine the extent of older homelessness seven days were spent in Glasgow in early January 1997 during which services working with homeless people were visited or contacted.

Information was available about the number of older statutory homeless people in Glasgow who are housed through the emergency procedures each year. This was easily obtained by contacting the *Hamish Allen Centre* which acts as a central emergency service for statutory homeless people. The total number of older homeless people (aged over 55 years) housed through this source during 1996 was 86 (65 males and 21 females) (Glasgow City Housing (GCH), personal communication). These figures excluded older homeless people who were rehoused by the local authority but who did not pass through the emergency service. But there was no “central agency” which could provide information about the number of older people in hostels who were non-statutorily homeless. This could only be obtained by contacting or visiting each hostel and collating statistics. A collation of numbers from six direct-access and temporary hostels and two “welfare hotels” for homeless people in Greater Glasgow during the first week in January found that approximately 252 residents were over the age of 55 years. Only eleven were female. These eight hostels offered 653 beds which means that approximately two-fifths of the residents were over 55 years.

There were seven comparable local authority hostels. Information about the number of older residents could once again be easily obtained through the *Hamish Allen Centre*. The hostels had a total of 1,186 beds, and in January 1997 a third of the residents (359 men and 30 women) were aged over 55 years (GCH; Glasgow Council for Single Homeless, 1996). The approximate older hostel population in Glasgow in early January 1997 was therefore 600 males and 41 females. This represented 35 per cent of the overall hostel population. Although some of the older people who were in local authority hostels would appear in the statutory homeless figures, nevertheless it demonstrates that a very high number of older homeless people are “non-statutory homeless” and do not appear in official statistics.

The number of people over the age of 55 years who are sleeping rough in Glasgow is not known. No agencies were able to provide this information. They believe, however, that homeless people (of all ages) sleeping rough have moved into hidden sites on the outskirts of the city and tend not to sleep in the city centre. Around 12 older rough sleepers are reported to use day and evening centres, but it is not known whether there is a “hidden” population of elderly rough sleepers. As mentioned earlier, one elderly man is known by a hostel worker to sleep in a rubbish skip.

“Round number estimates” can be mischievous but they are useful in indicating the scale of the task of coping with elderly homelessness in the City of Glasgow. A minimum number for the homeless population aged over 55 years can be assumed to be 750, so the consistent annual rate of accommodation in permanent housing achieved by the Housing Department offers a better future for one-in-ten. Neighbouring local authorities provide a few additional housing opportunities.

Two other factors are relevant to this assessment of the extent of older homelessness in Glasgow. First, some older people have been “resident” in hostels for years. Information was provided about the duration of residence of the older residents in the local authority hostels. Of the 359 males, 182 (51 per cent) have been resident for at least five years, and 67 (19 per cent) for less than six months. Among the 30 women, one-third have been resident for more than five years, and 8 for less than six months. The non-local authority hostels and the “welfare hotels” reported that some older people had been resident for more than thirty years.

¹ In addition 16 were rehoused each year by Renfrew District Council, and 5 by Monklands District Council (Wilson, 1995, Table 1).

Secondly, there is evidence of a transient older homeless population: the *Talbot Association: Bishopbriggs* facility to the north of the City discharged 76 men aged over 55 years during the nine months from 18th March to 22nd December 1996. Of these, 41 (54 per cent) stayed less than one week.²

The above synthesis was able to be achieved following seven days in the city visiting the hostels and statutory and voluntary agencies, through subsequent correspondence and telephone calls, and through the help of several people who gave their scarce time to producing these most valuable figures.

3.5 A Guideline for Enumerating Homeless People

A full evaluation clearly requires more than a short foray in a given location. But this report offers a suggested basis for the development of a system of enumeration. Obtaining a more accurate picture of the extent of older homelessness in a town or city requires details of older people who are:

- Registered as homeless with local authority housing departments;
- Resident in hostels, night-shelters, bed-and-breakfast hotels, and other temporary accommodation but not registered with local authority housing departments;
- Sleeping rough and using soup kitchens and day centres for homeless people; and
- Sleeping rough, isolated, and not accessing services.

Information about the first two groups can be collected directly from the providers. It is more difficult to obtain details about older homeless people who are sleeping rough, and it has to be built up from counts of users at day centres and soup kitchens, and observations and interviews. For those who sleep rough but do not use day centres, information should be sought from

- out-reach teams and soup runs who work on the streets;
- local people with relevant knowledge, for example the police, staff at bus and railway stations, toilet attendants, newspaper vendors, and cafe staff;
- homeless people who are sometimes aware of the existence of isolated homeless people; and
- observations on the streets, at railway stations, and in libraries, betting shops and places where older homeless people congregate.

Information should be obtained about (i) the number of older homeless people in a town or city on a single night and, *more importantly*, (ii) the number who are homeless in the location over a period, for example a year. Although this latter information will be extremely difficult to collect for those who sleep rough, it is available for those who are statutory homeless and is often available for non-statutory homeless people who use hostels and temporary accommodation. Although duplication may occur if older people book into more than one hostel in a city, this can be managed by collating the first three letters of surnames of residents and their dates of birth. In this way confidentiality would not be breached.

3.6 Summary

This chapter has highlighted the complexity of estimating the extent of older homelessness within a particular town or city, let alone the country as a whole. Without a large and detailed inquiry (which is beyond the scope of the current work), no accurate figure can be deduced about the number of older homeless people in a town or city. Through the visits to Liverpool and Glasgow (described above) however, it has been proved that even in a short time it is possible to collect more reliable figures on the numbers of homeless people than are currently being collected. It has also shown that the figures available for the number of statutory homeless people are only the “tip of the iceberg”, and that older homelessness is a much

² The former Resettlement Unit. Information from Mr J.Stevenson of The Talbot Association.

more extensive problem. But assessing the problem of homelessness in a town or city does *not* only involve enumerating older homeless people on a single night. More importantly, the problem needs to be examined over a period. The scale of homelessness is also affected by the availability of local services for homeless people, and their effectiveness in resettlement and in preventing relapses into homelessness. Such information must supplement enumerations.

Chapter 4

The Characteristics of older homeless people

4.1 Introduction

This chapter synthesises the characteristics of older homeless people found in the author's 1994/95 field study of 159 men and 66 women aged over 55 years in London, Sheffield, Leeds and Manchester. The sample was of people who were homeless or who displayed "homelessness behaviours", ie. they used soup kitchens and day centres, and congregated with homeless people (see Chapter 2). It is impossible to design a representative sample survey. Many studies of homeless people concentrate on the more accessible individuals in hostels and who use soup kitchens and day centres. This study was keen to collect information about *all* older homeless people, including those who sleep rough and avoid services. Conventional sampling methods are inappropriate because homeless people fail to appear on official registers and have "no fixed address". Therefore the sample was constructed through contacts "on the streets", in hostels and at day centres and soup kitchens. Most street contacts were in London and Manchester and involved many hours intensive field observation and tenacious inquiries to the staff of homeless services and to the police, railway station staff, newspaper-sellers and in cafes. The sample is one of "convenience" despite the difficulty of its compilation. Although the following profiles describe the most disadvantaged and disconnected older homeless people, no claim for statistical representation is made.

In all four cities, there are hostels and facilities for homeless people. After permission to talk to the older clients was obtained, several meetings were sometimes required to gain the subjects' trust before requests for interviews were explicitly made. Some respondents were inarticulate or incomprehensible and several interviews were necessary to collect all or a large proportion of the requested information. Furthermore, some were unable to provide reliable information, and information could rarely be checked with other sources. Of the 225 respondents, 145 were contacted in London, 34 in Leeds, 32 in Sheffield, and 14 in Manchester. A total of 123 men and 50 women were homeless and 52 respondents lived in secure accommodation (Table 4.1). All but nine of those in "secure" accommodation had been homeless.

Table 4.1 Present accommodation of respondents

Accommodation	Males		Females		Total	
	No.	%	No.	%	No.	%
Sleeping rough	49	31	22	33	71	32
In temporary accommodation ³	74	46	28	42	102	45
In secure accommodation	36	23	16	24	52	23
Total	159	100	66	99	225	100

Notes: The respondents are those interviewed during 1994-95 in London, Sheffield, Leeds and Manchester as part of the doctoral research by the author. This applies to all tables unless otherwise specified.

³ Includes hostels, night-shelters, squats, and bed and breakfast hotels.

Table 4.2 Age (reported⁴ and estimated⁵) of the respondents

Age group (years)	Males			Females			Total	
	No.	%	Ratio ⁶	No.	%	Ratio ⁷	No.	%
55-64	77	48	1.1	20	30	0.7	97	43
65-74	72	45	1.0	32	49	1.1	104	46
75+	10	6	0.5	14	21	1.9	24	11
Total	159	99		66	100		225	100

Of those who were homeless, one-third of men and women slept rough while the remainder stayed in hostels, night-shelters and resettlement units,⁸ and a minority in bed-and-breakfast hotels. Seventy per cent of those who slept rough stayed at night in isolated and hidden places, such as cellars, sheds and woods. Some assiduously concealed their existence: one man slept in an abandoned warehouse; and one lady aged 80 years slept in the coal-cellar of an uninhabited house. Others slept on the pavements of busy streets and were easily visible, and a minority wandered around at night and did not “bed down”.

Age, place of birth and marital status

Twenty-one respondents refused to state their age and five were unable to recall their age or date of birth. The ages of these 26 respondents were estimated in three broad age bands (Table 4.3). The average age of the men was lower than that of the women. Eight men and ten women who were sleeping rough were over the age of 70 years, including two respondents who were over 90 years of age.

Table 4.3 Comparison between the marital status of the respondents in this study and the older population of England and Wales in 1991 (%)

Marital status	Males		Females	
	This study	General population ⁹	This study	General population ¹⁰
Single/never married	59	7	39	8
Married ¹¹	9	76	27	51
Widowed	9	12	11	37
Divorced	24	5	23	5

Just under two-thirds of the men and the women were born in England or Wales. A distinctive feature however is that one-third of the men were natives of Ireland and Scotland. Irish women were almost as prevalent as Irish men, but there were relatively few Scottish-born females. On the other hand, although the numbers are small, 13 per cent of the women were born outside the British Isles, more than three times the male representation. Nearly one in ten of the women were born in continental Europe.

Nearly all the respondents were single, divorced or separated and no men and only one women was married. One in ten men and women were widowed. Women were more likely to have been married, whereas men tended to have remained single (or at least did not report a previous marriage). Three-fifths of the men were single and one-third divorced or separated,

⁴ Age reported by 199 respondents.

⁵ Age of 26 respondents estimated.

⁶ Ratio of percentage for the sex to the percentage for the entire sample.

⁷ Ratio of percentage for the sex to the percentage for the entire sample.

⁸ Resettlement Units (former Reception Centres) are defined and discussed in Chapter 1 above.

⁹ Calculated from 1991 Census estimate of 5,748,161 men in England and Wales aged 55 years and over (OPCS, 1993: Sex, Age and Marital Status, Table 1).

¹⁰ Calculated from 1991 Census estimates of 7,421,496 women in England and Wales aged 55 years and over (OPCS, 1993: Sex, Age and Marital Status, Table 1).

¹¹ Includes people who are separated. Although this study distinguished between those who are married yet separated, only the legal status is available from the Census data.

whereas two-fifths of the women were single and nearly one-half divorced or separated. This breakdown contrasts greatly with the marital status of older people in England and Wales, since the 1991 Census found that only ten per cent of those aged over 55 years were single and only five per cent were divorced (Table 4.3).

4.2 The Backgrounds of the Older Respondents

Childhood backgrounds

A total of 158 subjects described their childhood, and 58 per cent reported broken or disturbed homes. One-fifth had been separated from both their natural parents through death or desertion by the age of 16 and been brought up by relatives, foster parents or in orphanages. A minority had themselves left home so young because of family conflicts. Another quarter had been separated from one parent through death or marital breakdown. Others grew up with both parents but recalled disturbed childhood homes: either their fathers drank heavily and were physically violent towards their mothers, or one parent was adulterous. A few reported sexual abuse by relatives.

Marital and family backgrounds

Sixty-two men and 32 women had married and 14 more than once. Twenty-one men and three women had cohabited but never married. Eighty-nine respondents recalled the duration of their first marriage or cohabitation, and there was great variation, from less than five years for 15 respondents, to over 15 years for another 35 respondents. Fifty-nine men and 29 women reported that they had had children, including two women who had adopted children and two men who had helped bring up a partner's children. Only 12 men and nine women had brought up their children to 16 years of age, for most had left them as minors, usually through marital breakdown. Most had had little or no subsequent contact with their children.

Occupational backgrounds

Of the 139 men who gave details of their occupational histories (these details were not established for 20 men), just over two-fifths had been consistently employed until at least 50 years of age. One-half had worked regularly or had been in the armed forces until middle age, and had since worked casually and been only intermittently employed. Only a minority (eight per cent) had been unemployed throughout their working lives, mostly men with psychiatric problems. Apart from those who had been in the armed forces or unemployed, three-quarters of the men had been unskilled or semi-skilled workers, often as building labourers, road-diggers and factory hands. Among the 42 women who gave appropriate information (the details not being established for 24), one-third had usually worked until 50 years of age. Others had worked intermittently, been engaged in raising children, or had been mainly unemployed.

Experiences in the armed forces and merchant navy

Of the 150 men who provided details, 69 per cent had been in the armed forces or merchant navy. Most had joined before the age of 18 (all had been liable to conscription; only those aged over 69 years for service during the Second World War). One-tenth reported ineligibility or rejection on health grounds. Of those who served, two-thirds had been exclusively in the army, one-tenth exclusively in the merchant navy, and nearly one in ten in both these services. Fewer (15 per cent) had been in the Royal Air Force or the Royal Navy. One-third had been discharged within three years, yet 23 per cent had served for at least ten years, including 14 per cent who had served for more than 15 years. One in five women (eight out of a total of 49) had been in the armed forces.

The armed forces or merchant navy had had a strong impact on many of the men's lives. Several with long-term service had settled for the institutionalised and rootless barrack or sailor's life. They had neither married nor formed stable adult relationships, or, if married, had for long periods been an absent spouse having little contact with their children and extended families. Their childhood experiences, which for many were pathological or poor, may have

pre-disposed them to the camaraderie of service life. Three-tenths who had seen active service (28 of 94 who provided details) had experienced horrific events which had had a profound or enduring destabilising effect. Three had been held and tortured in Japanese prisoner-of-war camps for up to four years, and still became extremely distressed when recounting the experience during interview. Others described the fear and horror of being under attack or when they or their comrades were badly injured. Others described their revulsion of killing the enemy.

Mental health problems prior to homelessness

Women were more likely than men to admit past mental health problems. Of 175 respondents, 41 per cent reported mental health problems before they became homeless. Nearly one-half of the women and just over one-quarter of the men reported having received psychiatric treatment, with 35 per cent of the women and 20 per cent men receiving it as inpatients. Three respondents said they had been patients in psychiatric hospitals for more than ten years.

4.3 Current Circumstances of the Older Respondents

Contact with family

The majority of respondents lacked family or were estranged from their relatives (Table 4.4). Most said their parents had died; over one-tenth had never had brothers or sisters, and most others had had no contact with their siblings for years. Among those who gave the appropriate details 17 per cent had no parent, child, brother or sister alive. For the rest, many who had been married or who had partners were widowed or separated: nearly two-thirds had had no contact for more than 15 years. Only two estranged men had remained in contact with their spouse. Of 88 subjects who had had children, 56 per cent had had no contact with them for over five years. Women were more likely than men to have kept in touch with their children. Of those who provided details, one-half of the women had been in contact with at least one child during the past year, which compares with only one-quarter of the men.

In summary, 17 per cent had no living parents, children or siblings, but 27 per cent had seen a close relative within the past five years. The remainder believed that they had at least one living relative but had had no contact for at least five years. It should be remembered that some who experienced relationship difficulties or traumas may deny the existence of relatives and children, while others might have wistfully claimed contacts with children. Despite these uncertainties, the findings demonstrate that estrangement from family and relatives is common. Compared with a nationwide survey of older people, the respondents were much less likely to be in contact with their relatives (Bennett et al, 1996 Table 6.39).

Table 4.4 Contact with family and relatives¹²

Existence of relatives and most recent contact	Males			Females			Total	
	No.	%	Ratio ¹³	No.	%	Ratio ¹⁴	No.	%
Within past year	22	16	0.8	13	28	1.5	35	19
1-5 years ago	12	9	1.1	2	4	0.5	14	8
Over 5 years ago	79	58	1.0	23	50	0.9	102	56
No living relative	23	17	1.0	8	17	1.0	31	17
Total known	136	100		46	99		182	100
Not known	23			20			43	
Total respondents	159			66			225	

¹² Parents, children, brothers and sisters.

¹³ Ratio as a percentage for the sex to the percentage for the entire sample.

¹⁴ Ratio as a percentage for the sex to the percentage for the entire sample.

Present mental health

The intensive field survey did not collect medical histories or assess physical health problems, but information was collected about reported and observed mental health problems. Some described mental illness or “bad nerves” and psychiatric treatment, but for others, mental health problems were observed although not reported. Several respondents were interviewed on only one or two occasions, making it difficult to identify their problems, while others may have either “concealed” and denied mental health problems or deliberately behaved bizarrely to deter contact. One man was interviewed on ten occasions, each of which he was very deluded and unable to provide realistic information. One woman repeatedly referred delusionally to death, giants and space, describing “monsters with machinery inside them which are sending out laser rays to attack me.”

Just under a tenth of respondents were receiving treatment for a mental illness, and a similar number admitted that they were depressed but having no treatment (Table 4.5). One-third denied having any problem, an assertion which was not controverted by observation, but for half the respondents symptoms were observed but not reported. These included hallucinations, shouting and “answering” imaginary voices; paranoid expressions of persecutory ideas, disorientation and confusion producing seriously inconsistent responses. Two-fifths of men and nearly three-quarters of women had problems which were observed, but which were unreported and untreated. The proportion in this group was higher than among those sleeping rough (more than 75 per cent) and among those aged over 65 years (58 per cent), reflecting the higher proportion of women among the oldest. Mental illness was therefore common overall, with two-thirds either reporting or observed to have affective or psychiatric problems.

Table 4.5 Present mental health of the respondents

Reported or observed mental health	Males			Females			Total	
	No.	%	Ratio	No.	%	Ratio	No.	%
No reported or observed problem	63	41	1.3	7	11	0.3	70	32
Self-reported problem but no treatment	19	12	1.1	4	6	0.5	23	11
Having treatment for mental illness	11	7	0.9	7	11	1.4	18	8
Observed problem but no treatment	62	40	0.8	46	72	1.5	108	49
Total known	155	100		64	100		219	100
Not known	4			2			6	
Total respondents	159			66			225	

Movement from Town to Town

Transience was a minority characteristic, particularly among women. Over 75 per cent of the women and 50 per cent of the men had been in one town since becoming homeless. A few men were transient, however, and they frequently moved between towns. During the six months prior to the interview, 11 per cent of the men had stayed in at least four towns. They were generally men who had been transient for years, and have moved around the country staying at Resettlement Units and sleeping rough. There was a close association between transience, and reported but untreated mental health problems. By the fact of self-reports, the group were experiencing distress and “drifting” between towns and may have been a coping behaviour, as suggested in other studies (Belcher 1988; Lamb, 1984).

Use of soup kitchens and day centres for homeless people

Soup kitchens and day centres for homeless people provide cheap food, clothing, showers and laundry services, medical care and housing advice. When the extent to which homeless and accommodated respondents use these centres is compared, the finding is unexpected. Respondents who were homeless used the facilities less than those with secure accommodation (Table 4.6). Those in temporary accommodation tended not to use the centres - food and laundries are often provided at hostels - and those sleeping rough used the centres infrequently (three times a week or less). Yet the securely-housed used the centres regularly (four or more times each week).

The differences arise from the survey design, because only housed people who use soup kitchens were included in the study. But the findings highlight the fact that many older rough sleepers do not use the facilities designated for them. Two-thirds of female rough sleepers never used the centres, the others only occasionally. Among male rough sleepers, 18 per cent used them regularly and one-half occasionally. As one-half of rough sleepers use the centres occasionally but not regularly, the group is clear generally aware of these facilities, although it is apparently weakly bound to them. The respondents found the centres noisy, over-crowded and spoilt by the aggressive attitudes (and occasional violence) of some younger homeless users. Some rough sleepers did not understand or see the value of the available help, or they expressed paranoid ideas including the view that they would be harmed by the staff. Those in permanent housing said that they used the centres because they felt lonely and needed company, they were bored and had nowhere else to go, they were unable or unmotivated to cook at home or they could not afford to buy food. Being in a centre deterred them from drinking alcohol, and the centres helped to structure their day.

Table 4.6 Use of soup kitchens and day centres by the present accommodation of respondents

Frequency of use of facilities	Present accommodation of the respondents										
	Secure housing			Temporary accommodation			Sleeping rough			Total	
	No.	%	Ratio ¹⁵	No.	%	Ratio	No.	%	Ratio	No.	%
None used	10	21	0.4	71	74	1.4	28	42	0.8	109	52
Occasional use ¹⁶	14	29	1.1	12	13	0.5	31	46	1.7	57	27
Regular use ¹⁷	24	50	2.4	13	14	0.7	8	12	0.6	45	21
Total known	48	100		96	101		67	100		211	100
Not known	4			6			4				
Total respondents	52			102			71				

Use of alcohol

Heavy drinking was not a problem for many respondents and rare among women, 80 per cent of the women said that they never drank alcohol and only one-tenth admitted regular consumption, i.e. at least three times a week or excessively one to two days a week. Two-fifths of men reported drinking regularly, and only one-quarter claimed that they never drank. According to the *General Household Survey* (1994), only 12 per cent of men and 24 per cent of women aged over 65 years do not drink alcohol (Bennett et al, 1996, Table 5.7). Furthermore, one-third of older men and 17 per cent of older women in the British population are moderate or heavy drinkers. This suggests that older people in general in Great Britain are more likely to drink alcohol than the respondents in this study and that homeless women have especially low consumption.

¹⁵ Ratio of percentage for the sex to the percentage for the entire sample.

¹⁶ One to three times per week.

¹⁷ Four or more times per week.

4.4 Summary

Many characteristics and behaviours differentiate homeless older people from other older people in this country. The sample was predominantly male, in contrast with the older population as a whole, which has a preponderance of older women. The majority had never married or were divorced and separated, and they were socially isolated, most having either no relatives or little contact with them. Those who had married and had had children were rarely in touch. Rough sleepers make little use of centres and services for homeless people. Mental illness featured prominently, particularly among women and those sleeping rough. Although heavy drinking was rare among older homeless women, it was more common among some men.

Of all the respondents, 177 could be seen to fall into six broad sub-groups on the basis of their behaviour and histories (Table 4.7). The first group were those who were sleeping rough: were withdrawn, they seldom used soup kitchens or day centres, and they were isolated and often hidden and elusive. They had observed yet untreated mental health problems, and were often hostile when first approached. Almost one-quarter of the respondents, and particularly the women, were so described. The second group were men who were sleeping rough and who were heavy drinkers. They tended to remain in one town and congregate in busy public areas and were hence visible. They occasionally stayed briefly in hostels. Although estranged from their families, they socialised with other homeless men who were heavy drinkers and they sometimes used soup kitchens.

The third small group were mostly men under 65 years of age, who stayed in one town. They were active and independent, and sometimes worked casually or made money in marginal occupations such as trading phone-cards and collecting luggage trolleys at railway stations. They slept in hidden and inaccessible locations, and sometimes booked into hostels and used soup kitchens. Neither heavy drinking nor mental illness was common amongst this group. The fourth group were men who were transient and who frequently moved from town to town. They slept rough and stayed briefly in hostels. They were estranged from their families, seldom mixed with homeless people or congregated in public places, and they rarely used soup kitchens. They were not generally heavy drinkers, but a few had mental health problems. They were difficult to trace except when they booked into temporary accommodation.

The fifth group were men and women who had been in one hostel for many years. Mental illness was a problem for some, heavy drinking for others (particularly men). They generally did not use soup kitchens. Some integrated with other hostel residents whilst others were isolated. The last group were those who were apparently homeless (discussed in Chapter 2). They had permanent accommodation but were estranged from their families, and regularly used soup kitchens and congregated on the streets with homeless people. Some had a mental illness or were heavy drinkers, others reported feeling lonely or unsettled at home and unable to cope. The majority had once been homeless.

This typology prompts two observations. First, older homelessness is often a hidden problem, and the older people at soup kitchens or on the streets with homeless people are often not themselves homeless. Apart from older homeless people who are heavy drinkers and are visible in public areas, the rough sleepers are not readily found. Secondly, older homeless people are often isolated and estranged from their families and relatives. A small proportion socialise with others in hostels, at soup kitchens and on the streets, but others isolate themselves - even from other homeless people and services.

Table 4.7 The characteristics and behaviour of the respondents

Main distinguishing characteristics	Males			Females			Total	
	No	%	Ratio ¹⁸	No	%	Ratio ¹⁹	No	%
1 Sleeps rough, isolated, mentally ill.	20	16	0.7	21	44	1.9	41	23
2 Sleeps rough, heavy drinker	29	22	1.4	0	0	0	29	16
3 Sleeps rough, works casually	8	6	1.2	1	2	0.4	9	5
4 Transient, sleeps rough, uses hostels	19	15	1.4	0	0	0	19	11
5 In hostels 3+ years, mentally ill or heavy drinker	17	13	0.8	11	23	1.4	28	16
6 Securely housed uses soup kitchens	36	28	1.0	15	31	1.1	51	29
Total	129	100		48	100		177	100
Not grouped	30			18			48	
Total respondents	159			66			225	

¹⁸ Ratio of percentage for the sex to the percentage of the entire sample

¹⁹ Ratio of percentage for the sex to the percentage of the entire sample

Chapter 5

Histories of homelessness

5.1 Episodes of homelessness

Of the 225 respondents in the field study, 155 men and 61 women had been homeless. This chapter describes their pathways into and through homelessness experiences of resettlement, and highlights the preceding states and events which triggered homelessness. Case studies are interpreted, and names have been changed to preserve anonymity.

Three-quarters of 190 respondents who provided details had experienced a single episode of homelessness: some for just a few years, others for more than 20 years. Although 86 had been rehoused, 49 became homeless for a second time and nearly one in ten for a third time (Figure 5.1). The duration of the intervening periods of being housed varied. Between the first and second homeless episodes, 16 per cent were housed for less than three months, but a similar proportion had been housed for more than ten years.

Figure 5.1 Movement of 190 respondents between housing and homelessness

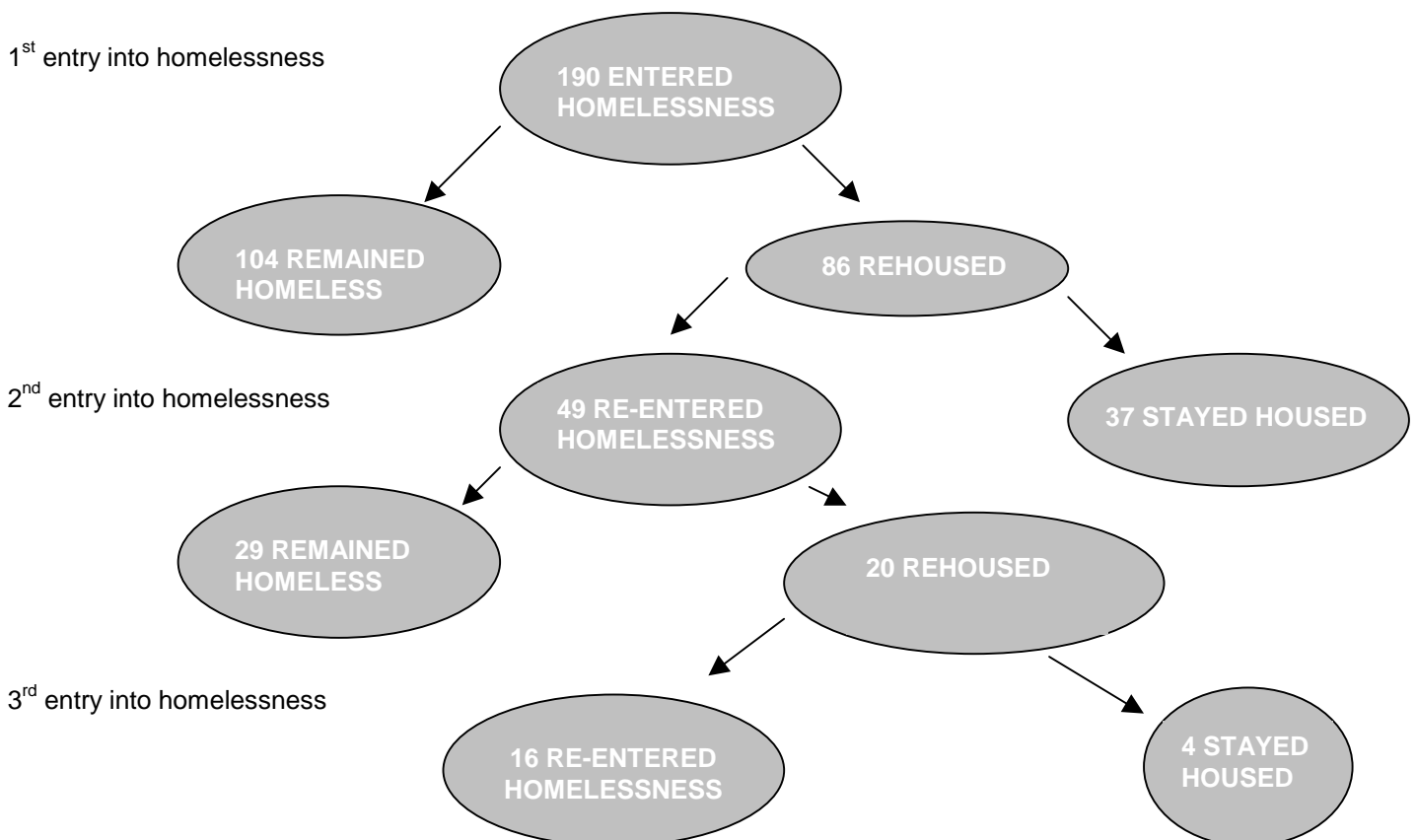


Table 5.1 Age when first became homeless

Age (years)	Males		Females		Total	
	No.	%	No.	%	No.	%
Up to 21	24	19	2	5	26	16
22 – 29	18	14	2	5	20	12
30 – 39	21	17	2	5	23	14
40 – 49	24	19	8	22	32	20
50 – 59	24	19	10	27	34	21
60 +	14	11	13	35	27	17
Total known	125	99	37	99	162	100
Not known	30		24		54	
Total who experienced homelessness	155		61		216	

Table 5.2 Accommodation prior to first becoming homeless

Type of tenure	Males		Females		Total	
	No.	%	No.	%	No.	%
Owner-occupation	19	14	7	18	26	15
Tenancy ²⁰	27	20	17	44	44	25
Lodgings and digs: no written tenancy	15	11	1	3	16	9
Tied accommodation with job, eg hotel	3	2	3	8	6	4
With armed forces/merchant navy	28	21	0	0	28	16
Institution: prison, hospital, orphanage	8	6	0	0	8	5
With parent(s) who had tenancy	24	18	9	23	33	19
With partner/relative who had tenancy	10	7	2	5	12	7
Total known	134	99	39	101	173	100
Not known	21		22		43	
Total who experienced homelessness	155		61		216	

5.2 First Entry into Homelessness

Details were provided about the age when the respondents first became homeless. Some could not say, since they had “drifted” into homelessness and were unsure when they began consistently to use hostels or sleep rough. Two men became homeless before they were ten years old, yet five men and four women first became homeless in their seventies. Men became homeless more likely to have become homeless at all stages; women for the first time in late life (Table 5.1).

Forty percent of the respondents had been in secure accommodation before first becoming homeless, as (sole or joint) owner-occupiers or as tenants of local authorities, housing associations and private landlords (Table 5.2). Twenty per cent had been living with their parents, while the rest had no written tenancy agreements, and lived in private lodgings, prisons, orphanages, mental hospitals, tied accommodation, work-camps, barracks, ships, and relatives’ or cohabittees’ tenancies.

Those who became homeless before the age of 40 years were most likely to have been living in communal settings or with families or partners, and only a minority lived alone (Table 5.3). The converse applied in the case of those who became homeless after 50 years of age, and among those in their sixties or older, over 60 percent were living alone immediately preceding homelessness.

²⁰ Local authority, housing association, private landlord

5.3 Resettlement Experiences

Of 216 respondents who had been homeless, at least 104 had never been resettled. Sixty-eight men and 18 women had been rehoused at least once, although many had been homeless for years before a resettlement attempt had been made. Eighty percent of the 86 who had been resettled had had secure tenancies. Most were rehoused by a local authority in independent accommodation or warden-assisted flats, or by housing associations in shared houses. The other 20 percent had entered less secure housing: some joined the army, and some moved into relatives' or cohabitants' homes. Forty-nine respondents (57 per cent) became homeless again, one-fifth after less than six months, and two-thirds after less than two years. Twenty had abandoned their homes, either because they did not want to live alone or because they had not coped with paying bills. Another 14 were evicted because they had not paid their rent. Twenty of the 49 respondents who became homeless for a second time were rehoused again, but most (16) became homeless again (Figure 5.1).

Table 5.3 Household composition prior to first becoming homeless by age when first became homeless

Age (years)	On own		With parents/partner/ relatives		In communal settings with lodgers		Total %
	No.	%	No.	%	No.	%	
Up to 29	2	4	14	30	30	65	99
30 – 39	3	13	15	65	5	22	100
40 – 49	12	39	13	42	6	19	100
50 – 59	16	53	12	40	2	7	100
60+	17	63	7	26	3	11	100
Total known	50		61		46		

5.4 Circumstances of Those Currently Homeless

All respondents were aged at least 55 years of age, and 14 per cent had been homeless since their twenties (Table 5.4). But the current episode of homelessness for half of all men and 70 per cent of the women had occurred after they were 50 years of age.

Table 5.4 Age at which current episode of homelessness began (those currently homeless)

Age (years)	Males		Females		Total	
	No.	%	No.	%	No.	%
Up to 21	6	6	0	0	6	5
22-29	11	11	1	4	12	9
30-39	15	15	0	0	15	12
40-49	15	15	7	25	22	17
50-59	26	27	9	32	35	28
60-69	18	18	6	21	24	19
70+	7	7	5	18	12	9
Total known	98	99*	28	100	126	99*
Not known	25		22		47	
Total currently homeless	123		50		173	

* Total do not equal 100 because of rounding

The duration of the present episode of homelessness varied. One-third had been homeless for more than 20 years, yet nearly one-quarter had been homeless for less than 12 months (Table 5.5). A higher proportion of men than women had been homeless for more than 15 years.

Table 5.5 Duration of current episode of homelessness (those currently homeless)

Duration of homelessness (months)	Males		Females		Total	
	No.	%	No.	%	No.	%
Up to 6	12	12	4	14	16	12
7-12	13	13	2	7	15	11
13-60	14	14	4	14	18	14
61-120	9	9	5	17	14	11
121-180	5	5	7	24	12	9
181-240	14	14	1	3	15	11
241+	36	35	6	21	42	32
Total known	103	102	29	100	132	100
Not known	20		21		41	
Total currently homeless	123		50		173	

5.5 Circumstances of Those Currently Housed

Fifty-two respondents were in secure accommodation. A majority (57 per cent) had been so housed for less than two years, and 38 per cent for less than one year. For two-thirds there was evidence of coping difficulties related to mental health, loneliness, budgeting, paying rent, cooking and other household chores. Many were at risk of re-entering homelessness. They spent little time in their accommodation, frequented soup kitchens and homeless centres during the day-time, and congregated with homeless people at night.

One woman in her late sixties with a council flat stayed on the streets several nights each week and used soup kitchens. She had a mental illness, believed that her neighbours were trying to harm her, and did not feel safe at home. One man with mental health problems had been recently housed but was unsettled, and had slept rough for a week. Others allowed homeless people to stay in their accommodation, usually for company. One woman allowed young homeless alcoholics to stay; the front door was always open. Her flat was appalling; the bed-clothes were filthy and smothered in flies; beer cans, wine bottles, cigarette butts and dirty clothes were strewn around; there was no carpet; and there had been a fire on the floor.

5.6 Pathways Leading into Homelessness

Studies which have been carried out in Great Britain often identify single incidents, such as bereavement or eviction, as the immediate causes of homelessness (Anderson *et al.*, 1993; Randall and Brown, 1993). However, the reasons for homelessness are more complicated. A single incident may act as a “trigger” i.e. the actual event that causes a person to leave or to be evicted from their home. But other factors (states or events) are usually involved. Although they do not directly cause homelessness, they nevertheless contribute to a person becoming homeless. For example, a person may have a mental illness, not be able to manage independently, and receive support from a parent or a spouse. Whilst the support is maintained the person is unlikely to become homeless. If the parent or spouse dies however, or there is a marital breakdown and no other support is available, the person may be vulnerable and become homeless. In this situation, although studies would often cite bereavement or marital breakdown as the “cause” of homelessness, mental illness was an underlying contributory factor.

Few studies, however, have collected detailed histories from homeless people, and analysed the interactions between events and states, or described the processes which lead to homelessness. The intensive, if partial, life histories of more than 170 elderly respondents collected for the study provide evidence of the pathways into homelessness, the contributory states and events, and common antecedents.

The breakdown of childhood homes

Nineteen respondents in this survey were homeless by the age of 21 years, including 15 before the age of 18 years. The majority reported broken or disturbed childhood homes. Four had been brought up in orphanages since infancy; others described stressful and disturbing events in family and foster homes. One man's mother died when he was eight years old and he stayed with relatives until his father remarried five years later. He then lived with his father and step-mother but his father died when the respondent was 15 years old. He continued to live with his step-mother but: "We argued (and) she only gave me bread and jam to eat. When my father was alive we had a proper meal". He said that he became homeless because "my step-mother threw me out of the house when I was 17 years old". He has lived in hostels since that time.

Six of the 19 "lifetime homeless" had never been resettled. For example, Alex never knew his father and he grew up in an orphanage. His mother did not visit him until he was 12 years old, when she married. Alex left the orphanage at 15, lived in a hostel and worked as a van boy but had to leave the hostel after two years because: "I was uncontrollable". Subsequently he has seldom worked and has moved around hostels, slept rough and been in prison, mainly for shoplifting and drunkenness. He was in his late fifties when interviewed and had been homeless for 40 years.

Discharge from the armed services in early adulthood

Sixteen men became homeless before the age of 29 years after leaving the armed forces, and of these seven were less than 21 years old when discharged. The majority had served between two and six years, and all but two had been in the army. Eleven became homeless immediately after discharge, the others returned home but became homeless within a few weeks. The majority (11) had experienced disturbed or broken childhood homes before entering the forces, five reported stressful experiences whilst in the army, and five recalled family problems when they returned home. Eight were also drinking heavily when they left the forces.

Two histories illustrate the pathways from the armed services into homelessness. Henry's father died when he was three years old. Henry said that his father was an alcoholic, who who occasionally slept rough, and he died of hypothermia whilst sleeping out. Henry's mother had "mental problems and she used to wander off", so he lived with foster parents from five years of age until he was 14. Henry then returned to his real mother but said: "we were like strangers; we did not know each other". At 16 he was sent to Borstal for shop-breaking, after which he joined the army. Leaving two years later, he then slept rough.

Len had been abandoned by his parents and adopted as a baby. He learnt this when 14 years old, and ever since has been angry towards his parents. He joined the army at the age of 17 years, served for six years, the last three-and-a-half years as a Japanese prisoner-of-war. Len became distressed when talking about the torture he suffered in the camp. On release from the army, he had not been able to settle, drank heavily, and slept rough. He was 74 years old when interviewed, and had been homeless for 51 years. Although the 16 men became homeless after discharge, many had had unsettled lives before enlisting. Some experienced distressing situations during active service, and some faced family problems when they returned home.

Bereavement

The death of a parent, spouse or landlady triggered homelessness for 31 respondents. Thirteen men and five women became homeless after a parent's death: usually the mother was the last surviving parent. The majority had always lived at home, they were characteristically in their forties, poorly socialised and had never had friends or intimate relationships. They had low occupational skills and forty per cent were mentally-ill. When their parents' support ended, they were unable to manage alone and became homeless in one of three ways. Some stayed alone at home but were evicted by the council within a few months, usually because they failed to pay the rent. Others lived with a relative briefly, but subsequently that support was withdrawn: in one case a relative became ill and needed care

themselves, but more often relationships were reported to have been problematic. A minority abandoned their home, the usual explanation being that it had too contained many painful memories.

Ten men became homeless on the death of their spouse. The majority had been in long-lasting marriages, six for more than 20 years. The bereavement occurred when seven were over the age of 50 years. Seven could not settle and found it too painful to remain at home; five sold their houses and either gave the money to their children or spent it on alcohol, and two ceded council tenancies. The other three men lost their tenancies because the council believed the house or flat was too large for one person, or private landlords had decided to sell. Five reported that they drank heavily after the bereavement and two had attempted suicide.

Two men and one woman became homeless after their elderly landlords died. All had lodged for over ten years and had to leave the property because it was sold when they were over 50 years of age. One woman had been over 70 years of age. Most who became homeless on the death of a spouse or landlady had experienced unsettled childhoods but the existence of a partner, it appears, had stabilised their lives. They had maintained long-lasting relationships, property titles and tenancies, and consistent work patterns. Two men had been carers for years, one of a wife who had been poorly for 15 years, the other for a partner declining with multiple sclerosis for ten years. Nevertheless, personal vulnerability was also evident: four had been heavy drinkers, four had had mental health problems, and four had regularly travelled and worked away from home. None had ever lived alone, and after the bereavement they were unable to cope on their own.

The breakdown of intimate relationships

Forty-four men and 16 women themselves associated homelessness with the breakdown of a marital or cohabiting relationship, although nine refused or were unable, to say more about this. Of the 51 who provided details, most had been in long-established relationships, nearly one-half for more than 15 years. Several interacting events and states progressed to the breakdown of the relationship and to homelessness. Nine men had chronic alcohol problems, which they associated with disturbed childhood homes, the deaths of children or close family members, and disturbing experiences whilst in the armed forces. Most admitted that the relationship ended because their wives could no longer tolerate their heavy drinking.

Seven women associated their marital breakdown and homelessness with long-standing physical abuse by their partners. They had been injured and some had needed hospital treatment. One woman said: "I was in and out of hospital. He hit me and I got broken jaws, a bruised face and black eyes". They usually attributed the violence to their husband's heavy drinking, but all had remained with their partners for years (four for more than 25 years). All were more than 40 years of age when they separated, and three were 50 plus. Other events compounded the stresses in the relationships and preceded separation. One woman explained: "He (became) more violent in the last ten years of our marriage, since he was made redundant. He was in his middle fifties at the time and he took his anger out on me". Three women finally separated when their husbands committed adultery, and others when their husbands became more violent. One woman reported abuse for 29 years until: "I was admitted to hospital with a stroke. He used to hit me around the head with an iron bar and this brought on the stroke."

Fourteen men and women reported that their marriages ended after crises and stressful events. Multiple and inter-related problems were described, including the infidelity of their partners, mental and physical illnesses, redundancy and heavy drinking. Albert, for example, was in his early sixties when his marriage ended and he became homeless. He blamed the estrangement on a fire at a neighbour's house a few years earlier. Albert had tried unsuccessfully to rescue the elderly occupant, but was nearly asphyxiated and had suffered from breathing difficulties ever since. "I turned into a miserable, cantankerous old bastard ... an angry and bitter man". Arguments became common with his wife: "the rows got worse, our relationship fell apart and she kept telling me, "I want you out of my life". He left home and slept rough.

Eight respondents had had several marital or intimate relationships, some becoming homeless when each one had ended. There were long-lasting and short-lived relationships, those which ended in separation and others in the death of their partner, and both problematic and stable partnerships. Some abandoned their homes, others were evicted. Some became homeless immediately the relationship ended, others after a period of being housed. Although the respondents associated their homelessness with their difficult relationships, for some these were short interludes in a transient, unsettled life history. Ten such men had been in the armed forces or merchant navy, and three had been migrant building labourers. Most had been mobile for many years before committing themselves to a relationship, which was then brief: in nine cases this was for less than five years. All became homeless immediately on separation.

Mental illness

Although forty per cent of the respondents reported mental health problems prior to homelessness, these problems did not always trigger the change. The common public perception is that homelessness occurs on discharge from psychiatric hospitals, but only two men became homeless in this way. Those with a history of mental illness became homeless after complicating stressful events, such as marital breakdown, widowhood, or the death of a parent. One sees again that homelessness occurs when habitual support abruptly ends.

Others became homeless following events that can be directly associated with their mental illness. For one woman, a long-standing mental health problem compromised her employment and led to retirement on medical grounds when she was in her fifties. Unable to budget and to pay her bills, she was evicted from her council flat. Five men and five women first became homeless after developing *ab initio* paranoid ideas or confusion: nine were over 50 years of age, three in their sixties and three in their seventies. All had been living alone, with no contact with their relatives, and many had previously had stressful experiences.

Amy, for example, was evicted because of mortgage arrears in her early fifties. She had been through several stressful events and had become mentally ill. She had been divorced for years, had worked and single-handedly brought up her daughter. Her father died nine years before she became homeless and in the same year her mother had had an accident, was hospitalised for months and afterwards lived with Amy, who said: "I was under a lot of pressure; I was working in two jobs, and looking after my daughter and my mother". Amy stopped paying the electricity bills because, "I had no money and the Government were plotting against me", so the supply was disconnected. Amy's daughter had left home by this time. Her mother was becoming increasingly confused and wandered the streets whilst Amy was at work. Her mother was taken into social services care, and died a few months later. In the same year Amy stopped work because "the firm were plotting against me; everybody at work was involved". Two years later Amy's home was repossessed because "I had no money to pay my mortgage and rates. I had had no electricity for three years. I was not working. Everybody was plotting against me. I was taken to court and my home was taken from me". Evidently Amy was under considerable pressure before she became homeless: bringing up her daughter alone, maintaining two jobs, caring for a confused mother, in financial difficulties, and without electricity. These stresses appear to have triggered a paranoid illness. Amy finally stopped work and eventually her home was repossessed.

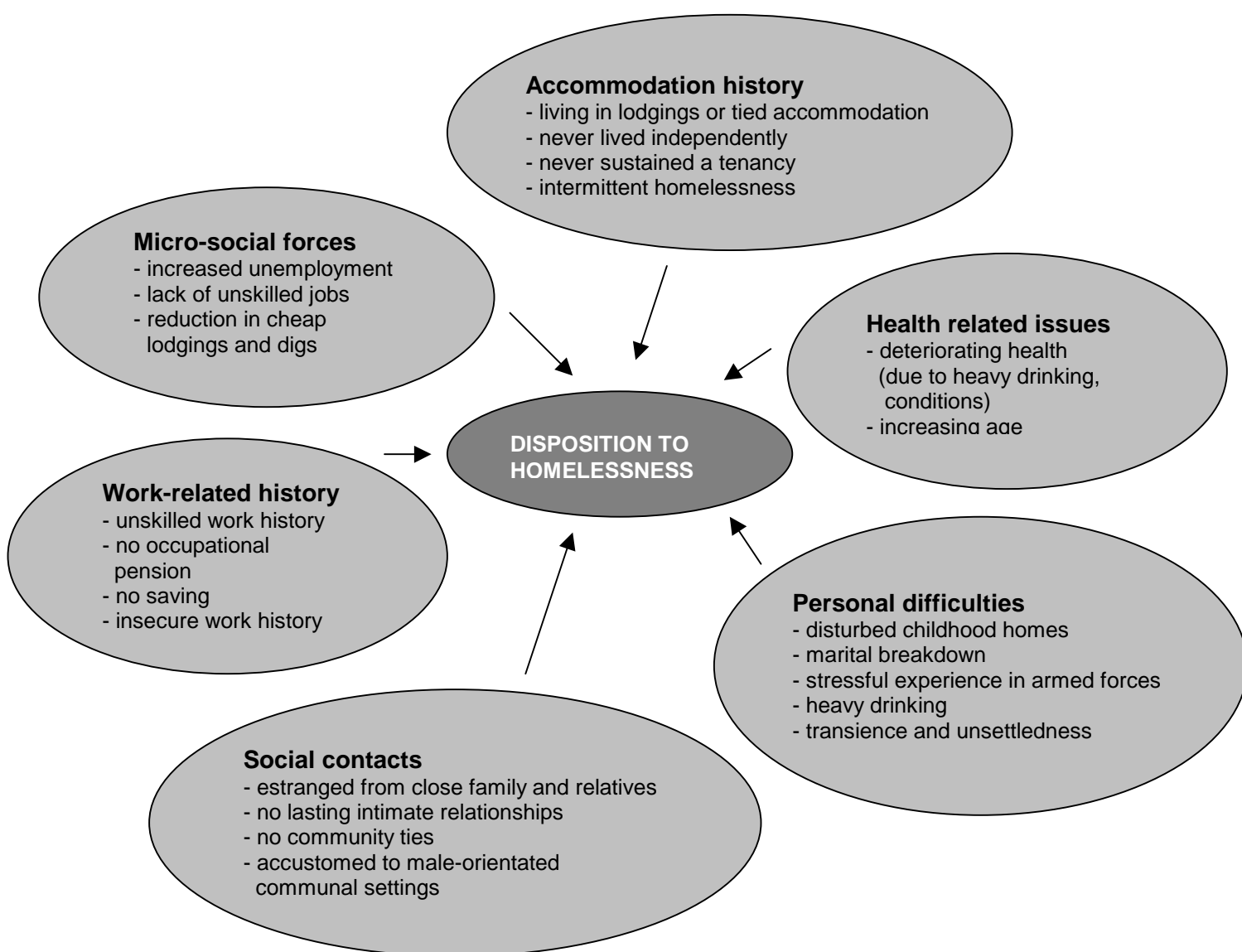
Mobile work histories

Forty-two men led transient working lives for many years before they became homeless. The majority had been building labourers, farm labourers or merchant seamen. They moved frequently, and never established roots in one place. Few had ever had a secure tenancy, and they lived in lodgings, digs, work-camps attached to building sites, or on ships. They had been "looked after" in tied accommodation or by landladies. In between jobs they stayed in missions, hostels and occasionally slept rough. Many were unskilled, and during the 1970s they "drifted" from regular work to "casual" work, and from marginal housing into homelessness. At this time unemployment increased in Great Britain in manufacturing and construction, and the demand for unskilled manual workers began to fall sharply (Burnett, 1994; Coleman and Salt, 1992).

The reasons why men adopt transient working lives and then become homeless are complex. For some, transience was preceded by disturbed childhoods, distressing war experiences and

marital breakdowns. The progression into homelessness followed multiple events and states and various economic, social, health and psychological disadvantages (Figure 5.2). Many during their forties or early fifties developed chronic health problems, they had already become estranged from their families, and had no community ties. Most had never lived independently or learnt to manage a home, and few had married or formed lasting relationships. Instead they had become accustomed to male-oriented communal living and habituated to heavy drinking. After becoming homeless, most of those who were resettled (16 out of 21) soon re-entered homelessness. Five kept tenancies but complained of loneliness or were unable to cope. They said that they preferred hostels which provided food and shelter, and male companionship.

Figure 5.2 Transient work history and homelessness in old age



5.7 Summary

For respondents in this survey, homelessness in later life occurred in two ways: some had always led an unsettled and marginal existence; but others had maintained a largely conventional adult life of marriage, bringing up children and working, until one adverse event too many led to homelessness. Episodes of homelessness were equally diverse. Some respondents had been homeless for just a few weeks or months, others moved between housed and homeless states, but many had been homeless for more than 20 years.

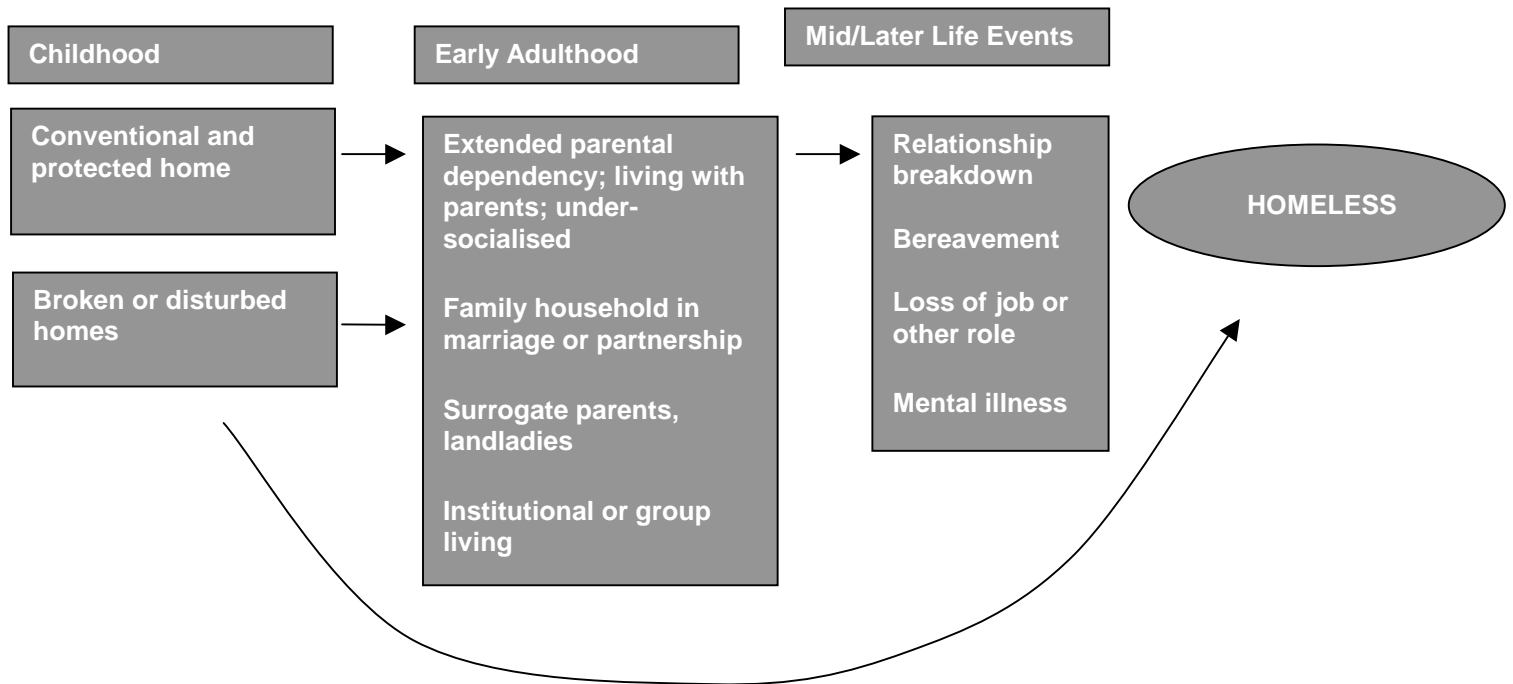
Figure 5.3 A schematic representation of the life course of older homeless people

Approximate age	Relevant states (S) and triggers (T)
Childhood & Adolescence	<ul style="list-style-type: none"> • Broken childhood homes (S) • Disturbed childhood homes (S&T) • Discharged from orphanages (T)
Early adulthood	<ul style="list-style-type: none"> • Leaving armed forces (T) • Mental illness (S)
Mid-life	<ul style="list-style-type: none"> • Death of last surviving parent (T) • Marital/relationship breakdown (T) • Drift by transient workers to less secure work and accommodation (S) • Mental illness (S)
Later life	<ul style="list-style-type: none"> • Relationship breakdown (T) • Death of spouse (T) • Discharge from armed forces and merchant navy (T) • Loss of tied accommodation (T) • Widowhood (S) • Retirement (S) • Downward drift by transient workers (S) • Increased severity of a mental illness (S)

Homelessness among older people is triggered by various events (Figure 5.3). For some respondents, the transition occurred in adolescence or early adulthood when they left disturbed family homes, orphanages, foster homes, or the armed forces. In mid-life it was triggered variously by the death of a parent, a marital breakdown, and a drift to less secure work and housing among transient workers. In old age it followed widowhood, retirement and the loss of tied accommodation, the increased severity of a mental illness, discharge from the armed forces and merchant navy, and marital breakdown.

Rarely does a single factor cause homelessness. There are, however, recurring features and events in the respondents' histories (Figure 5.4). These include broken and disturbed childhood homes, extended parental dependency, limited socialisation, unstable intimate relationships, stressful life events in adulthood, a dependency on others or work settings for support, low income, mental illness, heavy drinking, and transience. But none are sufficient reasons for homelessness, rather they lie at the roots of vulnerability at times of stress. Chains of causation are implied, for example, camaraderie and stressful experiences in the armed forces lead to heavy drinking, which in turn precipitate relationship difficulties, marital breakdown and sometimes homelessness. And the death of the last surviving parent leads to homelessness among those who are poorly socialised, mentally ill, and those who had never entirely shed entirely juvenile dependency.

Figure 5.4 Commonly reported pathways into homelessness



Being homeless is usually uncomfortable and persistently depressing. It reduces life to the basics of maintenance and survival. While few homeless people have endeavoured to become homeless or made an active choice, nonetheless their actions and behaviours are not self destructive. The life histories of the respondents contain signs that many people who become homeless are escaping from living situations that have become intolerable and are perceived to be worse than being on the streets - violence from parents or spouses, persistent arguments, paranoid ideas, and straightforward loneliness and boredom. We know too little to generalise about the psychology of voluntary homelessness, except to be clear that the variation among individuals is immense, and that the element of social and psychological maladjustment is large, and is more likely to be the determinant than a person's rights of occupation to a house.

Shortage of housing is often only one factor in generating homelessness, although clearly whether there are suitable housing vacancies will condition the speed and success of rehousing. Some respondents had never lived in conventional housing, others had secure tenancies which they had subsequently abandoned, and others were evicted because they were not coping.

The origins of homelessness are therefore complex and deep-seated, and are intricately related to individuals' psychological and social problems. Homelessness will not normally be resolved simply by providing accommodation without the necessary support.

Chapter 6

Meeting the Needs of Older Homeless People

6.1 The Scant Attention to Older Homeless People

This chapter looks at the application of current policies, services and practice to the needs of *older* homeless people, and considers some examples of “good practice”.

No policies and few interventions are targeted specifically towards older homeless people although “the elderly” are accepted as a priority group for local authority rehousing (*Housing Act 1996*). Statutory help to older people is conceived under the community care provisions of the *National Health Service and Community Care Act 1990*, but in practice this is for people who are referred to the NHS or a social services department and not for those who sleep rough. Local authority social services departments have a responsibility to assess an individual’s needs, design packages of care, and secure services for people who are vulnerable because of old age or a mental illness (Department of Health, 1989). NHS health-care workers have a duty to meet health needs. The implementation of the Community Care legislation, however, is orientated towards those who are housed and in contact with statutory services, and it is expected that older people or their relatives will recognise problems and seek help (SHiL, 1995; Access to Health and Medical Campaign Project, 1992). Housing and social service departments rarely “search” for older homeless people on the streets who are in priority need or who have multiple health and welfare problems.

6.2 Current Services and Interventions

Street out-reach work

The role of street out-reach workers is to offer help and advice at an early stage to people sleeping rough who may not access services, and to undertake intensive case-work with long-term rough sleepers. It has been proved that, through persistent out-reach work and intensive case-management, isolated homeless people who are sometimes difficult to engage and who may have mental health problems, can be helped (Craig, 1995; Sheridan et al., 1993). Resources have been made available through the RSI²¹ and the *Homeless Mentally Ill Initiative* to provide out-reach and resettlement work to rough sleepers in London but none have been earmarked specifically for older people. Many homeless people are young: they tend to be more assertive and may thus dominate the time and case-loads of out-reach and resettlement workers. Generic workers may not have the time and resources to seek out, engage and resettle isolated elderly people.

There are older people who have been homeless and sleeping rough for years without being resettled. The field study interviewed 58 older people who were sleeping rough in London: at least 41 had been in that situation since the RSI was launched in 1990. This suggests that this group may need more intensive help than present generic out-reach workers can offer. An older homeless man who died on the streets in West London recently had been “living” in the doorway of a *Pizza Hut* for more than one year (Penhale, 1997).

There are several out-reach teams in London but few if any in other cities. In Glasgow, apart from the *City Centre Initiative* which works with young homeless street people, there is out-reach work two nights each week by *The Simon Community*. Similarly, apart from two street workers attached to *The Whitechapel Centre* and soup runs, there is little out-reach provision in Liverpool. The need for out-reach work with isolated older rough sleepers was expressed by several hostel and day centre workers in London, Liverpool and Glasgow.

Day centres and soup kitchens

Many older homeless people, particularly rough sleepers and women, never use day centres and soup kitchens. Some with severe mental health problems are unable to understand the value of the available help, whilst others express paranoid ideas about care staff (discussed in chapter 6). Others fear younger homeless users, as reported by several centre and hostel

²¹ The *Rough Sleepers’ Initiative* (discussed in Chapter 1).

workers in London, Liverpool and Glasgow. Even those who do use the centres are often inconspicuous, unassertive, and rarely do they ask for help. They sometimes go to a soup kitchen, collect food and depart so quietly that their presence is hardly apparent. They cannot therefore benefit from the other services such as medical care and resettlement programmes that are accessed from these points.

Some older people in secure housing regularly use day centres and soup kitchens, and make use of the offered housing support, welfare advice, and medical care. Some have mental health problems and a few are heavy drinkers. Many have been homeless for years and, although rehoused, are isolated from statutory services and relatives, and their only social contact is at the centres. They are therefore using the centres to obtain support which most of us acquire from relatives, friends and statutory services. This use of day centres by older vulnerable housed people was reported in London, Liverpool and Glasgow, with some workers arguing the need for a centre for older homeless people who have been resettled. Such a centre could combat loneliness and provide training in budgeting, cooking, managing money, paying bills and claiming benefits. Day centres for homeless people have been described as one of society's "safety nets ... in (times) of crisis" (Llewellyn and Murdoch, 1996, p. 6).

In London many older people circulate between centres, and some use three a day. Several centres are open for only a few hours each day and there is little provision by late evening. Hence the field study respondents were frequently seen on the streets and at railway stations in the evenings. In Glasgow, two centres provide services to homeless people until late evening. Both are well attended by older homeless people and by those who have been rehoused. Besides offering a safe refuge for rough sleepers, the centres attract those who are isolated.

Temporary accommodation

Temporary accommodation for homeless people has decreased substantially since the 1980s and the closing of traditional hostels and Resettlement Units (SHiL, 1995; Garside *et al*, 1990: discussed in Chapter 1). Most had offered direct-access accommodation, whereby people could be immediately accommodated provided a bed was available, without needing to be referred through an agency. There is a high demand for such hostels. In London direct-access hostels are often full: in February 1996 their occupancy rate was 96.9 per cent and 87 homeless people were turned away each day (Harrison, 1996). Cold-weather shelters have operated in London from December to March since the early 1990s. They provide direct-access beds funded through the RSI, to encourage people off the streets and into temporary accommodation. They have proved successful in attracting long-term homeless people with mental health and alcohol problems (Randell and Brown, 1996).

Older homeless people use direct-access hostels and cold-weather shelters. Many of the respondents in the field study have been using direct access accommodation for years. They have complex problems and long histories of homelessness. Some have been transient and frequently move from town to town, others have slept rough for years but have intermittently booked into direct-access hostels as respite from the streets. For many, the only contact with helping agencies has been through direct-access hostels. A minority have used such hostels briefly during marital and family disputes.

Not all direct-access hostels provide 24-hour shelter and services. A few respondents were staying in hostels which required them to leave the premises in the early morning and not to return until the evening. They therefore had no option but to circulate the streets and around soup kitchens and day centres. This probably increases their vulnerability, decreases morale, and provokes physical ill-health. Of 49 direct-access hostels surveyed in London in 1996, twelve required residents to leave the premises during the day (Harrison, 1996).

Some direct-access hostels are unable to cope with homeless people who have mental health problems or who are heavy drinkers. In Liverpool and Glasgow it was reported that several older homeless men had been banned from hostels because of their disruptive behaviour. To be banned is likely to foster unsettledness and a sense of rejection. Other hostels do accommodate people with difficult behaviour but the staff have special expertise or qualifications to provide treatment, rehabilitation and resettlement. Recognising these difficulties, Sunderland Health Authority and a *Salvation Army* hostel established a joint scheme whereby a psychiatric nurse works with residents who are mentally ill and supports the hostel staff (*Priorities*, 1996).

On the other hand, some older homeless people become long-term residents of temporary accommodation and are never resettled. 28 survey respondents had lived in direct access hostels for more than three years, and a few for over 20 years. Some had severe mental health and alcohol problems and obviously needed long-term support, but others displayed no apparent mental health problems and could be successfully resettled with support. In Glasgow, some older homeless people had been living in direct access accommodation since early adulthood i.e. *for more than 30 years*.

However, in some hostels, attempts are being made to resettle older homeless people with long histories of homelessness. In Glasgow, for example, the *Loretto Housing Association* is aiming to resettle the residents of *Duke Street Hostel*. This is a large direct access hostel which, when visited in 1997, had 125 male residents of whom 62 were over the age of 55 years. A high proportion had long histories of homelessness, mental health problems and heavy drinking. Intensive resettlement programmes are in operation, and the aim is to resettle the residents over the next five years into independent and supported tenancies.

Some direct access hostels in Liverpool and Glasgow accommodate older residents with physical and mental health problems but have insufficient staff or inadequate facilities to be appropriate for those with a high level of needs. The staff nevertheless continue to provide for vulnerable older homeless people because of a lack of more suitable long-term housing. Many care staff in Liverpool and Glasgow mentioned the need for supported accommodation for older homeless people with alcohol and mental health problems. One such 34-bed male hostel in Liverpool is generally full and, in December 1996, there was a waiting list of five. In Glasgow, two such projects (of 53 and 20 beds) rarely have vacancies and, in January 1997, had a combined waiting list of 17.

Resettlement and long-term support

As mentioned above many homeless people, housing alone is not a solution to their problem. Homeless people need intensive resettlement programmes and sometimes long-term support once they are rehoused (Randall and Brown, 1996; Spaul and Rowe, 1992). Resettlement workers have been funded in London through the RSI and the *Homeless Mentally Ill Initiative*. It was initially assumed that the support needs of rehoused people would decrease with time, but it has been found that many homeless people continue to need a high level of support even when they are resettled (Craig, 1995). Some homeless people who were rehoused during the first phase of the RSI wanted, but did not receive, help with benefits and rent payment, and they soon accumulated rent arrears. Support services were intensified during the second phase (Randall and Brown, 1996, 1995).

Clearly older homeless people need intensive resettlement programmes and long-term support to help them exit from homelessness. Just over one-half of the field study respondents had never been resettled. Others had been rehoused but became homeless again because of mental health problems, loneliness, or poor coping skills. They had often been rehoused in independent accommodation without support. Some abandoned their homes, others had been evicted because of rent arrears. The problems associated with managing a home were often the reason why they first became homeless. Yet they had been rehoused in similar circumstances, and the difficulties recurred. According to staff in London and Glasgow, many older homeless people who have been rehoused continue to use day centres, as they are unable to cope at home and need support with paying bills and household chores. Some have found themselves in court after throwing away bills and welfare entitlement forms which they did not understand.

6.3 Examples of Good Practice

For many older homeless people more than a roof is required. Their disaffiliation and alienation from conventional social roles, their low morale, apathy and hopelessness, and their inability to cope with conventional independent living all have to be addressed if re-housing and rehabilitation is to be successfully and durably achieved. While it is possible to make proposals about the more intensive and specialist forms of support and guidance that might be effective, the opportunity to visit homeless peoples' facilities and organisations in several of

the largest British cities has brought to notice some especially innovative, imaginative and targeted schemes.

6.3a The Over 55s Accommodation Project, St Anne's Shelter and Housing Action, Leeds

The *Over 55s Accommodation Project* at the *St Anne's Day Centre*, Leeds, is a pioneering scheme to resettle homeless older people in supported and conventional housing. It has been developed by *St Anne's Shelter and Housing Action*, from a day centre for homeless people in Leeds founded in December 1971. Since 1974, the Association has been developing supported housing schemes and projects for vulnerable people throughout West Yorkshire and, to a lesser extent, in surrounding counties. It now offers a range of accommodation and services for people in need, including homeless people.

Shared houses and self-contained flats in supported housing schemes

St Anne's Shelter and Housing Action provides secure tenancies in supported housing schemes for homeless people of all ages. The organisation currently accommodates and supports 32 people in shared houses and 66 people in self-contained flats in Leeds and Dewsbury, West Yorkshire. In the shared houses, three or four people live together, they have their own bedrooms, and share kitchens and sitting-rooms. Hence they have both social contact and the privacy of their own rooms.

The supported housing schemes are for those with special needs and who wish to have their own home but are unable to manage in independent accommodation. For some, it is their first experience of having a tenancy. According to individuals' needs and preferences, non-resident housing support workers and housekeepers visit the schemes daily and provide support. They teach budgeting and cooking skills, ensure that residents are registered with a general practitioner and that they keep necessary appointments. In the shared houses a cooked breakfast is prepared by the housekeepers. If residents need more intensive support, then care packages are devised by *St Anne's* to draw upon statutory and voluntary services. Although residents may stay in the schemes indefinitely, it is the aim of the housing support workers to prepare residents to move into independent accommodation.

The Over 55s Accommodation Project

The experience that *St Anne's* has acquired in the support and resettlement of vulnerable people has been adapted for older homeless people; The *Over 55's Accommodation Project* was funded for three years to resettle people aged over 55 who are homeless or are threatened with homelessness. Because of its success, the project has been extended for a further three years.

Objectives

The project's objectives and activities are:

- To make contact with older people who are homeless or insecurely housed, and assess their housing and social care needs.
- To resettle clients in secure accommodation which is appropriate to their needs and preferences.
- To provide support packages for clients which are designed to meet individuals' needs.
- To refer clients where appropriate to other services, including social services, local authority housing departments, detoxification programmes, community psychiatric nurses, and temporary hostels.

Operational strategy

One full-time manager, two half-time resettlement workers, one half-time resource worker, and two volunteers are attached to the project. Self-referrals are accepted, as are referrals from local authority housing and social service departments, nurses and particularly social workers at local hospitals, the Citizens' Advice Bureau, and hostel and day centre staff. Staff from the project conduct a monthly surgery at the Leeds Resettlement Unit (taken over in 1996 by the *English Churches Housing Group*) and make contact with potential clients.

The project leader and the resettlement workers undertake intensive case-management work which involves assessing clients' needs, and developing care packages and resettlement plans. A key preliminary is to develop a trusting relationship with the clients, who are often estranged and suspicious of help, partly because they have shunned or rejected statutory services. Each client is made aware of realistic housing options which are available. It is necessary to recognise the degree of encouragement, support and guidance which clients need at different stages of the resettlement process.

Intensive support is offered to clients at the time of the resettlement "move". The project workers support the resettled clients until their housing situation has stabilised and the statutory agencies are providing needed services. Contact is maintained with resettled clients even after this is achieved, through a monthly luncheon club, and Christmas and birthday cards, partly to remind clients that the project is always available if they need help. The manager works to promote confidence in the project by the local authority housing and social services departments, housing associations, health service workers, and voluntary organisations. This includes "opening doors" for the project by seeking out and activating potential services, and producing a monthly newsletter.

Achievements

- Since the project's inception more than five years ago, over 300 older people have been rehoused. In the year ending September 1996, the project received 87 new referrals of older people, and rehoused 70 clients into secure tenancies, most of the homes comprising independent accommodation, sheltered flats and shared housing schemes.
- The project has increasingly intervened on behalf of people who are threatened with homelessness, and plays an effective and growing role in the prevention of homelessness.
- The project has become a specialist social welfare resource in Leeds. When assessing older people who have long or complex histories of homelessness, statutory and voluntary agencies seek the expertise of the project workers at case conferences and in joint case-management work.
- There is strengthening collaboration between the project workers and local housing departments and service providers. Housing providers inform the project manager of vacancies, and refer older people to the project who are experiencing housing difficulties and are at risk of becoming homeless.

Lessons learned

- It has proved possible to resettle older people who have long histories of homelessness, who have alcohol-related or mental health problems, and who have never lived alone or managed a tenancy.
- Resettlement is sometimes a slow process which involves several moves to progressively less supported housing. Some clients move from sleeping rough to a hostel, and then into a shared housing scheme, before they learn the necessary skills and feel confident to manage in independent accommodation.
- Resettlement is regarded as successful when a client is able to manage for six months after being rehoused, without getting into arrears with their rent or bills, and without experiencing housing-related crises, and when they are confident enough to use local amenities and community facilities.

- Some older homeless people need long-term support once they are rehoused.
- Resettlement is not always successful. Some older homeless clients have shied away once accommodation has been found, and some have returned a few months later to seek help.
- It is vital that a project develops a collaborative relationship with local accommodation providers, particularly the local housing authority and local housing associations, so that they are regularly informed of housing vacancies.

Perceived needs

- There is a steady flow of older people becoming homeless in Leeds. Some have been resident in Leeds for years, others have returned to their “roots” after having lived elsewhere or travelled for many years.
- As the project workers become increasingly involved with older people who are insecurely housed, new problems are recognised. There is concern about some older people in private-rented accommodation in Leeds but little evidence to support the concern. A minority are helped through the project. Many others are believed to be insecurely housed and living in poor conditions, but without help.
- There is a need for workers who can support clients at home once they are resettled, to teach skills such as budgeting and cooking. At present, neither the project nor statutory services have the resources for such work. Training is needed to enable support workers to understand the particular needs of clients with an unsettled lifestyle.

6.3b Out Reach Work and Accommodation Specifically for Older People Sleeping Rough: St Mungo Community Housing Association, London

The *St Mungo Community Housing Association* (originally the *St Mungo Community Trust*) was established in 1969 to provide accommodation and support to homeless people in London, particularly those sleeping rough. It now manages just over 50 projects, which accommodate more than 1,000 people each night and employ over 400 staff. It provides a wide range of services for homeless people, including direct-access hostels, supported housing schemes, high-care homes for those who are mentally or physically ill, training and employment schemes and workshops, out-reach and resettlement teams.

A cold-weather shelter specifically for older homeless people

Raised awareness of the special needs of older homeless people led the Association to set up, in the winter of 1996-97, a cold-weather shelter exclusively for *older* rough sleepers. The shelter has 30 beds and was originally designed for 20 men and ten women. Referrals were made through the organisation’s out-reach team.

This is the first RSI funded cold-weather shelter specifically for older homeless people. Although it had been open for only six weeks at the time of writing this report, several preliminary assessments have been reported by the manager:

- Through intensive street work, the out-reach team has been able to encourage older homeless men who have long histories of rough sleeping and who have refused services to use the shelter. The shelter has operated at full occupancy as a hostel for men.
- It has proved more difficult to engage older homeless women who are sleeping rough and to persuade them to use the shelter.
- The shelter has proved effective in retaining (at least for a short period) older homeless men who have often refused to stay in accommodation in the past. This increases the opportunity for them to be helped and resettled.

A 24-hour drop-in centre and hostel for older homeless people

St Mungo’s opened a pioneering project for older homeless people in London in mid-January 1997. This was the outcome of research conducted in 1990, which highlighted that many older rough sleepers in London were isolated, had welfare problems, unmet physical and mental

health problems, but were not accessing services (Crane, 1993). The proposal for the centre by the author of this report followed a visit to a project in New York (Cohen *et al*, 1993; 1992).

The centre is aimed at older homeless people who are sleeping rough, are isolated, and not accessing services. It is a combined 24-hour drop-in centre and hostel. The aims are to make contact with older people on the streets, to assess their problems and needs, and to develop individual resettlement programmes. Three out-reach workers are based at the centre and their role is to make contact with older homeless people on the streets and to encourage them to use the drop-in centre. A van enables the out-reach workers to bring older people to the project. Although based in the London Borough of Westminster, the project works with older homeless people in all London boroughs.

The 24-hour drop-in centre enables older homeless people to access the centre at night even if they are reluctant to use the hostel. At the same time, their trust can be gained and they can be encouraged to accept help. The centre offers food and laundry services, and specialist medical and psychiatric care, counselling, resettlement programmes, and help with alcohol-related problems.

6.3c Project Workers for Older People in Day Centres

Because some older homeless people stay away from day centres and others are unassertive and undemanding, four day centres in London have established projects and workers specifically for older homeless people. The scheme at the *North Lambeth Day Centre*, entitled the *Resettlement Outreach Project, Elderly Services (ROPES)*, was initiated by *Help the Aged* and set up in January 1995. Funding was secured for a person to work specifically with day centre users over the age of 50 years. This enabled a worker to devote time to the older clients who were isolated and undemanding of services. A similar scheme at *St Martin-in-the-Fields Social Care Unit* was set up in February 1995 because older homeless people were staying away from the Unit. The project at the *Passage Day Centre* started in March 1996 to engage older homeless people with services in the community, and to support those who are rehoused. Similarly, the scheme at *St Giles Trust* was established because older homeless people who had been resettled still used the day centre and needed support.

All schemes operate sessions specifically for older homeless people and those who have been resettled but still need support. Within 18 months, 70-80 older people were attending the sessions at *St Martin-in-the-Fields*. Although there are fewer clients at the other projects, there are regular attenders at all. The schemes enable designated workers to "seek out" older users, gain their trust, identify their problems and needs, help them utilise services, and to support them once they are rehoused. Some staff, however, feel that they are not trained to deal with the severe mental health problems and the unresolved stresses and traumas with which some older people present. They believe that specialist help is needed from trained psychiatrists and counsellors before such people can be effectively resettled.

6.4 Summary

There may be other equally imaginative, dedicated and effective schemes around the country as those described above. The enthusiasm, confidence and plain good sense of all who are connected with the described projects is infectious, and their early outcomes are encouraging. Nothing exceptional or mysterious needs to be provided. Rather it is chiefly a matter of realising that there is a substantial group of older homeless people who have considerable and specific needs, and responding accordingly. Largely they have not been helped, they are supine. Many can be resettled, but only with intensive, humane and long-term support. It is not that vast amounts of new provision are required - but there are many places that presently have none. In the final chapter, recommendations for the development of facilities and services are made.

Chapter 7

Recommendations

7.1 Introduction

This concluding chapter presents our recommendations for developing services and support for older homeless people.

The chapter first examines the issues strategically, and then sets out in detail the services which are needed and how these can be developed. For the needs of older homeless people to be addressed, a raised awareness of their circumstances and the effectiveness of various interventions and services would be helpful. As this report has pointed out, older homeless people are often isolated and unassertive: neither individually nor collectively will *they* make known their needs. Another problem is that the idiosyncratic behaviours and complex problems of some make this a difficult group to help. But whatever the special difficulties of supporting these older people, the fact that many have been homeless intermittently or consistently for many years should not be tolerated. The innovatory schemes in Britain show clearly that prolonged and persistent case-management work which is appropriate does succeed in resettling people in conventional settings.

The Government's and the welfare profession's response to homelessness has developed rapidly in recent years, and there have been many positive innovations. We are no longer satisfied merely to contain rough sleepers and vagrants, to "park" them in minimum cost, demeaning and barrack-like hostels. Increasingly it is recognised that people living on the streets often have psychological and social problems of long standing, and that these can only be ameliorated by intensive, personalised and sustained assessment and support. There is increasing professional and financial support for the provision of various forms of special needs, supported and shared housing. The difficulty to date has been that the problem of homelessness has been too strongly focused on the plight of young people. There are many compelling reasons to resettle and rehabilitate those who become homeless at the start of their lives, but the needs of older people are no less important and they must also be considered.

7.2 Age-Related Needs and Provision

The "generational gap" in attitudes, habits and behaviours is no less evident among homeless people than it is for the population as a whole. It is therefore not surprising if hostels and day centres thronged with adolescents provide uncomfortable settings for people who are perhaps three times their age. As we have shown, many older homeless people are withdrawn, passive and isolated: many deliberately shun the services which are available.

The primary recommendation is therefore that special facilities are made available for the older (and middle-aged) homeless person. It is not suggested that rigid age limits are applied for defining eligibility, nor that the guiding principle is to provide supplementary or better provision on the grounds of age. "Older" in this application principally contrasts the needs of mature adults against those of adolescents and very young adults, mainly in terms of the settings in which contacts are first made and support and advice is provided. It also hints at the likely incompatibility, added difficulties or ineffectiveness of facilities which attempt to serve all ages. The distinctive facilities and out-reach teams that are recommended would from time to time appropriately help people in the forties, and many clients will probably be aged in their fifties or older.

7.3 Prevention

Action should be taken at all levels to prevent people becoming homeless. Public policy-makers must be sensitive to the issue and guard against measures which would directly or indirectly exacerbate homelessness. It is important that statutory providers take responsibility for the care and resettlement of all single homeless people in priority need. This requirement needs to be incorporated into the Community Care and Mental Health Acts. Statutory, voluntary and health service workers need to be aware of the triggers to homelessness, to be able to identify and support people who are in vulnerable situations, and to make appropriate cross-referrals for people at risk of homelessness. Furthermore, it must be a requirement that any training takes full account of the specific needs of older homeless people, and that appropriate services are developed which reach the target group.

This study has illustrated the pathways into homelessness and warns of various events which can trigger this problem. People who are vulnerable may become unsettled when they are faced with difficulties such as the breakdown of family and support networks, independent living, pressure from landlords in both the private and public sectors, and insecure or fragmented work patterns. The *Over 55's Accommodation Project* in Leeds (discussed in the previous chapter) has found that it is possible to prevent homelessness if it is recognised in time and appropriate action is taken.

From the histories of the older homeless people in this study, situations can be identified which may suggest that a person is vulnerable and about which agencies should pay heed. Attention should be given to people who are housed but:

- are subject to repeated physical abuse by their family or partner
- are expressing paranoid ideas about their neighbours and requesting accommodation moves
- lose a support network and are left alone
- are mentally ill or have alcohol-related problems and live alone
- suddenly stop paying their rent or mortgage, having been regular payers
- live alone, find difficulty with coping at home, and repeatedly have rent arrears or default with paying bills
- leave tied accommodation or an institution and have never lived alone
- frequently present at casualty departments, social services, or housing departments with mental health and social problems.
- have previously experienced homelessness.

7.4 Single Homeless Strategy - Giving Attention to the Needs of Older Homeless People

Before services for older homeless people are funded and established, there should be, as part of an assessment of all single homeless people, an intensive assessment of the needs of this client group in a city or town. This should gauge the extent of the problem, the availability and effectiveness of current services, and the distinct needs of local older homeless people. If a need for services is identified, local organisations with a good record of effective intervention should be encouraged to develop plans.

There is a strong case for this strategy to be developed through consortia, comprising voluntary and statutory organisations. Its terms of reference and responsibilities would be (a) to monitor the problems and needs of homeless people; and (b) to promote high quality and effective service responses.

In relation to older homeless people important tasks would be:

- to encourage the development of an effective and well-connected range of services that provide a continuum of contacts and support from out-reach teams, open-access drop-in centres through supported housing and the monitoring of clients recently resettled in conventional housing;
- to promote information exchange and efficient cross-referrals among housing, health and personal social service organisations;
- to offer advice on the staffing and costing of projects;
- to encourage the dissemination of models of good practice;
- to develop and disseminate training programmes and assessment tools for the staff who work with older homeless people;
- to commission experimental and demonstration projects and related evaluations and research;
- to contribute to generalised evaluations of the effectiveness of individual resettlement programmes and social rehabilitation and
- whether supported with Government or charitable funds, to provide independent advice to the Department of Environment and the Department of Health on policies for older homeless people.

7.5 Recommended Services for Older Homeless People

There need to be specialised and intensive assessments and programmes of support to help older homeless people to be resettled and remain housed. It will not be easy, nor will it always be appropriate, to establish large facilities, and it will be difficult to avoid high capital and labour costs per client. Pilot and exploratory projects for older homeless people should be established and evaluated, so that the most effective services and methods of resettlement can be understood and implemented.

Specialist out-reach and counselling workers

There need to be specialist out-reach workers, with experience of psychiatry and counselling, to work with older homeless people. In areas where there are large concentrations of older homeless people, there is a case for designated workers to work specifically with this client group. Their role would be (a) to seek out and assess the needs of isolated older homeless people on the streets and refer to appropriate services, (b) to provide counselling and intensive support to clients on the streets and at day centres, and (c) to develop a rehabilitation and resettlement package of care and support.

Resettlement projects

In a town or city with a substantial number of older people who become or are at risk of becoming homeless, a well-funded and professionally staffed resettlement project with a designated worker specifically for older homeless people is invaluable. The aims of the project would be:

- to resettle older homeless people who sleep rough and who are in local hostels;
- to support those who are vulnerable and at risk of becoming homeless; and
- to arrange long-term support for and to monitor those who have been rehoused through the project.

Successful models have been described in this report. A project could be jointly developed between the local authority housing department and an experienced local homelessness organisation. It would normally be established first as a pilot scheme (for a minimum of two years), evaluated throughout, and continued if a continuing need was manifest and its services were proved to be effective.

Supported accommodation

It is recommended that supported accommodation be made available for older homeless people who are unable to manage in independent tenancies. The available accommodation should include independent housing with support at home, shared housing schemes, and small high-care group homes for those with severe mental health problems. Most placements in the supported housing (particularly the first categories) should be seen as temporary, and assessments, rehabilitation programmes and resettlement work by experienced staff should aim to rehouse the older people into less supported accommodation.

Direct-access as an interim form of support

Direct-access accommodation should be available as an *interim measure* for older homeless people who shun resettlement programmes and are not ready to be rehoused. Once an older person is accessing a hostel, intensive support should be undertaken to encourage resettlement. Because many older homeless people refuse to access services which are dominated by younger homeless people, it is recommended that some hostels should provide accommodation specifically for older people, for example those aged 50 years and over. In each large city, one direct-access hostel could, at modest cost, be converted to provide services exclusively for older homeless people who will not use the existing provision.

7.6 Training

Training on the needs and characteristics of this vulnerable group is absolutely vital within organisations connected with the problem of older homelessness. As the report repeatedly makes clear, older homeless people are difficult to reach, and it is vital that staff at all levels are motivated to make contact and deal effectively with individuals in this group. In order that older homeless people are not ignored, it must be a requirement that statutory providers recognise the needs of older homeless people and that this requirement is included within training programmes. Older homeless people do not come forward voluntarily: staff must learn how to identify those who are vulnerable to homelessness, and seek out those who have become homeless.

There needs to be carefully structured training and support for the hostel staff working with older homeless people who are mentally ill, heavy drinkers and disruptive (and who have been banned from existing hostels). It is possible that a collaborative scheme could be established between a housing association and a NHS mental health trust to provide psychiatric input into the hostel.

7.7 Improved understanding and further research

There is little known about older homeless people in Britain. There needs to be:

- Increased understanding of the reasons why older people become homeless, the ways in which older people at risk of becoming homeless can be identified, and services and interventions which are effective in preventing homelessness.
- Increased awareness of the extent of older homelessness in British towns, cities, and rural areas, and improved enumeration of older homeless people which include single unofficial, as well as statutorily-defined, homeless people. It is essential that we have as accurate a picture of the problem as possible if we are to be able to plan services and monitor their effectiveness. Statistics should be collated on older homeless people in hostels, at day centres, and with whom out-reach teams are in contact, and which give an indication of the extent of older homelessness in a particular location over time.

- Increased understanding of services which enable homeless people to be effectively resettled. There is a need for longitudinal information which monitors homeless people through time, and which explains the association between interventions, resettlement strategies, histories of homelessness, and personal difficulties and incompetencies.

To date, the needs of many older homeless people have been ignored. They have been “allowed” to live on the streets although they are mentally ill, and remain “parked” in temporary accommodation without being resettled. It is time that specialist services were developed to help these people resettle back into the community. This is long overdue.

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